DEVELOPMENT PAPER

Orphan and AIDS-program of the ELCT ND (OAPND)

Diacionical Department of ELCT ND

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CONTENT

PREFACE

Editorial

Abbreviations

ART =Anti-Retroviral Treatment

CBO = Community Based Organization

ELCT = Evangelical Lutheran Church of Tanzania

ELCT ND = Evangelical Lutheran Church of Tanzania Northern Diocese

FBO = Faith Based Organization

HIV = Human Immune-deficit Virus

HBC =Home Based Care

HuYaMwi = Huduma yaYatima Mwika (Orphan Ministry of the Lutheran Bible School Mwika)

KIWAKUKI= KIkundi cha WAnawake Kilimanjaro Kupambana na UKImwi

OAPND = Orphan and AIDS program of the ELCT ND

OI = Opportunistic Infections

PLHA = People Living with HIV/AIDS

PMTCT = Prevention of Mother-To-Child Transmission

LBS Mwika = Lutheran Bible School Mwika

NGO = Non Government Organizaiton

SIP = Small Income generating Projects

TACAIDS = TAnzania Commission for AIDS

TMAP = Tanzania Multi-sectoral AIDS Program

VCT = Voluntary Counseling and Testing

THE AREA OF SERVICE

Statistics and epidemiological data

Geographical description

The ELCT Northern Diocese is divided in five districts:

1. Kilimanjaro East (headquarter: Himo)
2. Kilimanjaro Middle (headquarter: Moshi)
3. Hai
4. Siha (headquarter: Sanya Juu)
5. Karatu

The headquarter of the diocese itself is located in Moshi. The diocese is represented by 151 parishes.

Relation to the political region of Kilimanjaro

The districts Kilimanjaro East and Middle, Hai and Siha are located within the Kilimanjaro Region. There is some correlation between the political councils and the church districts.

POLITICAL COUNCIL	CHURCH DISTRICT	DIOCESE
Siha council	Siha district	ELCT ND
Hai council	Hai district	ELCT ND
Moshi urban council	Kilimanjaro Middle	ELCT ND
Moshi rural council	Kilimanjaro Middle+ Kilimanjaro East	ELCT ND
Rombo council	Kilimanjaro East	ELCT ND
Mwanga council	Kilimanjaro East	ELCT ND
Same council		ELCT Pare

Therefore general data comparison between statistics of the governmental and church authorities is possible, however a detailed analysis is difficult as there is no full overlapping of the political and church areas.

The total population living in the overlapping district is estimated by the government for 2006 as follows:[1]

COUNCIL	POPULATION
Hai and Siha	279.381
Rombo	259.869
Moshi rural	419.423
Mwanga	120.000
Moshi urban	160.841
Total	1.239.514

Population of the diocese

The diocese has the following number of Christians: [2]

GROUP	
Adults	162.624
Children	153.508
Total	316.132

In some rural areas the population is almost 100% Lutheran, for example in East Kilimanjaro. So measures passed by ELCT ND will reach almost 100% of the population. In other mainly urban areas there is a mixture of different religions and denominations.

There are approximately 12.000 Lutheran Christians in the Karatu district of the ELCT ND. To give a rough estimate this figure must be deducted from the number of all Christians (316.132-12.000= 304.132) to get a comparable figure. This means 304.132 people in the above mentioned population (1.239.514) in the overlapping council are Lutherans. A percentage of **24,53%**. This means the ELCT ND represents almost a quarter of the population.

General epidemiological data

Of course there is a lot of epidemiological data available from different sources:

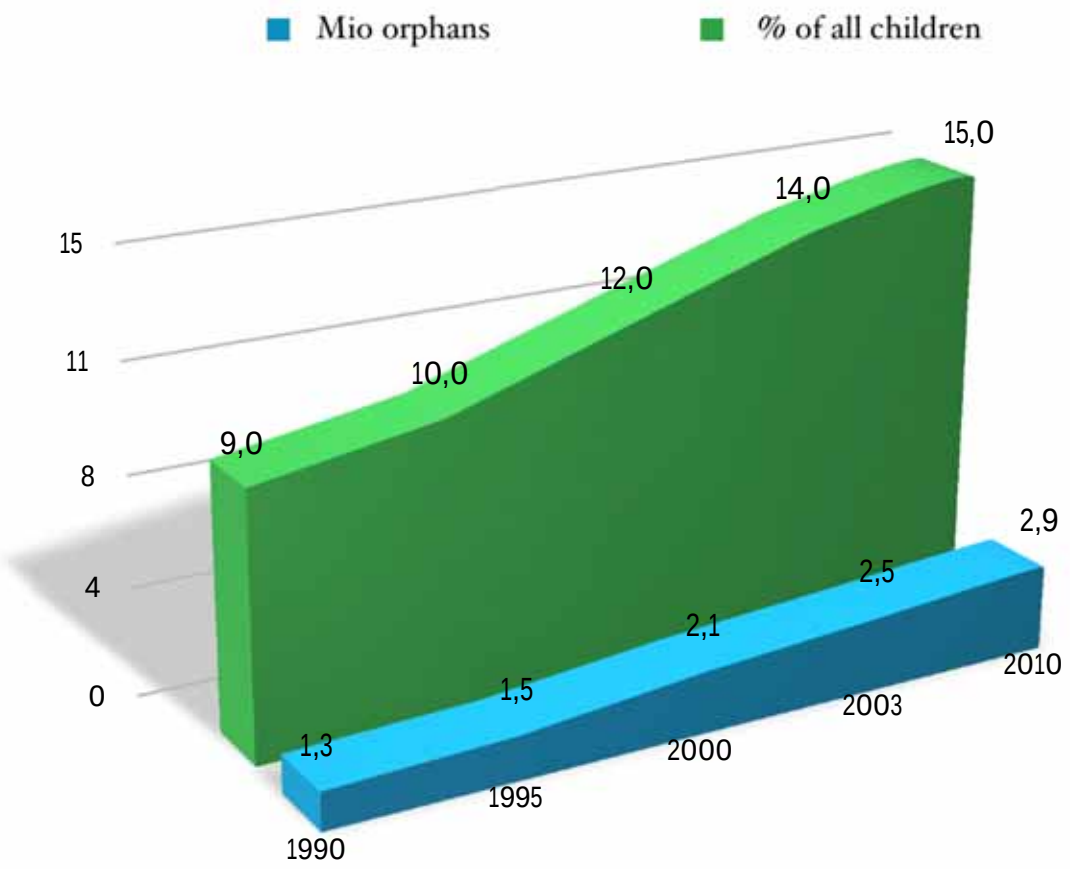
„According to the Joint United Nations Program on HIV/AIDS (UNAIDS) the country had 1.3 million adults and children living with HIV/AIDS, 1,100,000 chil-

[1] See United Rebublic of Tanzania, Kilimanjaro Region Socio-Economic Abstract, p.2.

[2] See KKKT Kalenda 2006, p. 24.

dren orphaned by HIV/AIDS, 140,000 HIV/AIDS deaths and an adult HIV prevalence of 8.09% in 2000. In 2002, the national adult HIV prevalence was 7.8% and 1.5 million adults and children were living with HIV/AIDS. 30% of pregnant women pass HIV to their babies during pregnancy, delivery and 10% through breast-feeding. Out of the 1.6 million babies born annually, 89,856 are infected with HIV before their second birthday."[3]

The UNICEF paper „children on the brink" (2003) is giving the following summary about the number of orphans in Tanzania:



So for 2003 the paper is estimating a total number of 2,5 Mio orphans, equal to 14% of children.

The Tanzanian Atlas of HIV/AIDS indicators is giving a figure of 11% orphans for the end of 2004, the Kilimanjaro region is categorized between 12,1% and 13,9%[4]

3 WCC: The church confronted with the problem of HIV/AIDS

4 TACAIDS, Tanzanian Atlas, p. 28.

The Kilimanjaro region reports a prevalence rate of 7,3% in 2004, which is slightly below the nations average.[5] The average of orphans in the region was counted in the general censor of 2002 with only 0,98%. But this is definitely to low.[6]

The prevalence rate will give us an imagination, about the number of people living with HIV/AIDS (PLHAs):

CATCHMENT AREA	POPULATION	PLHAs
ELCT ND (2005)	321.562	23.795
Kilimajaro Region (2002)	1.376.702	100.499

About 15% of the population have ever received an HIV-test (Kilimanjaro region 15,4%-19,8%).[7]

Nevertheless all of this overall data can be helpful for comparison. In the following pages I will present data we have collected ourselves in order to get a clear picture of the problems in our catchment area.

Statistics and researches of HuYaMwi[8]

So far we have only our own data about orphans. We are counting all children between 0-18 years who have lost one or two parents as orphans, not regarding the cause of their parents death. This is in compliance with the Tanzanian policy on orphans.[9] Generally it is difficult to count the number of real AIDS-orphans, as AIDS is still stigmatized and is therefore not reported as the official cause of death. UNICEF estimated that almost half of all orphans are AIDS-orphans.[10] So roughly orphans can also be used as an indicator for deaths caused by AIDS.

If you count 1000 orphans, half of them are estimated to be AIDS -orphans (500). The average household size is calculated with 4,6 persons.[11] This means, that there is at least an average of 3 children in every family. 500 AIDS orphans indicate, that

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[5] See United Republic of Tanzania, Kilimanjaro Region Socio-Economic Abstract, p.20.

[6] Source quoted, p. 35. May be full orphans have been counted only. The bases of this study are only children between 0-14 years.

[7] TACAIDS, Atlas on HIV indicatoirs, p. 26.

[8] Compare: HuYaMwi, report 2003-2006, p. 11-14.

[9] See United Republic of Tanzania, Mwongozo na Mikakati ya Huduma kwa Watoto Yatima, p. 1.

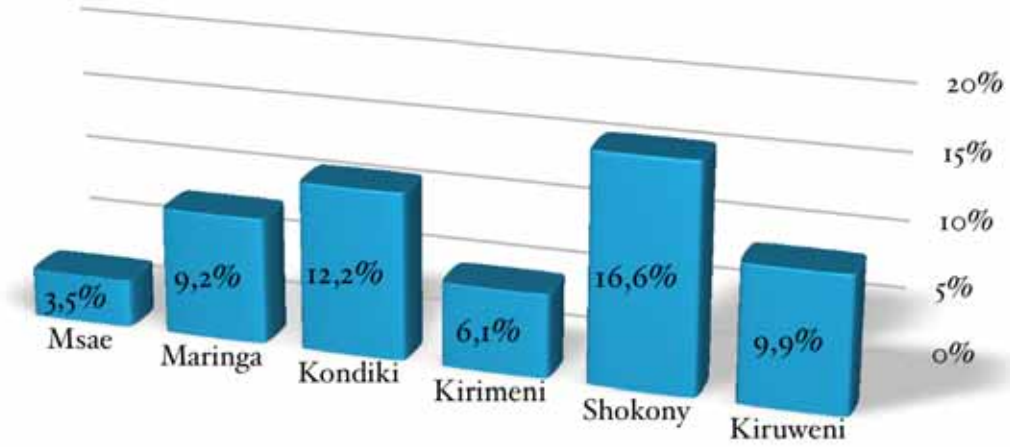
[10] See UNICEF, Children on the brink (2002), p. 28. For Tanzania a figure of 54% AIDS-orphan is estimated. The update in 2004 contains no estimate.

[11] See United Republic of Tanzania, Kilimanjaro Region Socio-Economic Abstract, p..2.

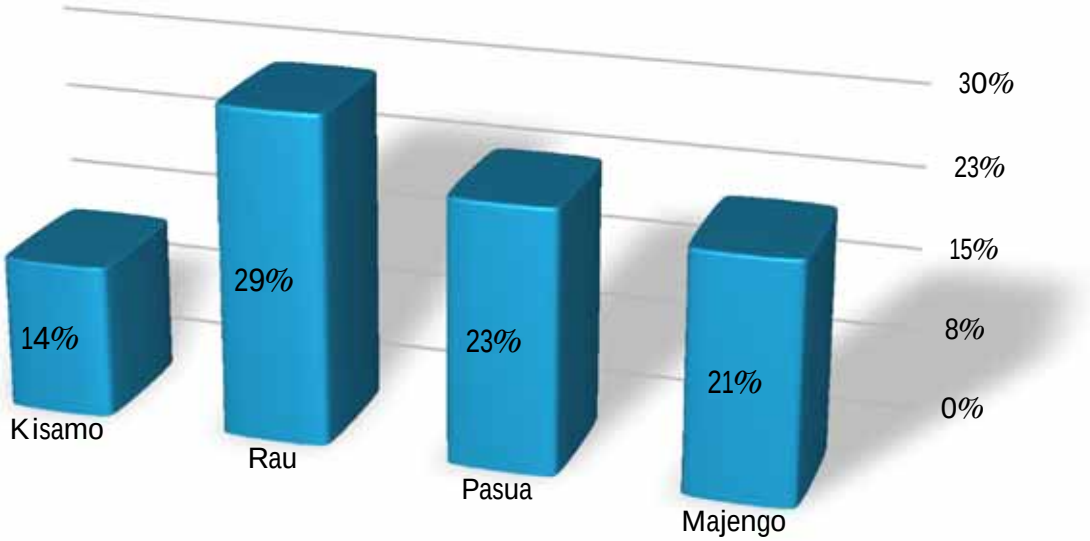
there are 166 families who lost at least one parent because of AIDS. Estimating that 25% of orphans are full orphan only (see below) we must add 25% to the number of families to get the real number of death case, which is then 207. This means **1000 counted orphans** indicate almost **200 death cases** due to AIDS, a ratio of 0,2.

NUMBER OF ORPHANS

Our statistic from 2006[12] using our advanced registry method ("Counterbook") is counting 2339 orphans in 16 congregations using a base of 18938 children and 15858 adults. There is an average percentage of 12,4% of all children between 0-18 years. This is still below the estimate of UNICEF in 2003 (see above).



Percentage of orphans in Mwika rural area



[12] See HuYaMwi, Handbook paper 10.

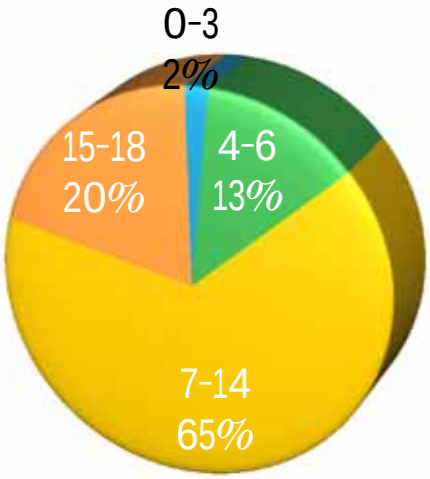
Percentage of orphans in Moshi urban area

The two charts above are showing the difference between the rural and urban area.

Our studies in 2003 have revealed the infrastructure of this huge amount. We counted almost 25% of them as full orphans[13]

AGE GROUPS

The division of age groups is as follows:



Distribution of orphans to age groups

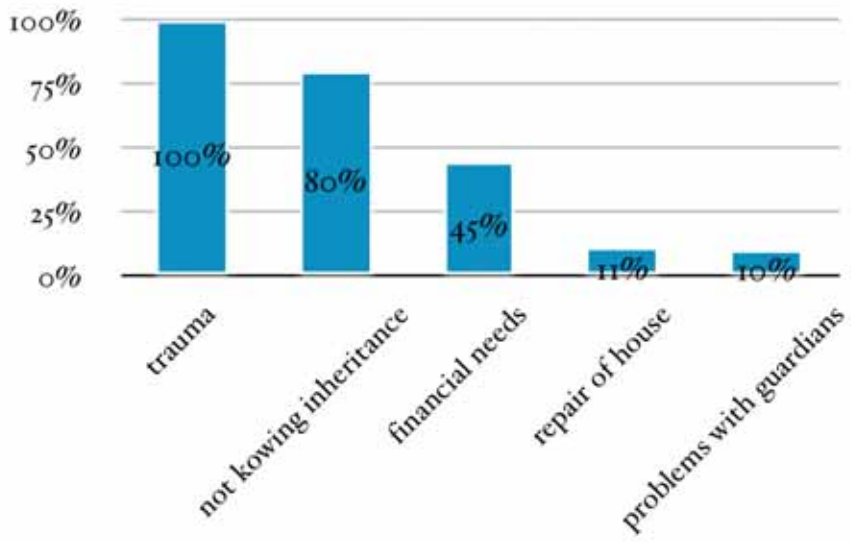
This means that the biggest part of the target group is still visiting the primary school and is still kept by a social net. On the other hand almost 20% have left primary school and are missing in many cases further education.

NEEDS

Our studies in 2004[14]estimated the appearance of different needs amongst all orphans:

[13] See HuYaMwi, Handbook paper 5.

[14] See HuYAMwi, Handbook paper 5.



The study revealed, that psychological and legal problems may effect even more orphans than financial needs.

In 2006 using our counter book registry, we clustered the orphans in groups of different needs:

This means 70% of all orphans are in need of financial help.

44% can be helped with small annual contribution for school- uniforms, stationaries, food, mainly identical with the age group from 7-14 attending primary school.

21% need a long term plan either for education, repair of houses or to start income generating projects. Most of them may be identical with the age group 15 to 18 (20%), who are need of further education.

5% are worst cased in need of urgent actions.

Summary

The data can be used to estimate the total number of Lutheran orphans in our diocese: Using the number of all children in the diocese (see above) and the researched percentage of 12,4% of orphans, we will expect almost 19.000 Lutheran orphans in our diocese.

CATCH-MET AREA	CHILDREN	12,4% ORPHANS	20% DEATH CASES DUE TO AIDS
ELCT ND (2006)	153.508	19.034	3.806
Kilimanjaro region (2002)	591.981	73.405	14.681

Data from the five districts

Also our five districts have collected some data:

DISTRICT	ORPHANS	WIDOWS
Kilimanjaro East		
Kilimanjaro Middle	2343	2022
Hai	2741	1834
Siha	1890	
Karatu		
Total	6974	3856

Data from our hospitals

As all three of our hospitals are performing VCT and are participating in the program of the government to provide retroviral drugs, we can use some data from our hospitals.

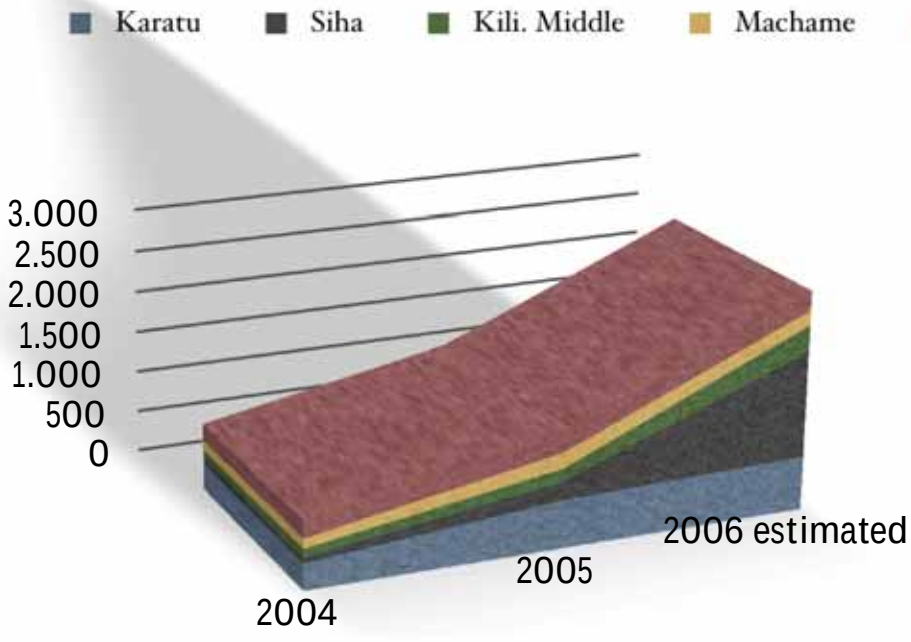
The table is showing the of annual treated PLHAs in different health services from January to August 2006 :[15]

[15] I tried to standardize the available data. However as drawn from different source the data may not be fully homogenous. For example the demarcation line between adults and children.

HOSPITAL/ AREA	MALE	FEMALE	CHIL-DREN	TOTAL
Karatu hospital	160	238	22	420
Siha	305	450	83	838
Kilimanjaro East	105	103		208
Machame hospital	61	33	24	118
Marangu hospital	39	112		151
Total	670	936	129	1735
%	38,62%	53,95%	7,44%	

To estimate the workload, I quote the statistic of the VCT-centre Marangu: They received a total number of 1344 patients, from which 151 patient were positive.

The following chart is showing the growth of annual treated PLHAs from 2004 until the end of 2006 (estimated):



THE FRAMEWORK OF RESPONSE

Short evaluation of services outside of the ELCT ND

Introduction

The ELCT ND is not the only organization providing HIV/AIDS related services. I tried to get some relevant data from governmental and non governmental authorities. However the data collection is difficult and I am still waiting for more response. Meanwhile I quote from a report from Mulonzya (2003) [16] and a research done by Lyamuya in the Kilimanjaro East district (2003)[17].

The Tanzanian governmental authorities

RESPONSES TO AIDS/HIV

Generally it is stated, that the United Republic of Tanzania is having a good and advanced AIDS policy and program[18], summarized by Mulonzya (2003):

„A national policy on HIV/AIDS/STDs was put into effect in 1995 by the government with the goal of mobilizing and sensitizing the community to get actively involved in preventing further transmission of HIV and to cope with the social and economic consequences of AIDS. Specifically, the policy aims to: increase the community's awareness of HIV/AIDS and its consequences through information, education, and communication, prevent further transmission of HIV/AIDS through the use of such preventive measures as safer sex, testing, and counseling, provide infected persons and their caregivers with appropriate social, medical, physical, and spiritual support through the existing health care system and through home based care, safeguard the rights and interests of infected persons by preventing discrimination in relation to employment, housing, treatment, travel, education, and other social services, support and promote research activities geared to strengthening the national efforts toward control and prevention of HIV/AIDS/STDs, safeguard the rights of the community as a whole against infection with HIV/AIDS/STDs, define and coordinate the roles of different players involved in AIDS control and prevention and create a national institutional framework that

[16] WCC, The church confronted with the problem of HIV/AIDS.

[17] Lyamuya, The ministry of the Church to the HIV/AIDS orphans.

[18] Compare also the different policy and guidelines mentioned on the source page.

will coordinate the mobilization of financial, human, and material resources for AIDS prevention and control.

The national policy on HIV/AIDS/STDs stipulates that HIV/AIDS patients receive the same level of care as other patients and counseling is expected to be a basic component in the care of HIV/AIDS patients. The government encourages home based care, where patients can be cared for and nursed by family members, although effective mechanisms to ensure home based care are yet to be put in place. The policy also enumerates specific strategies for prevention of HIV/AIDS, including activities targeted to groups involved in high risk behavior, although cultural, religious, and political factors have precluded significant government supported activities directed to these groups."[19]

However Mulonzya is seeing also the following obstacles:

„According to the strategic framework the country's national response to HIV/AIDS faces the following obstacles: lack of trained personnel and training manuals for a management of sexually transmitted diseases, irregularity in the supply of drugs against sexually transmitted diseases and a total lack of female condoms, difficulty in reaching highly mobile populations with HIV/AIDS prevention and education messages, difficulty in approaching sex workers with condoms and HIV/AIDS education materials due to stigmatization and governmental denial of the reality of commercial sex work, lack of libraries in Tanzanian schools making it difficult to make HIV/AIDS education materials available to students, shortage of drugs to treat opportunistic infections, lack of qualified counsellors to provide care and support to persons living with HIV/AIDS and widespread acceptance of multiple sex partnerships"

Meanwhile the government has started to give out retroviral drugs free of charge to all who meet the required criteria. The positive outcome of this measure may be:

1. Reduction of the costs to treat opportunistic disease.
2. An addition of life expectancy of people living with AIDS of at least five years.
3. Reduction of stigma as AIDS is not longer a disease causing death.
4. People will be more ready for voluntary testing and counseling
5. As result of this, even a drop of the prevalence rate may be possible.

[19] See: WCC , The church confronted with the problem of HIV/AIDS .

However there may be still some obstacles, which may prevent these positive prognoses. First of all there are some reasons within the health system of Tanzania. [20]

1. A growing number of treated AIDS-patients will increase the need of drugs, of testing capacities and of trained personal. It was even reported to me, that for some weeks there was only one CD4-cells testing machine running in the area of Moshi, because the otherones were in need of service by specialists from South Africa.

2. Not only the management of the growing quantity of patients might be a problem, but the application of retroviral drugs at low medical standards. It can cause the virus to get resistant very early towards the available drugs. The same effect is already seen in the common application of antibiotics: where as European physicians are more and more reluctant to prescribe antibiotics to avoid resistances. In Tanzania even a small cold is treated with antibiotics.

At the moment the governmental health-program is running well at high quality level, but there is still a lot of capacity available to care even for more patients. For example the current prescription interval may be expanded from one month to three months.

A second issue is the local availability of this treatment.

1. For good reasons the treatment is still limited to larger hospitals to keep the standards high. However a lot of patients need to travel once a month to attend the clinic and receive their monthly dose. For a lot of poor patients, especially widows, it‘s a problem to get the small cash to pay the bus fare.

2. In some cases VCT is free of charge, in other case there is still the need to pay 1500-3000 Tsh.[21]

3. The other preliminary examinations(eg. CT4 count) are not yet free of charge, which may costs about 10.000 Tsh per patient.

4. Also some patients will not have funds to buy drugs to treat opportunistic diseases.

5. Other patients have not even the information about the possibility of the treatment, because they are illiterate, not connected to any radio or TV-service and because of stigmatization the neighborhood is not talking about AIDS-issues.

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[20] I got the following considerations during a conversations with representatives of „St Egidio“, who are providing quality AIDS-treatment in a lot of African countries.

[21] In Marangu hospital testing adults is free of charge, children need to pay 1500 Tsh, as Anganza is not supporting testing of children due to their policy

RESPONSES TO THE ORPHAN CRISIS

Even one year before the AIDS policy, the government released a policy of orphans in 1994. Lyamuya is writing in his master thesis about this policy:[22]

„In order to handle the issue of the problems of orphans effectively, the government through its Ministry of Works and Youth Development – The Department of Social Welfare, set some guidelines and strategies for all those who render services to the orphans. The need to have the guidelines and strategies was due to the rise of the death toll of parents who died of various reasons, AIDS being the main cause.

Just like other children in the society, orphans have equal rights to get good care. In order to survive, these children need some help from the society they are living in. It is therefore the responsibility of everybody in the society to take care of these desolate children. It is from this point of view that the government has prepared the guidelines and strategies for the rearing of the orphaned children of this country. The preparation of the document took into consideration the common understanding of the main issues among those who would be engaged in the whole exercise of taking care of the orphans. The document does not deal with a special kind of orphans. It is meant for all kinds of orphans. In its definition it states that an orphaned child is not more than 18 years old, whose parents, or one parent, have died. The cause of death is not a question.(...)

In order to render good service to the orphans, the government identified committees to deal with orphans at different levels, from grassroots to the national level, and their responsibilities and roles. (...)“

The guidelines then describe the duties of each level starting from the family, the sub-village / village, the ward/district etc. up to the national government level.

In the paper Lyamuya documents how difficult it is to implement this policy in reality. In a letter by the Commissioner of Education on the 6th of May 1999 it was ordered: „ NB. Pupils who are orphans (whose father and mother are dead) and whose orphanhood have been confirmed by the headteacher and the school committee, should not be subjected to any contribution – and this includes UPE fees Tsh. 2000/=“

Contrary to this official order we experience up to now (2006) that orphans are sent home from primary school because of not paying their school contributions. We discussed this issue with a headmaster. He insisted on this practice, because otherwise he would not be abel to run his school, as the government is not paying for the missing contribution of the orphans.

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[22] Lyamuya, The ministry of the church to the HIV/AIDS orphans.

In 2003, the government moved a step further to help the orphans. The government decided to subsidize school fees and some basic needs for some form-one-students coming from poor families who cannot pay for their school fees and afford for their needs. Those who are lucky will receive Tsh.180,000/=. The amount will be divided into two parts. Tsh.100,000/= will be sent to their respective headmaster or headmistress for school fees and other contributions and the remaining Tsh.80,000/= will be given to the student to help him/her to buy things like school uniforms and some school material. Some of it will also be for his/her pocket money.[23]

On the basis of our experience we know that only a few orphans get benefits from this program and there are many more, who qualify for governmental secondary education than there will be helped by the government. For example a headmaster asked us to pay only half of the school fees for five orphans in order to keep them at school. The remaining half would be contributed by the school itself.

Lyamuya summary: „As far as the government is concerned, the study revealed that only the sector of education has done something clearly to help the orphans. Although there is still a long way to go, but at least something has been done."

Generally the situation did not change since the research of Rev. Lyamuya in 2003. The main reason why the policy on orphans from 1994 is not yet fully implemented is, that orphans still have almost no share financially and physically in the governmental authorities of different levels. Therefore it is necessary, that the orphans may organize themselves to found an „orphan government", which will make a follow up of orphan's rights.[24]

The work of non-governmental organizations

Since the 18th and 19th century it is obvious, that the modern state can not deal with all welfare issues, but must rely on NGOs and FBOs.

Therefore also national Tanzanian AIDS-program started to involve NGOs: „ A review of the national program in preparation for the second medium term plan for 1992-1996 revealed the need to further decentralize planning, decision making and activities in order to improve responsiveness and regional propriateness of the program. The second medium-term plan (MTP II), therefore, strongly advocated for a horizontal multi-sectoral program implementation structure to engage institutions

[23] Compare Lyamuya.

[24] Reference, 10/3/114.

both within and outside the Ministry of Health, including the full involvement of non governmental organisations."[25]

Today there is a countless number of different NGOs dealing with AIDS and orphans beyond the possibility to evaluate their work in this paper. All NGOs are registered by the government and normally the Council Commissioner is receiving an quarterly report of each NGO. However the government is not allowed to share this data to the public, neither the government has really the opportunity to coordinate and harmonize the work of the different NGOs. The government can only direct needy people to the respective NGOs.[26]

KIWAKUKI

Mulonzya is giving the following summary of KIWAKUKI.

„ KIkundi cha WAnawake Kilimanjaro Kupambana na UKImwi (KIWAKKUKI) (Kilimanjaro Women's Group Against AIDS) was started as an ad hoc response of women in the town of Moshi to the AIDS crisis in the Kilimanjaro region of Tanzania. The first AIDS case in the region was reported in 1984 and since then more than 6,000 cases have been reported in a population of one million people. Widespread denial of the existence of HIV/AIDS within the local communities and society at large and the inability to cope with the burden of caring for the sick and dying and their dependants drew the organisation's attention.

The organization was founded in 1990 as a membership organization for women who sought to respond to AIDS especially in addressing the issues affecting women and education for HIV/AIDS prevention and to restore the dignity, self respect, and purpose to the lives of individuals and families affected by AIDS. The organization gives health education on HIV/AIDS prevention to empower the infected and affected make informed decisions, determines early diagnosis and treats opportunistic infections. The target is the youth, peer groups, villages and places of work.

Sensitization of people living with HIV/AIDS about positive living is also facilitated through the training of appropriate community based counsellors and educators. Home based care and counseling accompanies the health education program. Material support, school sponsorship and ideas for income generation are also provided to the infected and affected.

Daily education sessions using video, puppet theatre and group discussion are carried out in the organization's Moshi-AIDS-Information-Centre. One-to-one counseling and education by volunteers is also carried out in the centre. The organiza-

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[25] WCC, The church confronted with the problem of HIV/AIDS.

[26] Reference, 10/3/114.

tion also holds monthly meetings for reporting and education, runs seminars about HIV/AIDS in schools, workplaces and community groups, carries out home visits to offer care and support to the infected and affected, offers material assistance to people living with HIV/AIDS, their families and children orphaned by HIV/AIDS and runs the Centre of Hope-a support centre initiated by people living with HIV/AIDS in the organization to learn skills, income generating activities, counseling and medical care.

The organization relies on voluntarism of its members in all its programs. The organization's community outreach program involves counsellors and home based care providers. Counseling focuses on the reduction of stigma and home based care entails home visits and care and support for people living with HIV/AIDS.

The organization has embarked on a major expansion out of Moshi town and has involved community based organizations in the establishment of branches, many of them are based in churches and mosques. By 1998, the organization had established ten branches with a membership of over five hundred women from all walks of life. This has been followed by capacity building for the branches and the establishment of the 'centre of hope' that also serves as a forum for group counseling to people living with HIV/AIDS and also for sharing issues affecting them.

The organization is also involved in the support of children orphaned by HIV/AIDS. A process of orphan identification and support started in earnest in 1999 and has since helped over 2000 children orphaned by HIV/AIDS in their education, vocational training and meeting their basic needs. The organization also runs a school health program that uses peer educators to reach the fellow youth. In the program, it uses drama and young artists who use songs, poems, and puppets in awareness creation on HIV/AIDS.

The organization has benefited from support of the government and religious leaders and is in the process of exploring collaboration with traditional healers. It works in collaboration with Terres des Hommes in the orphan support program and has also worked with Youth Alive Tanzania in life skills training of young people that focuses on behavior change and the inculcation of positive living and values in life.

The organization is confident that its expansion leading to the creation of over 32 grassroot branches has assisted a lot in achieving its objectives. The centre of hope that caters for people living with HIV/AIDS has also witnessed an increase in membership from 5 in 1990 to 50 in 2001. The membership in the organization has also increased from 8 to 1,300. The orphan support program has also revived the hope of many young people orphaned by HIV/AIDS. There is also evidence of increased awareness on HIV/AIDS, increased number of people seeking voluntary counseling and testing services in the target population. The organization does not sell or distribute condoms but calls for informed decisions in their use.

Among the challenges the organization faces in its work is, that it meets the increasing demands for services that has over-stretched the limited staff, it deals with volunteers who are getting burned out and sustaining programs and it is also involving the community in the ownership of the programs such as home based care and training at the local ward level of home based care givers. The organization seeks in future to put more emphasis on children and youth in the HIV/AIDS programs, to have the communities participating fully in the programs and to reduce its role only to monitoring, to get feedback from the community and meeting emerging needs and giving refresher courses to community volunteers. The organization is also seeking to hand over the education program to the communities and is engaged in the training of peer educators and community based counsellors.

It is the organization's feeling that after a decade's work with a community it is imperative to hand over the running of most of the programs to the community especially those who involve it directly.

The organization is a member of the AIDS NGOs Network in East Africa, the AIDS NGOs Network in Tanzania, the Kilimanjaro AIDS NGOs Cluster and the Moshi Urban AIDS NGOs Cluster. The organization works in collaboration with the government, musicians, Rainbow centre-a Roman Catholic HIV/AIDS service centre in voluntary counseling and testing, Youth Alive Tanzania, the Muslim community and churches in its target area. A partnership with the Evangelical Lutheran Church of Tanzania has seen the organization uses the church's parishes in its community outreach programs and in the provision of primary health care.

The organization underscores the need for research on the role of polygamy in the spread of HIV/AIDS, and the nature of HIV prevalence in monogamous and polygamous families and the prevalence rates among the two groups and the coping strategies adopted by the different families. The organization also seeks to see the development of information, education and communication materials including posters, newsletters and leaflets on home based care, the truth about HIV/AIDS and the truth about condoms. It plans to publish a manual on home based care for local ward information centers. This is accompanied by the lobbying of district leaders and ward councillors for support in the work of volunteer community health workers and the inclusion of HIV/AIDS as a priority agenda in the local/district development committees."

Instead of these marvelous picture, we receive also other reports:

1. A lot of local KIWAKUKI leaders, especially in the rural area reported, that they are receiving almost no funds from the mother organization. This fact was also confirmed by a KIWAKUKI official in Moshi.[27]

[27] Reference, 10/3/88.

2. An other issue is the handling of scholarships. We have some reports, that scholarships have been promised to orphans, but later these promises have not been fulfilled. Or scholarships have been stopped immediately with the argument, that the sponsor has withdrawn his commitment.

The response of faith based organizations (FBO)

THE ELCT IN GENERAL

Again I quote the summary of Mulonzya:[28]:

„The Evangelical Lutheran Church of Tanzania has 20 dioceses and a membership of more than 3 million faithful people in the country. The church runs 20 hospitals and over 120 health centers and dispensaries all over the country and contributes to over 13% of total health services in the country. The church's public health care/ HIV/AIDS control program was established in 1986 to spearhead the diocesan efforts to fight HIV/AIDS and control its impact. The impact of the epidemic is severe and has led the church to declare HIV/AIDS as a mission issue in capacity building.

The church now realizes that with no cure in place, education on preventive methods must be a top priority. A special committee oversees the implementation of the HIV/AIDS program. Much of the work is carried out by volunteers, who include pastors and evangelists trained on HIV/AIDS.

The church seeks in its HIV/AIDS program to share the love of Jesus Christ in word and deed with those suffering from the disease and their families. Therefore the church educates, cares for, counsels and motivates the target population for the prevention of HIV/AIDS. The church has developed a teacher's handbook for teaching HIV/AIDS in primary schools and provides psychosocial support, home visits, hospital visits, medical care and support and nutritional advice to people living with and affected by HIV/AIDS. It is also involved in advocacy for the respect of the human rights of people living with and affected by HIV/AIDS. It uses its healthcare centers, hospitals, and clinics in the provision of voluntary counselling and testing and other HIV/AIDS services. The staff in the health institutions participate in HIV/AIDS awareness raising in their respective areas. The church also supports people living with HIV/AIDS and children orphaned by HIV/AIDS depending on availability of funds. Minimal support for food, clothing and school fees is provided.

[28] WCC, The church confronted with the problem of HIV/AIDS.

The ministry of the North Western Diocese especially in Kagera towards children orphaned by HIV/AIDS and women widowed by HIV/AIDS has been quite successful.

The church plans to increase education and training opportunities for the HIV/AIDS program staff, pastors, evangelists and its health institution's medical personnel in order to strengthen the HIV/AIDS program. It is also promoting ethical discussions on how to avoid the spread of the HIV infection in the society and seeks to integrate information about HIV/AIDS into theological and christian education for children, youth and adults. It also underscores the importance of documenting and disseminating information and statistical data in order to increase the ability of social partners to address the pandemic in an all-round manner economically, socially and politically.

The church is in the process of reviving its HIV/AIDS program, and is engaged in developing a policy with regards to HIV/AIDS and a strategic plan. It collaborates closely with the ministry of health and an ecumenical umbrella organization, the Christian Social Services Commission.

At Regional level the church works closely with a regional network on health financing in eastern and southern Africa."

Summary

1. There is a big difference between written policies and the already reached implementation down to the grass-root level. For example the Tanzanian government, as well as the ELCT have written very good policies about AIDS and orphans, but the implementation is lacking due to funds or other organizational reasons.

2. There might be a incline of service between highly reached areas (mainly the urban areas) and almost „forgotten" areas (mainly rural areas). People living in an urban area have better access to information (internet, libraries), to medical services (hospitals) and to governmental authorities. Most of the NGOs have, for the same reasons, their headquarters located in the urban area. But to reach a large urban area is expensive, if you are not locating office close to the people.

3. This report shows already a lot of activities and there might be many more. The society, the church is responding, a good sign. However the danger of duplicated services is increasing with the number of involved NGOs or departments and precious resources will be wasted. The need of cooperation and coordination is high.

PRESENT SERVICES OF THE ELCT ND

Oral interviews with head of departments and project leaders

Hospitals and dispensaries[29]

The ELCT is running three hospitals in Karatu, Machame and Marangu. All three of them are now participating in the governmental AIDS-program and are providing voluntary testing and counseling.

However even if a lot of materials, seminars and funds are available from the government, the church, running these hospitals, must secure a high level of medical support in this places.

1. CD4-cells -testing machines will be only provided to governmental district hospitals. Even if the investment and running costs for these machines are high, it must be considered carefully, whether church hospitals will need to run these machines themselves in order to maintain a quick and effective ministry to AIDS/HIV patients.

2. In order to maintain a good service to a growing number of patients, the hospitals need to recruit new personnel or to train the existing staff, especially in counseling[30]. The measures of the government providing a two week seminar may not be sufficient to cover all needs of training: For example: The voluntary testing in the Machame and Marangu hospital is right now performed by AMREF/ANGAZA. Limited by their policy these NGOs are not providing counseling to children below sixteen. So the hospitals need to look for trained counselors for children.

3. The government is not yet providing free medication to treat the opportunistic diseases. So there might be the case, that patient may qualify to receive free ARV but will die, because they have not enough money to treat TB.

The same problems will occur if the government will expand AIDS/HIV treatments to the dispensaries. The 24 dispensaries run by the ELCT ND are presently not staffed and equipped properly to cope with this task.

Additional the hospitals and dispensaries need to improve save blood transmissions and the treatment of sexual transmitted diseases.

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[29] Reference, 10/3/74 health department,10/3/95 Marangu Angaza, 10/3/96 Marangu Hosptial

[30] According to my interview in Marangu, the government is not longer supporting the training of counselors, but has left this to different NGOs.

The idea of Home Based Care is present, but so fare I have no report of an existing larger program.[31]

The basic health education program[32]

There are basic health care committees in almost every congregation of the diocese (approx. 141 from 151). There are almost 4682 trained health educators.[33] So far the program seems to be well established in the diocese. However there are some shortcomings weakening the program:

1. As the diocese is not able to pay any kind of reimbursement a lot of the trained committee members are running over to NGOs, who have the fund to pay honoraria.
2. The program was designed to educated about basic health issues, but not to provide medical or material support. Therefor there are no funds to even provide simple medical support.
3. Due to AIDS the local committees have expanded their responsibilities beyond the possibility to work effectively. The district committee reported to try to handle the following tasks:
   - Proper construction of houses and toilettes.
   - Proper food and save water.
   - Vaccinations.
   - Nature conservation.
   - Family planning.
   - Agriculture.
   - AIDS prevention.
   - Care for orphans and AIDS-victims.

Instead there had been a lot of seminars in the recent years the issue of home based care has not yet been taught sufficiently. And therefore this might be a theme for training in 2007.

Generally the ministry needs to be reshaped to work effectively:

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[31] There has been started a small program from Marangu hospital by Dr. Hartung (ELCT headquarter) but it is hospital based not community based.

[32] Reference, 10/3/74.

[33] KKKT, Kalenda 2006, page 25.

1. To narrow down the goals of the ministry to health issues in order to work effectively.
2. To provide more training in this respective area to get more and better „specialists".
3. To move from volunteers to semiprofessional workers, who will work for one or two days a week receiving a small reimbursement.[34]

Department of education

PRE-SCHOOL [35]

The diocese is running 110[36] primary schools using mainly the Montessori system of education. There are lessons about basic health issues, but there are so far no subjects especially about AIDS in the syllabus.

SUNDAY-SCHOOLS

Almost every congregation is inviting children for sunday-school. So far no lesson has been introduced about AIDS/HIV.

CONFIRMATION CLASSES

The diocese reported to have 11.494 children attending confirmation classes in 2005[37]. Since 2001 at least one 45 min period during the two year program is recommend to be about AIDS / HIV. A revision of the syllabus by the ELCT is in progress and there are some suggestions to extend the teaching about AIDS. However classroom lecture will be not enough to achieve persistent behavior change. So other methods like group discussions separated into gender groups or drama must be introduced. Generally a luck of sophisticated material (video, booklets, poster) is reported.

Even young adults may be trained in home based care during confirmation classes.

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[34] However even if we pay 10.000 to a male and 10.000 to female health consultant in each congregation per month, we will need a budget of 38 Tsh. Mio a year.

[35] Reference, 10/3/92.

[36] KKKT, Kalenda 2006, p. 25.

[37] KKKT, Kalenda 2006, p. 24.

SECONDARY SCHOOLS AND VOCATIONAL TRAINING[38]

There was a seminar on the 26th of April 2006 gathering reports from all 14 secondary schools run by the ELCT ND[39]. The reports show, that in almost every school the recommendation of the national AIDS-policy are implemented to have counseling facilities and available info-resources about AIDS/HIV.

However to maintain this service the department needs to make follow ups and to provide annual seminars for the school counsellors.

A special problem is the growing number of orphans, who do not need material support only, but also counseling.

The department has already started a scholarship-program for 30 pupils funded by Southwood/Nebraska.

An other meeting of all principals is scheduled for the 9.1.2007.

BIBLE STUDY GROUPS[40]

The diocese is having many local bible study groups. Normally they are using a booklet prepared by the department of education of the ELCT ND. This booklet is also going to be adopted by the whole ELCT.

So fare there are no special themes about AIDS/HIV in this booklet covering 2006/2007. But it would be possible to print an appendix covering up to twelve optional lessons concerning these issues.

FURTHER EDUCATION AND STAFF DEVELOPMENT

The big need for further education and staff development.

So it would be helpful to prepare a one week compulsory training for all **pastors** of the diocese concerning AIDS-issues, especially counseling.

Under the supervision of the pastor **evangelists** and **parish-workers** are doing the major parochial work, e.g. home visit and counseling. As they mainly have to be trained for word service (e.g preaching and teaching) or domestic services (cooking

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[38] Reference, 10/3/78.

[39] ELCT ND, HIV/AIDS Strategic plan workshop[for secondary schools] 26.4-28.4.2006.

[40] Reference, 10/3/92.

and tailoring) they need an update to be able to cope with the burden to care for orphans and PLHAs.[41]

Youth department[42]

The department has reached from January to August 2006 approx. the following number of young people by different measures:

MEASURE	PARTICIPANTS	@	TOTAL
Easter conference	1.250	1	1.250
Week with the bishop	300	1	300
Seminars in congregations	100	12	1.200
Seminars at schools	800	8	6.400
Total			9.150

This means, that the department is reaching out to at least 10.000 young people per year. 15% of the seminar expenses are paid by the department, the remaining 85% are paid by the young people themselves.

The department applied to receive money from TACAIDS to conduct 40 seminars (five in each district), but so far no response have been seen.[43]

Normally each measure contains a separate teaching about HIV/AIDS (120 min), but the issue is addressed also together with other themes.

Especially before a large audience consisting of different age groups the department is reluctant to talk about the use of condoms, to avoid the misunderstanding, that the church generally allows the use of condoms. There is the fear, that a simplified understanding of the use of condoms would promote early sexual intercourse with changing partners amongst young unmarried people, which is of course one of the main reason of the fast spread of the HI-Virus.

[41] Reference, 10/3/93.

[42] Reference, 10/3/109.

[43] The application was turned in in November 2005, with a project some of about 4 Mio Tsh.

Women's department[44]

In 2005 and 2006 almost all parish-worker and leader of women-groups were participating in seminars about stigmatization.

In November 2006 the department is planning an other one-day-seminar in all districts with three participants from each congregation concerning stigma-reduction. Of course a one-day-seminar can not really deal with all aspects of the issue, but it helps to sensitize leaders of women-groups throughout the diocese.

There are presently 80 parish workers employed by congregations, but more are even dormant, because they stopped working for different reasons. The department wishes to reintegrate these dormant human resources into the working process, as there is a big need to care for orphans and elderly people. The main problem however is, who will pay the additional costs for those church workers.

If funds will be available in 2007 the department is planing to prepare a six weeks long seminar for parish-workers about nursing and home based care. This can be done in cooperation with the training offered by HuYaMwi.

So far there is no measure to reach young girls.

Department of projects and development

THE LIVESTOCK PROJECT[45]

Since 1991 the project has distributed the following livestock:[46]

KIND OF LIVESTOCK	NUMBER OF ANIMALS
cattle	139
goats	89
chicken	440
beehives	20
fish pools	6

A total number of 1256 person was benefiting of this program. The aim of this measure is to help poor people to start income generating projects, including orphans, widows and PLHAs.

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44 Reference, 10/3/73 and 10/3/110.

45 Reference 10/3/108.

46 Report delivered: ELCT ND, Halmashauri Kuu 198.

People receiving livestock will be trained with different measures, especially on a two week lasting seminar at Tengera covering basic AIDS-issues also.

This program has an annual budget of approx. 7000$ for livestock and education, mainly sponsored by HEIFER Project international.

So far the coordinator Rev. Mchange is working almost alone to run and monitor these projects. Therefore there is the urgent need to install the following positions:

1. A project counselor in each congregation.
2. A livestock-expert in each sub-district (HEIFER will pay 33% of his/her wage).
3. A project coordinator in each district.

THE ELCT ND DEVELOPMENT FUND[47]

The goals of this fund are,

1. to provide food to poor people,
2. to raise education,
3. to save the natural environment and
4. to get new land for poor people and to enable them to settle down.

The final resources of this fund will be contributed by Christians of the ELCT ND and external donors. Although the target group of this fund are only poor people in general, money from this fund may be later used to contribute to OAPND.

The orphan ministry of the LBS mwika (HuYaMwi)

The Lutheran Bible School Mwika is located in an area highly affected by AIDS/HIV. One of the main effects is the increase of orphans. Many of the local Dshagga tribe are working as officers, teachers or engineers in all places of Tanzania. When they are about to die of AIDS they come back to be buried at the place of their birth and also to leave their abandoned children with their grand parents or other relatives of the extended family. Close to the bible school we have Lutheran parishes, which have between 100 and 300 orphans to take care of. And still people continue to die.

In 2003 the former principal Rev. Dr. F. Shoo (now assistant to the bishop of the ELCT Northern Diocese) and the Bavarian missionary Rev. Dr. M. Burkhardt founded the Orphan Ministry Mwika (HuYaMwi) as a department of the Lutheran Bible School Mwika. As an institution of education the Bible school wants to fulfill

[47] Reference, 10/3/112.

its responsibilities towards the society to handle the orphan crisis. The main objective of our ministry is therefore to raise awareness about this problem in the society and to train different groups of people concerning the ministry of orphans (caretakers, church workers etc.)

However to maintain this service faithfully, the LBS Mwika itself needed to go to the field and so we started to cooperated in 2003 with four pilot-parishes. This number was expanded up to sixteen in 2006. In these congregations there are aprox. 2200 orphans.[48]

Orphanages and orphan centers.

The Kalali orphan centre of the Ushirika wa Neema

In 2006 the Lutheran sisters of Usharika wa Neema started an orphanage in Kalali. The centre will accept only orphans between 0-3 years, selected by governmental authorities. The final capacity is about 100 children. On the same premises the sisters are also planning to start a nursing school in order to provide qualified staff for nursing and child care.

Due to sponsors in Germany and to the agricultural work of the sisters the centre seems to be well funded. However as the centre will mainly receive orphans directly from the government the ELCT ND will not benefit directly from this institution.

The Rafilk-village

Until March 2007 the „Rafiki Foundation“ will open its training village near Moshi (close to Machema road). „These villages are funded by donors outside Africa and staffed by Rafiki professional missionary staff and hired nationals. A „Rafiki Training Village“ consists out of 16 homes for 10 orphans each (total 160), schools for these orphans, three-year vocational training, day schools for 60 vulnerable teenage girls and 60 boys, medical care for occupants, and facilities for training other groups to replicate Rafiki's efforts.“[49]

Later Rafiki is planning to plant smaller satellite villages to reach out to a larger area, even outside of the ELCT ND. In the MOU between Rafiki and the ELCT ND[50] promises to run the main centre for fifteen years.(until 2019) Satellite villages are at least funded for five years.

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[48] See HuYaMwi, report 2003-2006.

[49] Source: website of Rafiki.

[50] ELCT ND, Memorandum of understanding..

As the final procedure of receiving orphans has not been announced nor the number of orphans who will be received from the ELCT, the final impact for the ELCT ND can not yet be estimated.

The Kilanya orphan centre

In May 2006 the congregation of Kilanya (district Hai, near Lyamungo) has started to construct an orphanage with a final capacity of 100 beds. This project is funded by the Faith-Network located in Flagstaff, Arizona.

Up to now, the responsible congregation has not yet presented a project write up. Also the necessary permissions from the government have not yet been asked for.

As the sponsors have only promised to fund the construction, presently there is no money available to start service. The sponsors promised to try to raise 20$ per month and child, but this will be not enough to run the centre.

Fuka Orphan and Vulnerable Children Centre.

The congregation of Fuka (Siha district) has started a small centre mainly providing free vocational training to some orphans and gathering orphans twice a month on Sunday afternoons.

Diaconical department

Rev. Urassa, who was the head of department until his death in September 2003, started a lot of different activities, for example the Amani-Center for street children in Moshi (meanwhile taken over from an other NGO). In his last year he was working on new guidelines for diaconic ministries in the ELCT. Until October 2005 the chair was vacant, until Rev. M. Burkhardt was called to be the new diaconical secretary of the ELCT ND.

Building on the thoughts of Rev. Urassa, the diaconical department was able to pass new diaconical guidelines for the ELCT ND through the Executive Committee in March 2006. The main thought is to build a separate diaconical infrastructure with committees and functioning budgets on all levels (parish/district/diocese), as the respective existing medical committees (see above section on basic health education) seem to be overloaded in the times of AIDS. At least one diaconical professional should be installed in each district.

The implementation of these guidelines has already started. Until the end of 2006 we will have committees in almost all parishes and districts and district coordinators for diaconical work in at least three districts. Until 2009 there is a plan for continuous training for the members of these committees.

Considering the huge number of orphans the department launched an other program: „The orphan and AIDS-program of the ELCT ND“ whose basic guidelines have already been passed by the Executive Committee in August 2006. This program will set up the infrastructure of a sub-autonomous entity of diocese governed by separate board. The five districts and HuYaMwi are invited to be founding members in order to start an area covering ministry to orphans and AIDS victims. Other institutions like the above mentioned orphan centers are invited to be co-opted members.

The program will mainly adopt the already functioning method and guidelines of HuYaMwi in order to maintain high standards of service.

After approval of the board members by the Executive Committee in November 2006 the program can take of on the 1.1.2007 opening regional offices in all cooperating districts. In the beginning the program will use the new existing diaconical infrastructure, e.g. the diaconical coordinators of the districts will function as district program coordinators.

Summary and final evaluation

The ELCT ND is aware of the problem and has already started a lot of different responses. Mainly all of these responses are welcomed and have a good intension. However we must see the following short comings:

1. There is a luck of funds to implement all good ideas.
2. There is a big need of coordination to avoid duplication even within the ELCT ND between -
   - 2.1. -the different departments of the headquarter;
   - 2.2. -the headquarter and the districts;
   - 2.3. -the headquarter and the different centers;
   - 2.4. -the different branches of the diocese and NGOs.
3. So far there is no master plan to develop and organize the different activities systematically.

The already objected „Orphan and AIDS program of the ELCT ND“ will improve many of these obstacles.

1. It will look for funds
2. It will coordinate the different efforts of the diocese concerning orphans and AIDS.

2.1. Between the different departments on the diocesan level by setting up a central office and board.

2.2. Between the different departments on the district level by calling a district program coordinator.

3. It will set up a master-plan, which will be proposed in this paper.

4. It will bring the service close to the people even in distant areas by implementing regional offices at district level and using the already implemented infrastructure of diaconical committees on the parish level.

HIV/AIDS AND THE CHURCH

Challenges and possible responses

A socio-historical approach

In the beginning I want to state my main thesis: **HIV/AIDS can be seen as a positive challenge to the society and to the church to develop itself.**

Why is AIDS/HIV so much spreading in sub Sahara Africa? - You may quote, because of poverty, low education, reluctant development and much more. However the so called developed countries faced a lot of crises during their history of development. For example:

1. The thirty-year-long war from 1618-1648 AD killing almost 1/3 of the population in Germany which caused a deep desire for religious unity beyond the limits of denomination which later forwarded the period of enlightenment.

2. The big plague also called the „black death" caused 25 Mio causalities in Europe from 1347-1352 AD. Until the 19th century it threatened Europe in several epidemics. The shock of the first outbreak influenced the spiritual history of Europe and caused a deep religious desire for eternal life and salvation still seen in the life of Martin Luther.[51]

Nevertheless the reasons for these crises are negative ones, e.g. a war or a epidemic, the caused crisis's however can be considered to have positive effects on the society itself, and especially the victims of these crises are are a challenge for the society's love and compassion.

So Martin Luther himself adviced to assist the dying victims of the plague. „From Luther we can learn, that the church, the government, the society and family have a major role to play, not only in the caring of the people living with HIV/AIDS, but also in educating and training people on the need to prevent the spread of the disease. The need remains to love and help the infected and affected (...)"[52]

So we can narrow even down the main thesis: **Not only the orphans need the help of the society, but also the society needs to deal with the orphans in order to develop itself.** Each society needs constant consideration about its own foundation. Social responsibility and social engagement are still the fundaments

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[51] The so called „devotio moderna" a religious tradition in which also Martin Luther was brought up originated in the event of the „Black death" Compare Philip Mc.Nair Seeds of Renewal. In: The history of Christianity, p. 352.365, especially p. 353 „during the 15th century Europe can be considered as a death oriented society"

[52] So Scriba, Marin Luther's reaction to the ravishing plague, p.8

upon each human society is build. The orphan crisis as well as the AIDS-pandemic will challenge the society to develop and enlarge this fundaments. To marginalize the orphan crisis, e. g. sending orphans to orphanages or leaving them in the hands of professional caretakers, will extinguish these great chances of development. Orphans as well as AIDS must be a public issue.

This even in compliance with the teaching of the apostle Paul in 1 Cor. 12,22-26: „On the contrary, the members of the body that seem to be weaker are indispensable, and those members of the body that we think less honorable we clothe with greater honor, and our less respectable members are treated with greater respect; whereas our more respectable members do not need this. But God has so arranged the body, giving the greater honor to the inferior member, that there may be no dissension within the body, but the members may have the same care for one another. If one member suffers, all suffer together with it; if one member is honored, all rejoice together with it.“

In this scripture Paul is using an old metaphor for a well functioning society, saying that in a community, those who seem to be useless or a burden have also their specific function. Paul is even saying that God has arranged this way to cause mutual care for each other in order to prevent distention within the body. In other words: The weaker members are there to teach us how to love, the essential glue of every society or community.

HIV/AIDS as a challenge for the church‘s theology

GODS LOVE AND COMPASSION FOR ALL PEOPLE

First of all there is no theological reason not loving PLHAs, because God‘s love has no limits, like we read in Matthew 5,45: „so that you may be children of your Father in heaven; for he makes his sun rise on the evil and on the good, and sends rain on the righteous and on the unrighteous.“ So wether someone is infected by the virus by his personal fault or not, he or she is still loved by God and we are challenged to love him or her. Further more we read a lot of examples in the NT, how Jesus ministered in love especially to „sinners“, like prostitutes or tax collectors even sharing meals with them.

A more difficult question: Is the church allowed to condemn PLHAs? Even as sexual intercourse is considered as the main reason of HIV infection, a personal fault of a PLHAs is not always obvious,as the virus can also be transmitted during birth, due to unclean blood donation or as an accident during medical service injecting a used needle of a PLHA.

Also the virus can be transmitted during rape (a big problem in areas of wars) or in a morally undoubted sexual intercourse between married couple, where one partner is HIV+ and the other one HIV-.

So the simple conclusion; a PLHA is a sinner, is theologically not correct. And even if the PLHA would be a convicted sinner, he or she can confess his or her sin, and can receive God's full forgiveness and must be received again as a full brother and sister in Christ, because we all are only reprieved sinners and Jesus said in John 8,7: „Let anyone among you who is without sin be the first to throw a stone at her." And even stronger Math 7,1-2: „Do not judge, so that you may not be judged. For with the judgment you make you will be judged, and the measure you give will be the measure you get." So we must be carefully to condemn a PLHA, because even if the PLHA failed, we might be judged by God because we failed to love the PLHA and care for him or her.

STIGMATIZATION OF PLHAS

HIV related stigma is mainly caused by two reasons:

1. Lacking knowledge about the transmission of HIV leading to fear.
2. Values, norms and moral judgment causing prejudices[53].

As stigmatization is limiting the efforts of testing, treatment and prevention,[54] it must be a general concern in the fight against AIDS to reduce stigma.

The church must play an important role to reduce the fear of HIV by;

1. providing proper education about the transmission of HIV, as stated by the ELCT HIV/AIDS policy: „We will develop educational programs on the way how HIV is transmitted",
2. providing proper education and equipment how to care for PLHA, for example gloves[55],
3. avoiding all statements in sermons and messages increasing the fear,
4. teaching that „There is no fear in love, but perfect love casts out fear; for fear has to do with punishment, and whoever fears has not reached perfection in love." (1 John 4,18) A good example is Martin Luther himself who decided not to flee away from the plague, which is even more infectious than HIV.

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[53] See ICRW, HIV- related stigma, p. 15 ff.

[54] See source quoted, p. 33 ff.

[55] Compare: United Republic of Tanzania, Jinsi ya Kuhudumia Wagonjwa wa Ukimwi Nyumbani, p..11f.

The church of course must review its proclamation of moral standards, whether it is increasing or reducing stigmatization.

A main concern is the spiritual dimension of illness, especially in the African context. „Specific illnesses or sets of symptoms are associated with having broken one or more social prohibitions“.[56] Although this point of view is not unknown in the biblical context[57], it is rebuked by Jesus healing the blind man in John 9,2: „Neither this man nor his parents sinned; he was born blind so that God's works might be revealed in him.“

Theologically we will put us on the place of God, if we start discussing which PLHA deserves our comfort and treatment, because he or she is innocent and which PLHA must be excluded from our community and care, because he or she is guilty. So like Jesus we must finish this moral debate, stating that all PLHAs need God‘s love and mercy ministered by us to them. So also the ELCT HIV/AIDS policy formulates the objective: „We will teach that stigma and discrimination and that people living with HIV/AIDS and affected by the disease are invited and welcomed to our churches.“

ABC - PREVENTION

The ABC stands for three strategies in prevention and behavior change:

A= Abstinence

B= Be faithful

C= Condoms

The idea is to speak about three saving boots: „If life becomes dangerous or unbearable on board switch from one boat to another“. So if someone feels uncomfortable with one strategy he or she can switch to an other one. For example

- A wife is following the B-strategy, however if she has doubts about the faithfulness of her husband she must switch either to A or C.
- A young adolescent, who does not want to be abstinent, but has no idea about the HIV-status of his or her partner, must use C to minimize the risk.
- Someone who doe‘s not want to risk anything, may choose A or if he has no doubt about the faithfulness of his or her partner he may choose B.

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[56] See ICRW, HIV- related stigma, p.20.

[57] Compare for example the discussion of Job and his friends.

None of these strategies alone will grant to provide full AIDS-prevention [58]

1. The proclamation of abstinence alone will only delay sexual activity. Of course it is 100% effective if ‚used' with perfect consistency. But common sense suggest that in the real world, it can and does fail.[59]

2. The „be faithful" strategy gives no 100% security, because everyone can only grant for his or her own faithfulness, but never for the faithfulness of his or her partner. So even by following ‚B' you are able to be infected.[60]

3. The use of condoms grants also no security, as condoms generally guarantee no total protection against pregnancy and STI.[61] Low quality and wrong usage errors will even enlarge the risk.

So the basic idea of this ABC-strategy is, that everyone should choose the best method according to his life-stile and life circumstances in order to keep up at least a basic standard of prevention. Therefore all young people must be introduced also to all options.

They are good reasons to state, that Ugandas's success in reducing the prevalence rate may be caused amongst other measures by the ABC-strategy. [62]

	1988/9	1995
Prevalence	15% (1991)	5% (2001)
Median age of women having first sex	15,9 years	16,3 years
Premarital sex reported by men 14 to 24 years	60%	23%
Casual sex in the recent year among men	35%	15%
Casual sex in the recent year among women	16%	6%

[58] Compare Guttmacher report, lessons from Uganda.

[59] Compare Guttmacher report, understanding abstinence.

[60] Compare Guttmacher report, promoting the B' in ABC.

[61] Condoms heave a pearl-index of 3 - This means amongst 100 sexual active women whose parters using quality condoms properly as contraceptive method for one year, three women will get pregnant. Compare Guttmacher report, public health advocates say campaign to disparage condoms threatens STI prevention efforts.

[62] Compare Guttmacher report, lessons from Uganda. Additional data from articles out of AIDS and behavior.

	1988/9	1995
Condom used amongst unmarried women within the last four weeks	1%	14%
Condom used amongst unmarried men	2%	22%

Even if the final details are still discussed among experts[63], we must acknowledge that the combination of all three strategies will enlarge the prevention efforts, as one strategy alone will not grant full security.

Without any doubts the church can promote strategy A and B. As christian ethics state, that sexual intercourse is reserved for married couples only. With in a multi -sector-al frame work the church can still play an important role to promote the ABC strategy. Leaving the promotion of the C-strategy to NGOs or to the government.

This task split may work perfectly if all involved institutions honor the point of view of each other and will stop condemnations:

1. The church must accept, that the government (and other NGOs) are responsible to apply up to date methods of AIDS prevention, and of course the use of condoms is a method which will reduce the risk of infection.

2. The government (and other NGOs) must accept, that the church is mainly bound by the word of God promoting monogamous marriage, which will of course also reduce the spread of HIV.

The task split can be built on Martin Luthers teaching about the two realms, the political, where the government needs to maintain order and security and the spiritual where the church needs to proclaim the gospel and repentance.[64]

However the church can remain silent about the use of condoms, which is not even mentioned in the ELCT HIV/AIDS policy, which only states the objectives: „We will fulfill our teaching role on sex and sexuality“ and: „We will promote effective means of prevention, practice that saves lives, and behavior to minimize the risk of

[63] Compare the two articles in the „AIDS and behavior“journal.

[64] Compare for this problem: Makundi, the use of condoms. Sue Perry from WCC states:“FBOs are often tagged onto the end of a line of agencies as if to add to degree of inclusiveness and credibility to a program that claims universal consultation and collaboration. Funding for programs is often linked to the aspects of prevention that might be in conflict to the beliefs of the FBO. To put it more crudely: The dollars come wrapped in condoms“ (WWC, Responses of the Faith-Based Organisations)

infection.“ Somehow the church needs to develop a policy on the use of condoms, which may result in AB-strategy with a modified „C“ component:

1. Especially in premarital and marital counseling there must be a policy to use or not to use condoms:

   1.1. For family planning.

   1.2. In case that there are doubts about the faithfulness of one partner.

   1.3. In case one partner is HIV+.

2. On the last AIDS-world conference in Toronto a study was presented about a AB-strategy by John B Jemott: A group of 662 pupils from the USA were divided in two groups. They were educated using the ABC or the AB strategy. After two years they were asked, how many of them had sex at least once in this period.

	GROUP 1	GROUP 2
Prevention Strategy	ABC	AB
Had sex at least once in the year after prevention education	61%	48%

   2.1. In this case ABC means to put „C“ method into the syllabus and teach in details about the right use of condoms.

   2.2. AB means that condoms were only mentioned, if the pupils were asking. In this case however the educators were **not talking in a negative way** about condoms.

   2.3. Likewise the church may not promote condoms, but if we were asked especially by young people, we need to say something beyond a general condemnation of condoms.

3. The numbers of the study of Jemott, as well as the above mentioned numbers from Uganda show, that what ever method you use, there will be still a rest of young people staying not abstinent. Theologically we say, that we are living in a world under the conditions of sin. And we might still question, whether the 48% of Jemott, who received only education using the ‚AB‘ but engaged afterwards in sexual activity, used a condom to protect themselves? So a pure ‚AB‘ strategy will be not enough to save the lives of this 48%[65]

[65] Compare Guttman report, understanding abstinence.

THE CHALLENGES OF HIV TO DIFFERENT SECTORS OF THE CHURCH.

The different challenges of HIV/AIDS can be distributed to different departments. (Note the departments of women / youth are included into the education sector).

SECTOR	EDUCATION	MEDICAL	DIACONICAL
BASIC TASK	Prevention	Treatment	Social support
PROFESSION	Pastors, teachers, evangelists	Physicians, nurses	Deacons, social workers, parish workers
CHALLENGES	-To raise awareness concerning HIV/AIDS - To work towards behavior change	- To care for PLHAs at different clinical stages	- To mobilize the resource of the society to care for people afflicted with AIDS
METHODS	Sermons, liturgy, lessons, seminars	VCT ART HBC	- Awareness building - Advocacy and human rights - Development of self reliance
WORKING PLACE	Classroom, church buildings	Hospitals, dispensaries, home visits	The society

Where as the ELCT has been strong and teaching in preaching, also in treatment, the diaconcial department, featuring a holistic few has been neglected in many places. In the ELCT up to now and also in the ELCT ND until 2005 it has been united with the medical department.

In order to render a full service in the area of HIV/AIDS the church needs to have a strong diaconical department. And therefore the diaconical department was separated from the medical in the the ELCT ND in 2005.

THE FOUNDATION OF OAPND

Additional to the strengthening of the diaconical department, the ELCT ND will launch the „Orphan and AIDS Program of the ELCT ND“

As a program of the diaconical department it will mainly concentrate on social support implementing an area wide infrastructure in close cooperation with its institutional members.

MEMBER ORGANIZATION OF OAPND	LOCATION OF DISTRICT/ ZONE OFFICE	MINISTRY SUB/ZONE	COORDINATOR
Karatu district	Karatu	Karatu	Rev. Temba
Hai district	Hai	Hai 1	Deacon Barikeli
	Sufi	Hai 2	Deacon Mmari
	(Kilanya)	(Hai 3)	(Rev. Urrassa)
Siha district	Fuka	Siha	Rev. C. Munisi
Kilimanjaro Middle district	Moshi	Kilimanjaro Middle rural	?
ELCT ND head office / diaconical department	Moshi	Moshi urban area	Deacon Kaaya
Kilimanjaro East district	Himo	Kilimanjaro East except area of HuYaMwi	Sr. Esther Tango
LBS Mwika, HuYaMwi	Mwika	Specified area of pilot congregations	Deacon Mori.

It will, of course, not take over the responsibilities of the medical sector and the education sector. But according to the guidelines, OAPND will coordinate all efforts within the ELCT ND and will look for funds.

Therefore in the following chapter this master plan will also contain suggestions for the other two sectors in order to present one unique plan to respective sponsors. If money paid to OAPND will be channeled to other institution, OAPND needs of course to receive reports and needs to evaluate the use of the donated money, like suggested in the following proposals.

However OAPND is not a self-operating NGO within the ELCT ND taking over all responsibilities of prevention, medical care and social report. Its main goal is to

enable all within the church to contribute to the fight against AIDS and its related problems. This is visible by;

1. taking over the idea of the diaconical guidelines of the ELCT ND to built the ministry up from the grass-root-level;
2. seeing the church districts as equal responsible partners (joint-venture-model);
3. cooperating with all departments of the ELCT ND.

Why to support the ELCT ND in her fight against HIV/AIDS?

There are several good reasons to support the ELCT ND as a FBO.

1. Statistical reasons (hard facts)
    1.1. The ELCT ND is representing almost 25% of the population.
    1.2. The ELCT ND has an area wide functioning network (151 parishes) run by trained staff (pastors and evangelists).
    1.3. The ELCT ND and its departments are reaching a lot of people at different ages and occasions.
    1.4. The ELCT ND plays an important role in the public health sector.
    1.5. The ELCT ND has a large reservoir of volunteer, which can be mobilized.
2. Strategic reasons (soft facts)
    2.1. God's love and mercy is a big motivation for Christians to be engaged.
    2.2. Christian ethics can support the ‚A' and ‚B' in a prevention strategy.
    2.3. Christian ethics also help to prevent the misuse of funds.
    2.4. The church with its education, medical and diaconical department can fight against HIV/AIDS with an holistic approach.

Because of these hard and soft resources the church can play a very important role, it is even sometimes called „a sleeping giant".[66] Perry is summarizing: „The multilateral, bilateral agencies and donor/Initiatives have technical expertise, information, training capacity, programmes and the resources. FBOs have access to the people and commitment as an expression of their faith."[67]

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[66] Compare WCC, Responses of theFaith-Based Organisations HIV/AIDS.

[67] Source quoted.

However we must also see the limits:

The church is not there to fight against AIDS only. The network of the church is used to distribute and carry a lot more things, like Christian education, evangelism, church services etc. So **HIV/AIDS related services must included in the ordinary church life**.and not be added to existing programs.consuming available resources.

PREVENTION OF AIDS

Awareness raising and behavior change

Introduction

AWARENESS RAISING VS. BEHAVIOR CHANGE

The awareness of AIDS in Tanzania is high.

„According to the 1999 Tanzania reproductive and child health survey, close to 100% of Tanzanian adults had heard of AIDS-an increase from 76% in 1996. 80% of women know at least one of three methods of protecting themselves from HIV, and almost half knew all three methods. More than 70% of men and 56% of women knew that condoms provide protection from HIV. Although knowledge about HIV prevention has increased markedly in the last several years, condom use remains very low in Tanzania. Only 16% of women and 37% of men had ever used a condom, mostly for family planning purposes“[68]

According to the Tanzanian Atlas of HIV/AIDS indicators the Kilimanjaro region shows the following knowledge of HIV/AIDS. [69]

TYPE OF KNOWLEDGE	% OF POPULATION
Comprehensive Knowledge about HIV	30,7-38,3%
Rejecting Common Misconceptions about HIV/AIDS	58,6-68,8%
Knowledge about Mother to Child Transmission	14,3-17,1%
Knowledge about HIV Prevention	48,4-52,9%

So even if their might be some need of further detailed education, the main issue today is not awareness raising in the sense of attacking someone's attention to something.

This can even be done by some TV-or radio spots or newspapers, which already play a important role in the Kilimanjaro region, shown by already mentioned atlas.[70]

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[68] WCC, The church confronted with the problem of HIV/AIDS.

[69] TACAIDS, Tanzanian Atlas, p.20ff.

[70] Sources quoted, p.13 f.

SOURCE OF INFORMATION	% OF POPULSTION
Listen to the radio at least once a week	77,9-89,6%
Watch television at least once a week	22,5-34,1%
Read a Newspaper or magazin at least once a week	28,2-44,2%

. Of course to keep up the awareness, to remind some of something, especially of AIDS is useful and necessary, but it will only have its effect, if this person has already developed a deeper and solid attitude towards AIDS.

However to develop this kind of attitude it needs more efforts than to watch aTV-spot or even to attend an one-day seminar about AIDS. It needs to set up different approaches and measures to confront human beings with the reality of AIDS at different ages and different occasions, because human beings need to learn different strategies according to their age to prevent themselves of being infected and to cope with the situation to live in a environment shaped by the epidemic. We can even talk of an on going spiral of behavior change.[71]

THE CHURCH AND BEHAVIOR CHANGE

There are a lot of arguments, why the church must be enrolled in measures of behavior change.

1. The church has the same and even better chances **to reach people of different ages and different status**. For example the government is getting all children only during primary school and thereafter only selected ones at the governmental secondary schools. The church is reaching out to them at baptism, in sunday schools, preschools, confirmation classes, youth choirs and in different secondary schools and vocational training schools. The above mentioned data (see chapter about department of education of ELCT ND) shows that the diocese can reach a lot of young people at different ages.
2. Additional, the church has been the **specialist for behavior change** for the last two thousand years. The Greek word „Metanoia“ means to change thoughts, is translated today into the English word „repentance“, which even has some negative connotations today, but it does include also behavior change, because it includes a full turn around of our personality, including thoughts and behavior.
3. The church is usually addressing a lot of people at **different occasions and in many places**. There is generally no need of adding expensive seminar or outreaches consuming traveling and facilitation expenses. The church is already present in many villages with human and other important resources, like offices

[71] Compare Macfarlane Burnet Centre, Facilitating sustainable behavior change., especially p. 13.

or meeting facilities. So compared with the most NGOs the church can offer a cheaper and more effective service.

On the other hand, to be honest, there are also some obstacles and handicaps:

1. **Pastors and evangelists are very busy** because they are facing a lot of different challenges every day. They will not accept any additional work or responsibility, if they are not easy to be handled and quickly to be done.
2. Even if pastors and evangelist are well educated people, their **methodological ability** to cope with the special need of AIDS/HIV prevention and counseling is still poor.
3. Due to poor and unreflected theology many church workers **feel ashamed to talk about AIDS/HIV or related issues**.
4. There is a lot of good teaching and training material available in English to implement AIDS prevention in the ordinary church life, but the **translation in Swahili** is missing.[72]

The behavior change program of the ELCT ND

GOALS AND PRIORITIES

1. To implement or to improve behavior change measures into ordinary church life.
   - 1.1. Education sector
     - 1.1.1. Pre-school
     - 1.1.2. Sunday school
     - 1.1.3. Confirmation classes
     - 1.1.4. Bible studies
   - 1.2. Church service and liturgy sector: to introduce sermons and parts of the liturgy dealing with AIDS/HIV on the following occasions:
     - 1.2.1. Ordinary sunday services.
     - 1.2.2. Weddings.
     - 1.2.3. Funerals.
     - 1.2.4. Special liturgical occasions with in the liturgical calendar.

[72] Compare the material published by WCC on the source page.

2. As a second goal (with less priority) different departments can try to arrange special seminars to reinforce behavior change within different target groups.. Noting however that on the long run, these measures will need additional resources concerning funds and work force:

   2.1. Special seminars for women (Women's department).

   2.2. Special seminars for men (however so far we have no department of men's work in the ELCT ND, may be this can be taken over by the department of education).

   2.3. Special seminars for young people (Youth department).

   2.4. Sensitization seminars on different levels (parish /district/ diocese) reaching out to all stack-holders.

STRATEGIES

1. To ensure the availability of easy to handle education concepts and teaching aids by;

   1.1. making a regular survey of existing material in cooperation with other institution and churches,

   1.2. translating and localize existing material, if needed,

   1.3. duplicating needed material in sufficient number and at reasonable costs.

2. To train church workers (pastors, evangelists, parish-workers, teachers etc.) to use and to implement these education concepts (TOT= Training of teachers) by;

   2.1. giving them a basic medical knowledge about HIV/AIDS,

   2.2. giving them an up to date theological frame of reference to interpret and to deal with HIV/AIDS,

   2.3. training them in up to date methods (e.g group -work and counseling) to initiate behavior change at different occasions.

3. To prepare standard seminars for different target groups and occasions, which then may be conducted by ELCT ND departments or institutions.

4. To support the founding of local groups dealing with different aspects of AIDS (for example peer-group education)

IMPLEMENTATION (ACTION PLAN)

Survey of existing materials

1. Select one office for data collection (for example LBS Mwika, department of education ELCT ND or central office of Orphan and AIDS-program of ELCT ND)
2. All departments and institutions should work together to suggest or to hint existing materials.
3. Additional data can be collected by internet researches.
4. The collecting office will pre-survey the collecting material and will transfer the results to a joint committee, which will make the final decisions (see number two).

Preparation of teaching concepts and teaching aids.

1. All departments and institutions of education will be welcomed for a joint committee, which will take the following decisions:
    1.1. The decision about the needed material and needed teaching aids.
    1.2. The decision about the needed translation and localization of this material and who is going to do it.
    1.3. The decision about the quantity of copies of the respective materials.
2. The central office of the Orphans and AIDS-program ELCT ND will then be responsible for;
    2.1. making the budget for production and distribution of this material,
    2.2. raising the needed funds,
    2.3. supervising the production of the material,
    2.4. distributing the materials to the different departments, districts and institutions.

Training Of Trainers (TOT)

1. The LBS Mwika, HuYaMwi will be the central institution to conduct seminars for trainers.
2. Target groups

PROFESSION	NUMBER
pastors	236
evangelists (approx.)	500

PROFESSION	NUMBER
parish-workers	80
total	816

3. Days of required training

   3.1. We think that all of the above mentioned professions will need at least a one week training, with the following content:

DAYS	CONTENT	METHODS
1	medical foundation	class room lecture and group discussion
1	theological foundation	class room lecture and group discussion
1	implementation of behavior change into ordinary church life	workshops for different topics: liturgy, sunday school etc.
1	up to date methods of behavior change	class room lecture and workshops
1	counseling	class room lecture and workshops

   3.2. If possible a follow up seminar should be planed after one or two years.

4. Within the next three years all church workers of the ELCT ND must participate at least at an one week seminar described above.

5. Sample budget for basic seminar for pastors

Days per seminar	5
All TOT ELCT ND	816
Total seminar days	4080
Cost per day Tsh	10.000,00
Total Tsh	40.800.000,00
Project period in years	4,00
Annual Expenses Tsh	10.200.000,00

Integration of other departments of the ELCT ND.

1. Each department of the ELCT ND should identify their unique target groups for education measures.

1.1. Final beneficiaries of the department (e.g. young people for the youth department, women for the women's department).

1.2. „Trainers" with in their target group who qualify for TOT -measures (e.g. leader of respective local church groups).

2. Each department of the ELCT is responsible to ensure, that sufficient education is supplied to their respective target groups.

2.1. *Either* by conducting seminars themselves within their annual plan of activities;

2.2. *Or* by placing clients into the central TOT -program (see above).

3. Each department will prepare an annual plan of required seminars and the needed funds to conduct these seminars and will present it to the Orphan and AIDS program ELCT ND which will;

3.1. harmonize the different measures in order to avoid duplication,

3.2. supervise the quality of the proposed measures,

3.3. try to look for needed funds either from its central budget or from the the budget of the district offices of the ministry.

E V A L U A T I O N

1. The completion of the action plan will be shown by regular narrative reports which will be prepared by the central office of the ELCT ND Orphan and AIDS-program, collecting report data from executing departments and institutions.

2. The ability of trainers can be tested by written, oral or practical examination. Additional a system of long term supervision will be installed to maintain a high standard of teaching. The supervision of trainers in the field will be organized by the district program coordinators of the Orphan and AIDS-program ELCT ND.

3. To measure the results of behavior change the central office of the Orphan and AIDS program of the ELCT ND will conduct regularly researches to evaluate different measures by using secret questionnaires.

MEDICAL CARE

Testing, treatment and counseling

Introduction

After the implementation of free medication for most people suffering from AIDS by the Tanzanian government the situation in this sector seems to be less hopeless than only a few years ago. Also VCT is now available in most region, even free or at low costs.

However generally the church is responsible in three areas to provide medical care.

1. As the church is the owner and facilitator of different hospitals and dispensaries, the church needs to secure, that the service to PLHAs is running smoothly and at the required standards.
2. Home Based Care and Counseling (HBC) is seen as an up to date method to care for a large number of AIDS patients to avoid an overcrowding of the hospitals.
3. As an institution of justice, the church needs to secure, that medical service is payable and reachable by all people, especially the poor.

Maintaining service at the hospitals and the dispensaries.

RESPONSIBILITY OF THE MEDICAL DEPARTMENT OF THE ELCT ND

As we are facing presently a lot of changes in this area regarding the number of patients and regarding the help offered by the Tanzanian government the situation of all hospitals and dispensaries needs to be evaluated regularly.

This, of course, is the duty of the medical department of the ELCT ND, which may prepare an annual report and request concerning these issues and present it to OAPND.

OAPND will analyze the requests and, if appropriate, tries to locate funds to meet the reported needs. The concerned hospitals and dispensaries will then report to the medical department, which will release a final annual report of used funds to OAPND.

PRESENTLY SEEN NEEDS

My present researches revealed the following needs:

Medical equipment

1. CD4-testing machines - However we still need a separate possibility to find out for each hospital, whether a machine is needed and can be run by the hospital effectively.
2. Equipment for blood testing may be needed to improve save blood transmission.

Staffing and staff-training

1. Generally all medical staff must be trained in counseling facing PLAHs at different occasions. This general training can be combined with the training of other church staff, like pastors or evangelists. This inter-profession training will also help to exchange knowledge between the professions. For example in group discussions pastors will learn from medical staff and vice versa.
2. There is need of counseling specialist, for example for children. Either new staff must be hired or existing staff must receive a training in debts.
3. The medical staff is in need of the update - training concerning issues related to HIV/AIDS, for example sexually transmitted diseases.

Development plans

Generally all medical institutions of the ELCT need to prepare a development plan, which faces HIV/AIDS related problems, especially dispensaries, which soon will play an important role in HBC (see below).

Home Based Care

REQUIREMENTS OF HOME BASED CARE

Home Based Care is already required by the national Tanzanian policy on AIDS/HIV.[73] In 2005 the government released special guidelines for Home Based Care, which states: „From various experiences in Tanzania and other countries in sub-Saharan Africa it is evident that clinical and psychological interventions are more effective and more sustainable if built upon a foundation of mutual trust between programmes and facilities and followed up within community care programs. The fulfillment of these conditions constitutes the continuum of care to PLHAs“[74].

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[73] See United Republic of Tanzania, policy on HIV/AIDs, p. 10

[74] United Republic of Tanzania, Guidelines for Home Based Care services, p. 8.

„ART can only complement ongoing HIV care and support services and will not replace the need and manage OIs or to provide Home Based Care.“[75] Also other patients with chronical diseases will benefit from HBC.[76]

The guidelines define a minimum package of HBC:[77]

- Access to counseling and testing.
- All elements of palliative care including pain management.
- Medication adherence.
- Functional referral system.
- Psychological support.
- Nutrition guidance and food support.
- Participation of PLHAs.
- Male involvement.
- Care for carers.
- Health care of children, orphans and vulnerable children including sick children.
- Recored and reporting system.
- Prevention intervention (e.g. PMTCT, condom programming).

HBC includes physical, emotional, social, spiritual, legal and economic support.[78]

The guidelines discuss the different responsibilities for hospitals, health centers/ dispensaries, local communities (including FBO) and the family of the patient.[79]

From this short review it is visible, that HBC needs a lot of financial, organizational and educational efforts to be implemented at the required standards.

THE ELCT ND AND HOME BASED CARE

[75] Source quoted, p. 11.

[76] Source quoted, p. 16.

[77] Source quoted, p. 21.

[78] Source quoted, p. 22f.

[79] Source quoted, see especially tables on p. 60-62, p. 73 f.

The responsibility of the church to install HBC

As part of the public health system the ELCT ND is required to introduce HBC within its medical institutions.

The present status of HBC within the ELCT ND

According to my present information, there are only reports about first steps in some places.[80] The Basic Health Care Education program has put HBC on its agenda for 2007. So there is still a lot of work to do.

How many people will need HBC?

So far I found no formula how to calculate the number of people in need of HBC. As ART has just started a prognoses is difficult anyhow.

Where do the funds come from?

Generally the guidelines of the government states, that it is the responsibility of the family /household to pay for drugs and supplies.[81] However many poor families will not be able to afford these aids and will depend on their surrounding communities. Due to the complex structure of HBC many local communities will fail to meet the required needs. Therefore the guideline invites CBOs, NGOs and FBOs to provide basic supplies and to start income generating activities.[82]

Meanwhile HBC is also supported by TMAP, which provides funds to CBOs, NGOs and FBOs. However this help is covering only education measures.[83] Home Based Care-kits are available from the Global Fund. So for many expenses the ELCT ND will still need to look for other sources of income.

Normally a HBC provider is considered to work on a voluntary base and is therefore expected to 3-5 patients only. The provider will receive only a bicycle, a monthly meeting and some symbolic presents as reimbursement. So HBC must be seen as an extension of the mutual help between neighbors. If a provider is going to care for more than 5 persons, honoraria must be paid to him.[84]

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[80] The Marangu hospital reports the start of small palliative program.

[81] United Republic of Tanzania, Guidelines for HBC, p.60

[82] Source quoted, p. 62.

[83] Reference, 10/3/113: This is a daily allowance for each trainee of 3000 Tsh for the 21 day course and a daily facilitation fee for the trainer of 20.000 Tsh, plus traveling and accommodation costs.

[84] Reference, 10/3/113.

How to introduce HBC with in the ELCT

In order to work effectively the ELCT ND must install HBC components on all levels. Hospitals and dispensaries must allocated the human resource for the required supervision and distribution of need aids, e.g. each institution must appoint a local HBC- coordinator or representative.

On the other hand the congregation must be mobilized. That is even more important, as many congregations are far away from a hospital, even from dispensaries. My basic suggestion is to remodel the existing Basic Health Care Education program into a HBC program, not only providing eduction, but also medical aids.

THE HOME BASED CARE PROGRAM OF THE ELCT ND

Objectives

To supply sufficient HBC in every congregation of the ELCT by;

1. following the guidelines and standards of the Tanzanian government,
2. having at least one trained community HBC provider in every congregation (151),
3. adding more trained HBC providers to a congregation, if needed,
4. having a small depot of aids in every congregation, if it is far away from a dispensary.

Strategies

1. To collect data of people in need of HBC in every congregation.
2. To calculate the quantity of needed aids and to require the needed funds or materials.
3. To raise the public awareness of the seen needs and to start local fund raising.
4. To set up a flexible response if it is necessary and a new trained HBC community provider.
5. To set up an annual training plan for the HBC community provider and to require the needed funds.
6. To install HBC supervision capacity into the hospitals and dispensaries of the ELCT. ND.
7. To link community HBC providers to;
   7.1. one of our hospitals or dispensaries,

7.2. or to an external supervision facility outside of the ELCT ND.

Implementation (action plan)

The implementation must be carried out by the medical department and its division for Basic Health Education.

1. To install HBC into our congregations by;

   1.1. getting the data of people presently needing or receiving HBC in our congregations,

   1.2. appointing one member of the local „Basic Health Education“ -Committee to be the first HBC provider,

   1.3. making a priority-list, where implementation is needed first,

   1.4. setting up a long-term plan, how to educate all 151 appointed providers quickly and effectively according to the syllabus of the government.

2. To install HBC into our hospitals and dispensaries by;

   2.1. appointing one HBC supervisor in each hospital and dispensary,

   2.2. analyzing the needed training for this staff to cope with their task and to set up a training plan.

3. To link activities of HBC by;

   3.1. drawing a „map“ of HBC supervision localizing the requirements of the Tanzanian government policy,

   3.2. modifing the existing guidelines of „Basci Health Education“ to need the requirements of HBC.

4. Funding

   4.1. The medical department of the ELCT will try to implement local fund raising as far as possible, e.g. contribution of the concerned families and communities.

   4.2. Beyond this option the medical department can ask the OAPND for assistance to raise funds.

Evaluation

1. The completion of the action plan will be shown by regular narrative reports which will be prepared by the central office of the Orphan and AIDS-program ELCT ND collecting report data from the medical department.

2. The work of the community HBC provider will be supervised and evaluated according to rules and regulation of the Tanzanian government.

3. Additional the district office of OAPND can conduct selected evaluation of the provide measures and services, especially if they are funded by money provided by OAPND.

Availability of medical service to all people

ANALYSIS OF THE PROBLEM

Availability of needed medical service can be hindered by the following obstacles:

1. The patient can not reach the service in time because;
    1.1. It is too far away;
    1.2. There is no adequate vehicle of transportation;
    1.3. The road is not passable because of wether conditions or accidents;
    1.4. The patient can´t be transported at all and no doctor will come to see him;
    1.5. The patient has not enough money to pay for the transport (financial problem).
2. The already arrived patient can not receive the required service because;
    2.1. He can not pay for it (financial problem);
    2.2. The required medication ran out / not available (technical /logistic problem);
    2.3. A physician / specialist is not present (human resource problem).

STRATEGIES TO SECURE AVAILABILITY OF MEDICAL SERVICES.

1. To maintain proper service at the existing hospital and dispensaries. This deals with #2.2 and 2.3 of the analysis. The issue is mainly covered in the first part of this chapter.

2. To expand services to reach the patients where they live. This deals with #1 of the analysis in general. This can be achieved by;
    2.1. mobile clinics,
    2.2. the installment of new dispensaries and health centers in the rural areas,

2.3. starting of HBC especially for chronicle diseases (see second part of this chapter above).

3. Improvement of transport facilities. This deals again with #1 of the analysis in general. This can be done by;

   3.1. advocacy work to build or to maintain streets properly and to improve public transport,

   3.2. installing transport facilities into our medical services to transport by an ambulance car.

4. To give financial support to those who can not afford transport and medication. this deals with # 1.5 and 2.1 of the analysis. This can be done by;

   4.1. the installment of a social department in hospitals,

   4.2. the exchange of information between the social department and the congregation, which knows their poor people.

   4.3. the placement of funds either at the social department of the hospitals/ dispensaries or at the congregations themselves.

THE AVAILABILITY OF HIV/AIDS RELATED HEALTH SERVICES.

1. Presently full HIV/AIDS services (VCT/ ART) are concentrated only to some hospitals.

   1.1. The church must do advocacy work to ensure the government is building up a just and reasonable infrastructure to ensure availability of this service to all people.

   1.2. The church must take measures to enlarge and to improve this service within its hospitals and dispensaries and by reinforcing HBC.

2. The church must add an effective social service to its medical institution to cover especially the following cost for poor people:

   2.1. Traveling expenses.

   2.2. Initial examinations before starting free ART.

   2.3. Treatment of opportunistic diseases.

THE MEDICAL FUND OF HUYAMWI AS A PILOT -PROJECT

History of the fund[85]

In our first seminar in 2003 HuYaMwi started medical screening, which then was repeated in several congregations. We paid medical expenses mainly to students of our scholarship program.

However we failed to develop a method to deliver payments for medical treatment quickly, as our parishes needed to apply first for help, before we could give them the security, we were able to pay for these expenses.

So we developed a method of health coupons. We gave out a limited number of health coupons each having a granted payment of 5000 Tsh. In case of medical needs the congregation will issue these coupons for a certain registered orphan, who will receive free medical treatment in two cooperating hospitals (Marangu and Uuwo) up to the granted amount. The hospital will return the coupon to us with the bill and report of medication and we will refund them.

In June 2006 we started the pilot phase with four participating congregations (Kondiki, Ma'ringa, Uuwo, Kirmeni). With the coupons we also sent out an application form for poor HIV positives, who can`t afford the remaining expenses to get free medication from the government, mainly needed for different initial medical tests and for the monthly fare to report to the hospital.

First responses

So far only a few coupons have been used and have been returned to HuYaMwi by Marangu. hospital. A problem of incomplete filling out by the hospital has been settled with its management.

So far no PLHAs has requested financial assistance, maybe because the form needs the declaration of a positive HIV status.

HuYaMwi will seek further discussions with Marangu hospital to improve the application forms and to discuss the issue of placing the funds directly within the hospital.

GENERAL CONSIDERATION OF INSTALLING SOCIAL MEDICAL SERVICES

A service of this type needs a close cooperation between;

1. the medical service, which examines a treatment of the medical problem,

[85] See HuYaMwi, report 2003-2006, p. 37.

2. the local community of the patient, who can testify the social status of the patient and

3. the sponsor, who needs;

    3.1. to be ensured, that the money is used for poor people in need of medical help only,

    3.2. to control that all expenses are with in its budget.

Generally there are a lot of obstacles of good communication between these shareholders:

1. The medical staff is reluctant to tell medical details of their patients to third persons, as they are bound by their duty to maintain confidentiality.

2. All parties are not interested to perform bureaucratic acts of record keeping or filling out forms as;

    2.1. they have no human resource to take over this duty,

    2.2. the bureaucratic act of record keeping is going to be very expensive compared with the medical service provided. (For example average service costs are below Tsh 5000, however each case would require correspondence between the three parties).

SUGGESTION OF A MEDICAL SOCIAL FUND OF THE ELCT

Generally we still must improve the pilot-project of HuYaMwi and learn our lessons. Therefore I can only make some first suggestions:

Goals

To provide medical treatment for poor people, especially those afflicted by AIDS:

1. PLHAs,

2. orphans,

3. widows,

4. vulnerable children and

5. seniors.

Strategies

1. Every congregation must have an up to date list of these people. How to get one will be discussed in the next chapter. The congregation will have a form to testify the social status of a member according to the registry.

2. Every hospital/dispensary will have a social service or at least one responsible person for social services. The concerned person will have a form to testify the financial need of certain medication or examination.

3. The district office of OAPND will have an annual budget for medical treatment (medical fund). There are three possible ways how to allocate this budget, which still needs to be discussed:

   3.1. OAPND will pay directly to the patient by receiving both forms from the congregation and the hospital.

   3.2. OAPND will grant and allocate the budget to the hospitals and dispensaries, which then will pay and cover the needs of their patients which will proof their social status by the form of their congregations. All forms will be returned to OAPND for approval of correct use of funds.

   3.3. OAPND will grant and allocate the budget to the congregation, which then will pay to their congregates after receiving the form from the hospital/dispensary.

   Note: The current method of the health coupon is still a mixture: The funds are allocated to the congregation which sends their orphans with a certification of their social status and the amount of granted money to the hospital. The hospital is testifying the financial needs sending the forms back to HuYaMwi which then will pay directly to the hospital.

Implementation (action plan)

1. The diaconical department of the ELCT ND will ensure, that all congregation will have a registry of poor people, starting first with orphans (three year plan of the department until 2008).

2. The medical department will discuss the installation of social services into hospital and dispensaries and will set up a plan of implementation.

   2.1. Appointing „Social officers“ in every institution.

   2.2. Training this staff for their respective task.

3. HuYaMwi needs to continue its pilot -project of the medical fund especially in cooperation with Marangu hospital and to prepare final suggestion for general implementation as soon as possible. (suggested deadline June 2007).

4. The diaconical department, the medical department and OAPND must work together to define the final proposal working on the following issues:

    4.1. The required forms.

    4.2. The issue of keeping secrets of patient information.

    4.3. The final strategy of funds allocation and documentation.

5. OAPND will try to raise funds from respective sponsors and to locate them to its district budgets.

Evaluation

1. The completion of the action plan will be shown within the reports of OAPND collecting date from the concerned institutions.

2. Financial as well as narrative reports will be sent by the concerned institution to the district office of OAPND, which then will report to the central office of OAPND.

3. Additional OAPND can conduct special evaluation by interviewing the concerned institutions and the targeted patients.

SOCIAL SUPPORT

Help for orphans, widows and PLHAs

Introduction

In the section of diaconical support HuYaMwi has modeled a ministry, which now can be easily adopted by OAPND.[86] The methods of HuYaMwi are already documented and evaluated.[87]

Nevertheless we must consider that the methods of HuYaMwi need to be extended and modified because of the following reasons:

1. HuYaMwi is mainly an orphan-ministry. PLHAs were included in the revised guidelines of HuYaMwi in 2006, but so far there are only a few measures in the pilot phase, like the above mentioned medical fund caring also for PLHAs. There we must consider to enlarge the target groups to;
   1.1. PLHAs,
   1.2. vulnerable children in general and
   1.3. sex workers.
2. The shift from the pilot-project to general implementation will cause some problems:
   2.1. The main idea of the pilot program, that one highly educated advisor (teacher of LBS Mwika) will care for only one congregation will not be reasonable any longer. In the new setting of OAPND one resource person will be responsible for ten congregations or more. This means, that some measures of HuYaMwi will not work or will work differently if carried out by OAPND.
   2.2. The money available per orphan and year will drop, if the ministry is extended to a larger field. For example to maintain the current ratio of HuYaMwi of 33.000 Tsh per orphan, OAPND will need at least 33.000 Tsh x 19.000 orphans= 627 Mio Tsh per year.
3. There are some types of services not yet rendered by HuYaMwi sufficiently for example:

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[86] See ELCT ND, Guidelines of „Orphan and AIDS-program“, §3

[87] HuYaMwi, report 2003-2006.

3.1. Advocacy for orphans and widows.

4. As a small ministry HuYaMwi needed to cooperate with other departments of ELCT ND or other NGOs, because it was doing local work only. OAPND will need to cooperate with and to include also for example;

   4.1. the SIP-program of the department of projects and development,

   4.2. other measures of the diocese to provide scholarship.

Target groups of the social support

Therefore the goals of the social support must be extended to the following target groups:

OAPND will provide social support for the following groups:

1. Orphans, according to the definition of the government (all children 0-18 years, who have lost one or both parents.
2. PLHAs.
3. Other groups of the society in social need, who are afflicted with AIDS or who are at high risk to be infected:

   3.1. Seniors, who have lost their children and are now caring for their grand children.

   3.2. Widows, who have lost their spouse and are now caring for their children alone.

   3.3. Vulnerable children (from families with poor social status).

   3.4. Sex workers.

Strategies

Generally the HuYaMwi strategic plan of intervention[88] can be adopted and can easily be adopted for the added target groups. Not to be too theoretical. I generally will talk about the „beneficiary“ or more simple about orphans only.

STRATEGIC PLAN OF INTERVENTION

Step 1: **To know your beneficiaries and their needs and to inform the society**. This can be done at low costs as only data processing is needed.

[88] See HuYaMwi, report 2003-2006, p. 16 ff.

Step 2: **To care for basic needs** of the beneficiaries. This is to look that every beneficiary in the target area has counseling, good guardianship, shelter, food, clothing, medication and access to respective education. In many cases advise and counseling is enough to improve the situation. In other cases small contributions can help (uniforms, stationaries, medication etc). Only the repair or building of houses requires higher expenses.

Step 3: **To create self-reliance** of the beneficiaries and to teach them to use their resources. After satisfying the basic needs many beneficiaries are eager to learn to develop themselves. Money is needed for seminars and as loans for capitals to start small-income-generating projects.

Step 4: **To start a scholarship program.** Mainly those beneficiaries who passed the programs of step 2 and 3 qualify to benefit from scholarship programs. Otherwise beneficiaries will fail, if basic needs have not been taken care of or if they have not been taught to be self-reliant. As further education is expensive, this step can only be accomplished for a great number of beneficiaries with the help of external sponsors.

According to their actual ability these four strategies (1-4) can be easily adopted also for;

1. vulnerable children, who have principally the same problem as orphans,
2. (young) widows, who may also need to benefit from scholarship programs,
3. sex workers, who may also need to benefit from scholarship programs,

For other groups only strategy 1-3 may be applicable:

1. Seniors,
2. PLHAs[89].

TO KNOW YOUR BENEFICIARIES AND TO INFORM THE SOCIETY

It is the task of the diaconical committee of each diocese to registry the different needy persons. The method of the „HuYaMwi“ - counter-books can be easily adopted for all required target groups.

[89] It is a very difficult ethical question wether the HIV-status of applicants for a scholarship program should be tested or not.

HuYaMwi is teaching to use a counter book to collect the data of the registered orphan. Within the book we are using cluster numbered from 0 to 5:

LEVEL	DESCRIPTION
0	not yet visited
1	is not longer an orphan, either has grown above 18 years or has moved away
2	needs advice and counseling only
3	needs only small help
4	needs a long term plan of help (education, repair of houses, SIP)
5	emergency cases

With this method we were able to kick out almost 20% of the former registered orphans. Additional we were able to reduce the target group being in need of financial help to 70%.[90]

Therefor in each congregation there should be a registry using this format of;

1. orphans,
2. widows,
3. seniors,
4. vulnerable children,
5. PLHAs and
6. patients with other chronic diseases.

The registry must be up dated regularly and must be presented to the parochial council, the assembly and must be sent to the diaconical district coordinator and the district coordinator of OAPND.

TO CARE FOR BASIC NEEDS[91]

" We can't do anything, because we have no money" - This argument was heard in the beginning of the work of HuYaMwi. Instead we discovered, that there are a number of measures, which can be carried out with even a low budget. After having started to teach about fund raising we are quite sure, that most communities can raise the money for the following measures themselves.

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[90] HuYaMwi, report 2003-2006, p. 17.

[91] Source quoted, p. 17-19

Spiritual comfort and counseling

These measures will not cause relief of financial burdens, but they will release spiritual comfort and counseling, which may help many beneficiaries to feel more comfortable and to relax and get relief of psychical pain. These measures will help all targeted people.

As many NGOs start their intervention with the distribution of material goods, this dimension of spiritual comfort and counseling must be seen as a domain of a church institution involved to care for needy people.

These methods are:

1. The teaching of **seminars** to the beneficiaries about different themes. For example our book "Advise for guardians of orphans" can be used as syllabus for a row of seminar days. We suggest at least once a year to have a seminar day for orphans and an other one for their guardians. Even if the taught theme will not be effective at all, the meeting alone at the church premises will be sign, that orphans and their guardians are not forgotten.
2. Even more effective in terms of spiritual comfort are regular **weekly or monthly meetings.** The periodical character will help the beneficiaries to build trust and so to be more open to receive counseling. Healing effects of group dynamic need more time to develop.
    2.1. For children (orphans and vulnerable children) these meetings may focus more on singing, playing, teaching of short themes.
    2.2. For adults (grown up orphans, guardians, seniors, widows, PLHAs) it will have a character of a self-help-group, exchanging information, organizing mutual help etc.

Distribution of small material help

The researches of HuYaMwi show that a lot of orphans can be helped with a little contribution in the area of;

1. school relevant materials like uniforms, shoes, notebooks, pencils etc.,
2. food and clothing,
3. medical treatment for daily illnesses,
4. symbolic gifts, like blankets, T-shirts, pictures etc, which are not really given to fill a financial gap, but as a sign of comfort.

Likewise the situation of other target groups can be improved by providing small material help.

However all kinds of financial distribution will face two problems:

1. It will create dependency, if not combined with other methods.
2. Especially at the mass contribution of small help, it will be very difficult to measure each case individually. So in many cases beneficiaries who are not really needy will participate in the contribution also. This factor will enlarge the costs of this kind of method, either the administrative cost to filter out the needy orphans or the value of the distributed good, as all orphans are treated equally.

Therefore we have been hesitating to start mass distribution of financial help, until we had introduced a transparent orphan registry. Finally in 2006 we organized the distribution of uniforms and bags to almost 300 orphans in four congregations and we have started medical care for orphans using help coupons. Nevertheless this methods have been used before on smaller scale by some of our parishes.

TEACHING SELF-RELIANCE AND SE OF LOCAL RESOURCES[92]

This is even better than the distribution of financial help only. We know from two congregations, who started an SIP-program themselves. For example the congregation of Kisamo was able to provide all their orphans with chicken projects including hen-cops for less than 40.000 Tsh each. Even if we doubt, that all of these local made hen-cops are durable, we must at least consider, that all orphans saw a sign of hope and were exposed to this kind of practical experience.

The results of this method depends mainly on a mixed system of seminars educating and monitoring the project and a combination of private responsibility and group assistance.[93] This means, the project belongs to one orphan and its family, but is monitored by a group of guardians or committee members. Only if all monitored projects develop well, other members of the groups will receive money to start their own projects.

SCHOLARSHIPS

Like mentioned above the following methods will only fit to orphans and vulnerable children or young adults, like young widows or sex workers.

Preschool

To sponsor orphans or vulnerable children for preschool education is a very good method as the family of the guardians will get relieve in watching the small children and they will be held in an additional social net.

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[92] Source quoted, p. 19 f.

[93] A very successful project of this type is reported in Uganda.

The annual fees are still reasonable and therefore even a local congregation may contribute to distribute some free places to orphans.

Unfortunately many of the congregational preschools are facing a lot of problems or are even dying, as the Tanzanian government has opened free preschool starting from five years on.

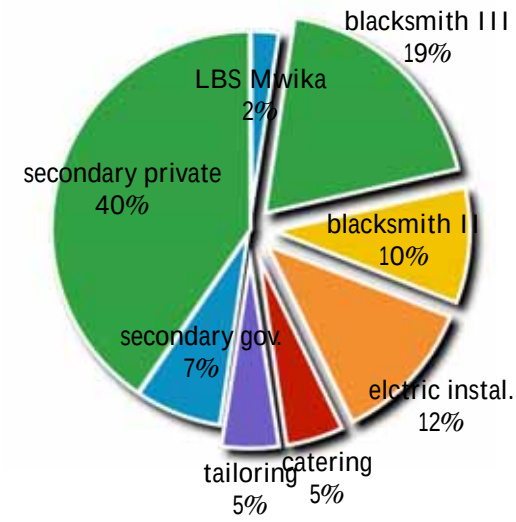
Primary schools

A scholarship is not needed as the Tanzanian primary school is free of charge for all children. Even orphans must be freed from all school contributions (approx. 15.000 -25.000 Tsh p.a.) for lunch, the cook, watchmen and renovations, as ordered by the Tanzanian ministry of education. Unfortunately many primary schools are following not this guidelines as the government is not paying any compensation for the orphans, but is expecting the local community to raise this money. So we regularly find orphans refused from school, because of not paying the required contribution.

After long discussions HuYaMwi decided not to pay money directly to the primary schools to take over the orphans contribution, as this might create dependency or even enter into some kind of illegal practice as we pay an illegal requested contribution to the schools. Instead we will either contribute material goods to the orphans directly (see above) or we will help the orphans to raise this money themselves by the SIP-method (see above).

Higher education

HuYaMwi is been involved in all kinds of scholarships:



Distribution to different school types June 2006

More than 51% of the students are receiving **vocational training**. Vocational training is preparing orphans for self-reliance in at least two years. And we have

cases, that orphans were able to join the working process even after one year of vocational training. At the secondary school orphans need at least four years to reach form 4 and then they have no guarantee for a job unless they join further education. Therefore vocational training is the better choice for orphans. HuYaMwi has done much to build local facilities for vocational training in the area of Mwika in order to gain a diversity of qualification in a good gender balance.

At the moment HuYaMwi is much more involved in **private secondary** school than in **governmental** school. A ratio we want to change as there are lot of disadvantages:

1. Private secondary education is very expensive and can only be provided to a selected number of orphans.
2. It is more risky, because many of the students failed the governmental qualifications to join governmental secondary schools.

However me must consider, that some orphans failed these qualifications only by little, caused by grief or other problems at home. Other were selected by the government but failed then to pay the school fees. It is a question of social justice to give a chance for secondary education also those, as there might be some talented students amongst them.

However to avoid failure an extensive **selection and monitor procedure** is needed for all school types. So far HuYaMwi is using the following methods:

1. Pre-trainee program in order to test our applicants under real life circumstances and to filter out problems caused by the special social situation of the orphans.
2. Assessment and pre-testing.
3. Tuition, especially in English.

The core program

GOALS

The goal of the core program is to enhance the capacity of the local community to deal with social issues themselves. This is done in compliance with the diaconical master-plan of the ELCT ND.

We think that the social burden of AIDS is still mainly carried by the members of the extended families, who of course need the support of their local communities, e. g. the sisters and brothers of their parish.

The ability of the local communities can be measured according to the following standards.

Minimum standard according to the diaconical policy of the ELCT ND

To organize this Christian diaconical help on the grass-root level the policy of the ELCT ND recommends as minimum standards:

1. The existence of a diaconcial committee.
2. The existence of a separate diaconical budget.

Extended standards according to the HuYaMwi guidelines

The HuYaMwi guidelines required the following standards to cooperate with HuYaMwi, which now I'm going to adopt for OAPND:

All partners must share the diaconical mission statement and must be ready to set up a ministry in the area of AIDS-prevention, pastoral care for AIDS-victims, orphans and widows, which must be evident in the following terms:

1. To spend part of its budget for this ministry.
2. To have defined annual program of this type of ministry.
3. To have a committee concerned with this ministry.
4. To have an updated list of orphans, widows and other AIDS-victims.
5. To participate in respective seminars and meetings conducted by OAPND.
6. To be committed to serve people regardless of their gender, social status and religious affiliation.
7. To provide evidence to OAPNDfor the intended use of the support provided.
8. To sign an agreement about the terms of partnership with OAPND.

Of course it will take some time to implement all these standards effectively.

Levels of capacity building

#	NAME OF LEVEL	STANDARDS
0	Starting level	no standard testified
1	Entry-level	standard level of ELCT ND diaconical policy testified
2	Trainee -level	working on implementing extended standards of OAPND
3.	Advanced-level	at least implementation of OAPND standards for one target group testified

#	NAME OF LEVEL	STANDARDS
4	HBC-level	HBC has been implemented successfully
5	Graduate level	extended standards testified by OAPND for all target groups

For example in HuYaMwi presently we have the following levels.

LEVEL	CONGREGATIONS	GROUP
Entry level	5	network
Trainee-level	8	network 5 and pilot 3rd year
Advance-level	8	pilot 4th and 3rd year.

The goal of the core program can therefore be defined:

To bring all 151 congregations of the ELCT ND from the starting level to the advanced level.

STRATEGIES

Seminars

Presently the seminar program of HuYaMwi is consisting of a five week long seminar program ("Community Based Diaconical Ministry") using the example of orphan ministry) including **three short classroom -courses**, which can be booked separately.

1. The basics of the orphan ministry (3 days), also published in a book („Ushauri kwa walezi wa yatima / Advice for guards of orphans").
2. The orphan ministry in the congregation (4 days).
3. Effective work in groups and committees (2 days) - also published in a book (Ufanisi wa Kikundi na kamati katika jamii / Effectiveness of groups and committees in the society).

The Seminar contains also the following **credits prepared by the students**:

1. A week of practice in one of the HuYaMwi's pilot parishes includes;
   1.1. visits of orphans' homes (2 days),
   1.2. visits of different HuYaMwi projects (1 day),

1.3. discussions with the local HuYaMwi committee (1 day),

1.4. exercises of different practical tasks like;

1.4.1. fund- raising,

1.4.2. teaching in a seminar for orphans or guardians.

2. The deliverance of the following papers:

2.1. Evaluation of the visited HuYaMwi -pilot -parish.

2.2. An action plan, how to start returning in the students home congregation.

This seminar is designed to achieve the required capacity building. Other components are in preparation.

Subsidization of seminars and teaching materials

According to the available funds OAPND will try to subsidize seminars or other teaching materials to the congregations, in order that all stake -holders can afford to buy those and to participate. Subsidization may require a certain certification level, at least the entry level, for certain measures even at a higher level.

Certification

Generally every congregation can apply to be certificated or to be admitted to a certain level. This can be done by;

1. sending a list to OAPND of the chosen committee and the used separate bank account to be certified for the entry level,
2. writing an application to OAPND to be admitted to trainee level. The district office of OAPND will then admit the congregation to the trainee-level according to the available human resources (see below.),
3. sending an annually narrative and financial report to OAPND to apply or to continue for the advanced, HBC or graduate level. The district office of OAPND will decide whether it can certify the required level;

3.1. by the documents sent in, only (normally done by a renewal of certification),

3.2. after evaluating the work of the congregation by visiting it (normally done by the first approval of the certification or at least after three years).

The first approval of certification for level 3-5 should be indicated by;

1. written certification document signed by the chairperson of OAPND,

2. the right to place a emblem in the church building indicating the reached level (for example as badge showing the stream of mercy flowing out from Jesus).

3. Both will be handed over by an OAPND official during a official ceremony.

We use a certain number of congregations as pilot-area. In this area we will test and evaluate our methods and strategies. On the other hand these congregations will receive also intensive training by seminars and by individual monitoring by our advisors (see picture). So the pilot program is establishing a two-way-communication. We teach our pilot parishes, but we also learn from and with them.

The congregation trainee program

Not all congregations will be able to reach the required standards by sending members to the above mentioned seminars. Therefore OAPND will offer a temporally limited service to boost up the ministry in one trainee -congregation using the HuYaMwi pilot congregation model.

This means the district office of OAPND will choose a limited number of congregations to work with them intensively until they reach the next level. (This can be even less than the four year period of being a HuYaMwi pilot parish). This measure will contain the following features:

1. A written contract between the trainee congregation and OAPND about the trainee-period, its lengths and its targeted certification level.

2. OAPND will contact the trainee congregation at least once a month by phone-calls or visits to make follow ups.

3. OAPND will conduct seminars and meetings with the local committees to teach and discuss important issues of the ministry.

4. OAPND will write an annual report reflecting the achievements and possible shortcomings.

5. OAPND may subsidize the annual diaconical budget of the trainee congregation by using the 1+1 method, e.g. every shilling offered by a Christian of the trainee congregation can be topped up by an other shilling contributed by OAPND according to the earmarked budget of OAPND.

Of course due to the required human and financial resources the district office of OAPND can only offer this service to a few selected congregation within its area of service.

Field-worker program

A fieldworker is a semiprofessional, who is hired for 2-3 days a week. After receiving training she or he will mainly visit the beneficiaries of his/her congregation and report to the parochial committee. Once a month he will meet with the district coordinator of OAPND. to deliver report and to receive further instructions. A monthly reimbursement of 30.000 Tsh. is equally shared by the congregation and OAPND.

HuYaMwi started the pilot phase of this program in June 2006 with field-workers from nine congregations.[94] We expect, that this program will improve the local capacity. However we are not yet sure, whether we can implement this program fully in OAPND, as there are almost 180.000 Tsh p.a. required as the contribution of OAPND to the honoraria of one field worker.

IMPLEMENTATION (ACTION PLAN)

Implementation can start after the installation of district offices of OAPND in January 2007.

1. Each district coordinator of OAPND must do the following:
    - 1.1. Request important data from the congregations (a questionnaire can be used) and doing a baseline survey by;
        - 1.1.1. identifying all congregations which are still at the starting level and to make follow up, that they fulfill the minimum standards to reach the entry level,
        - 1.1.2. identifying all congregations at entry-level,
        - 1.1.3. identifying all congregations who may fit to enter the trainee level,
        - 1.1.4. identifying all congregations who already qualify for certification.
    - 1.2. Set up a long-term plan (3-5 years) how to bring all his or her congregation from to level 5.
    - 1.3. Set up an annual plan containing planned activities and required funds:
        - 1.3.1. Budget to subsidize seminars and teaching aids, for example:

[94] Kondiki, Kiboroloni, Uuwo, Ma'ringa, Himo, Kirimeni, Kiruweni, Lole, Shokony.

MEASURE	PRIME COSTS TSH	SUGGESTED RETAIL PRICE TSH
1 seminar day at LBS Mwika	10.000	2500
Five week seminar at LBS Mwika	250.000	62.500
Book „Ushauri kwa walezi wa yatima“	400	500
Book „Ufanisi wa vikundi na kamati“	700	750

1.3.2. Budget to care for one trainee congregation. Presently HuYaMwi is using 200.000 Tsh p.a. for one training congregation, covering a reimbursement for the advisor and general running cost for communication, traveling and stationaries.

1.3.3. Seminars and other measures of building capacity not covered above conducted by the district office of OAPND itself.

2. HuYaMwi must prepare the following:

2.1. An annual plan of seminars including;

2.1.1. the syllabus,

2.1.2. the actual seminar costs.

2.2. Final evaluation of the field- worker program.

EVALUATION

1. The district offices of OAPND and HuYaMwi will report to the central office of HuYaMwi concerning the completion of this action plan.
2. The annual progress of this program can be evaluated by the number of new certified congregations.
3. The actual ability of the certified congregations can be evaluated by the central office of OAPND during the regular evaluation of one district office choosing randomly two congregations for evaluation.[95]

[95] See ELCT ND, Guidelines of OAPND, §20.

Complementary programs

INTRODUCTION

The goals of the complementary program are;

1. to provide funds for measures where the congregation themselves will be financially to weak to it alone (for example scholarship, building and repairing measures),
2. to organize measures which can be done more effectively conducted by a central office (for example scholarships),
3. to distribute funds restricted to certain regulations by the donors,
4. to stimulate the congregation to start certain activities (for example regular meetings with orphans).
5. The goal of these projects is to develop models of ministry in different areas. The experience may then be used within the congregations. However in most cases the experiences of these projects will be more useful for institutions, who must organize the orphan ministry in a larger area, for example at district or the diocese level.

Generally the management of these funds should avoid;

1. to quench down the decision making process and responsibility of the participating congregation,
2. to quench down local fund raising and contribution.

HuYaMwi is running the following funds complementary programs:

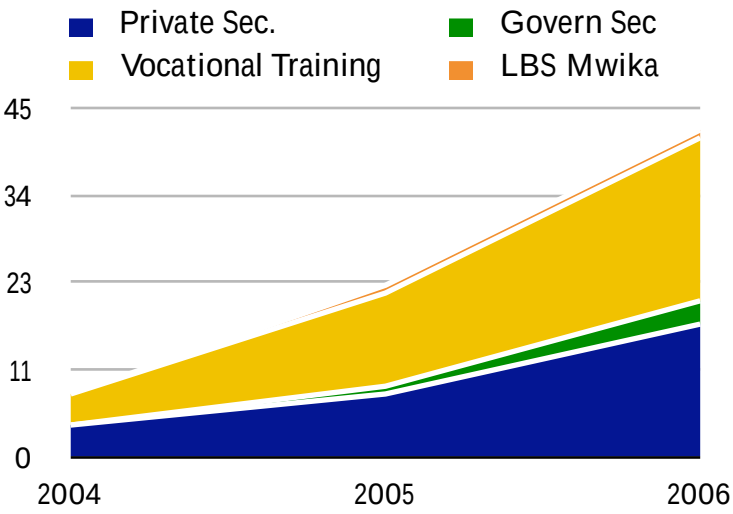
STARTING YEAR	NAME OF FUND MEASURES	AVAILABLE DOCUMENTS
2003	Support of MVCT	MOU with MVCT
2004	Scholarship fund	Handbook paper 9
2005	Building fund	Guidelines
2005	SIP	Guidelines
2006	Support of bakery project	MOU
2006	Medical fund	Guidelines
2006	Basic education fund	
2006	Fund for periodical meetings	

Generally most of these concepts can be taken over by OAPND. In some cases a modification of the guidelines may be necessary. Other funds than the above mentioned may be added in the future.

The district offices of OAPND will be mainly responsible to run these funds:

1. It will earmark donated money to the different funds in its annual budget.
2. The congregation can apply at the district office to get money out of these funds.
3. The district office will decide about the use of the funds considering the applications and will pay the money to the concerned receiver.
4. The district office will evaluate the use of the distributed money and will report to the central office.

THE SCHOLARSHIP PROGRAM



HuYaMwi started 2004 to provide scholarships. Meanwhile the program has been expanded[96]. Needing a lot of funds this program is possible by sponsors who have a long term commitment.

Nevertheless a scholarship program is important, as higher education is a major problem in the ministry to orphans and other beneficiary. After finishing primary school only few orphans have the chance to receive further education, mainly those who receive a governmental scholarship for secondary school.

Building on the experience of the HuYaMwi scholarship fund OAPND may quickly start its own scholarship funds which may be linked or incorporated in a proposed general scholarship fund of the ELCT ND. Scholarship as basic strategy of social support has already discussed above.

Works which needs to be done:

[96] Including program at MVCT, but not including trainees in patisserie project and at LBS Mwika.

1. Release of guidelines of a scholarship funds by OAPND. HuYaMwi may write a proposal using its experience.
2. Discussion about the installation of a general scholarship fund of the ELCT ND and its cooperation with OAPND.

FUND TO PROMOTE VOCATIONAL TRAINING FACILITIES

Vocational training is one of the best methods to provide further education to orphans and other beneficiaries. However in rural areas the facilities are often limited to carpentry for boys and tailoring for girls, a fact which will cut down the employment chances for the trainees dramatically.

HuYaMwi has been active to promote vocational training facility in the area of Mwika. The first project since 2003 is the **Mwika Vocational Training Centre**, a registered VETA training centre owned by Mr. Humfrey Mlay privately. HuYaMwi sponsored Mr. Mlay to build a classroom and to get tools in 2005 and also in 2006 to start the new electric course. In return he promised by a written contract to educate a certain number of orphans charging his prime costs only.The performance of the centre is high, although the students are only trained for one, to one and a half year where two years are usually. The students passed the practical examinations with very good results.

There are certain reasons for this success:

1. The training centre is integrated in a real enterprise. So the students have a good chance to do practical exercises and to learn real business.
2. The number of trainees is still small. This also helps for good practical training.
3. The school is owned privately. So all things are in good control.

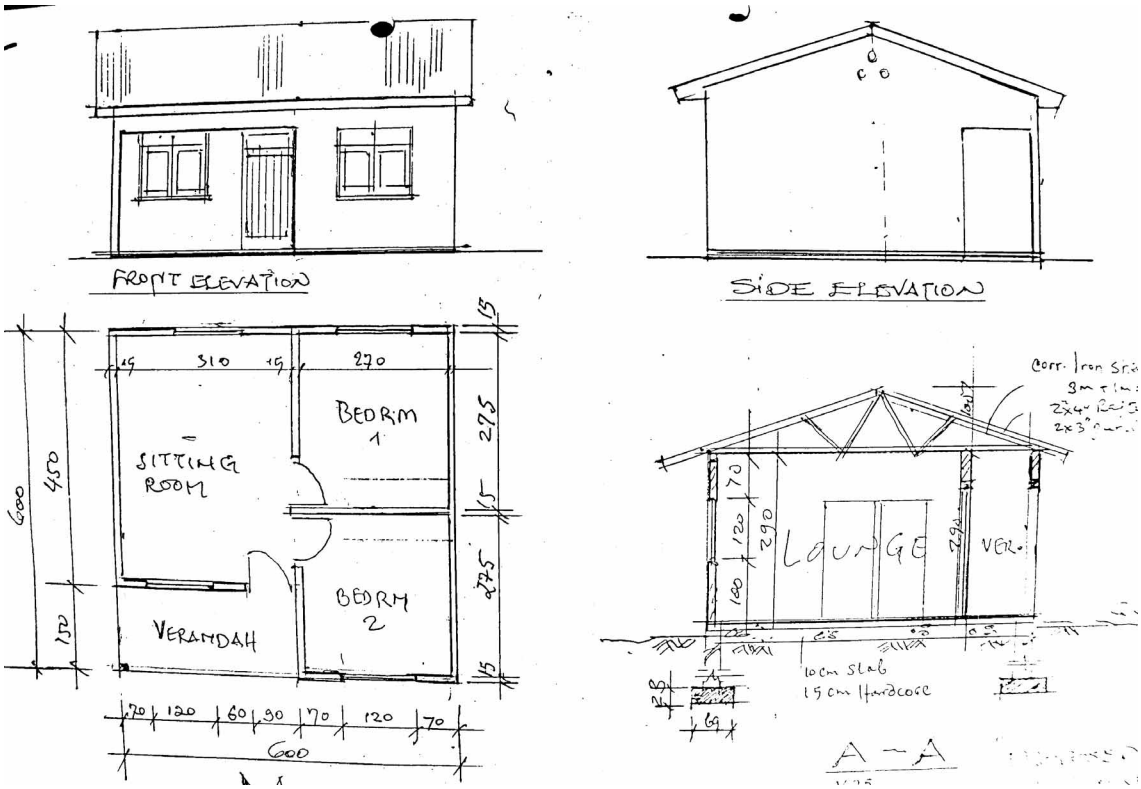
The second project is the patisserie project run as a non profit private enterprise led by Mrs. Ellen Burkhardt and Mrs. Monaichi Sillayo supported by HuYaMwi. All invested private property will remain the property of its owners, but the profit will be used to help orphans. Meanwhile the first orphan girls passing this trainee program have been employed by other enterprises in Moshi.

Work which needs to be done:

1. HuYaMwi needs to write a final evaluation of this project and to suggest general guidelines for this fund.
2. OAPND must make final decision, to introduce this fund.

THE BUILDING FUND

In 2005 HuYaMwi started this fund, from which congregations can ask assistance to repair or to build houses for orphans and widows. The guidelines limit the total expenses to 1,6 Mio Tsh and a contribution of HuYaMwi of 60% to the building costs.[97]



Two of the already built houses are using a master plan, a 6m x 6m house with one living room and two bed rooms built out of stone.

Due to raising material prices and difficulties to get the local contribution the building was carried out very slowly . So HuYaMwi needed to enlarge the original limits and the percentage of help.

Still the discussion is not finished, whether we should either build a quite expensive, but long lasting house of stone (in favor of the sponsors and the beneficiaries) or a cheap but not durable house of mud (in favor of all the other waiting orphans and widows). Recent home visits have shown even more widows and orphans in urgent need of this measure.

What needs to be done:

1. HuYaMwi needs to write a final evaluation and suggests revised guidelines to OAPND.

[97] According to HuYaMwi, Building and basic equipment fund. June 2006.

2. Guidelines of other donors (for example HABITAT, or TAMP) must be analyzed and incorporated in order to apply for additional funds.

3. OAPND must release the final guidelines.

THE SMALL-INCOME-GENERATING-PROJECT FUND (SIP)

In 2005 HuYaMwi started an SIP program in four congregations with five projects, which is continued in 2006 having now participants from six congregations with eleven suggested projects. According to the guidelines the program is backed up by four seminars.

CONGREGATION	TYPE OF PROJECT	FUNDS
Ma'ringa	goats	220.900
Shokony	chicken	87.900
Shokony	chicken	87.900
Uuwo	ducks	119.500
Kisamo	chicken	74.400

Work which needs to be done:

1. All providers of SIP within the ELCT ND must sit together to share ideas and to develop a master plan of these methods.

2. Guidelines of other sponsors (for example HEIFER) must be surveyed and included in order to apply for funds.

3. Generally the proposed infrastructure of OAPND can be used to distribute this method effectively:

   3.1. To schedule the requested seminars.

   3.2. To receive applications and distribute the loans.

   3.3. To evaluate projects.

4. However OAPND will not be able to provide agricultural advice or counseling, so it will be still necessary to establish a network of experts.

MEDICAL FUND

The medical fund has already been discussed . See the chapter about „medical treatment", part 3.

FUND TO PROVIDE SMALL FINANCIAL HELP

In 2006 HuYaMwi has gained experience to provide uniforms and bags to about 2005 orphans in Mrimbo.

Congregations can request money for these distributions and can proof their request by the data shown in their „counter-book“ registry. OAPND can either provide money from existing funds or can request money from TMAP en block.

Evaluation can be done by returned receipt sheets, containing the name of the orphan its registration number in the congregations orphan registry and the signature of the orphan/ guardian to testify the distribution of the goods.

What needs to be done:

1. HuYaMwi needs to write a first evaluation and to suggest guidelines
2. Guidelines of other sponsors need to be reviewed and implemented (for example TMAP).
3. OAPND must release official guidelines.

FUND TO PROMOTE PERIODICAL MEETINGS

This is a newly founded fund of HuYaMwi. Responses will be expected for the end of 2006.

The costs per meeting are low, approx. 20.00o Tsh for tea, nuts, paying aids or stationaries. Congregations can request money from OAPND by giving a plan of the proposed meetings and the expected number of orphans. OAPND can either provide money from existing funds or can request money from TMAP en block.

The evaluation can be done by written reports from the benefiting congregations to OAPND and random visits of OAPND officials at the scheduled meetings.

What needs to be done:

1. HuYaMwi needs to write a first evaluation and to suggest guidelines.
2. Guidelines of other sponsors need to be reviewed and implemented (for example TMAP).
3. OAPND must release official guidelines.

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