

Pastoral and Bio-medical Responses to HIV and AIDS by the Lutheran Communion in Southern Africa (LUCSA): Case Study of the Thusanang HIV & AIDS Project and Manama Mission Hospital in Zimbabwe

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Abstract

This article is an exposition of the Pastoral and Biomedical Responses to HIV and AIDS programming by LUCSA. This was done through engaging with members and workers of the church regarding their experiences of Home Based Care (HBC) training as a way of managing and holistically responding to the HIV and AIDS epidemic. This study explores the impact of the training for caregivers, nursing staff and pastors in HIV and AIDS management through a case study of the Thusanang HIV & AIDS project and Manama Mission Hospital of the Western Diocese of the Evangelical Lutheran Church in Zimbabwe (ELCZ) in Gwanda South. The study concludes that skills training in HBC and Palliative Care have made a positive and remarkable impact on the lives and work of HBC givers and pastors and that such training has contributed to the retention of caregivers.

Keywords: HIV and AIDS, Biomedical. Palliative Care, Pastoral Care, Stigma, Lutheran Church in Zimbabwe, Home-based Care.

Introduction

There is a growing need to care for people living with HIV and those affected

by the AIDS epidemic which has resulted in an increased demand for the recruitment, motivation and training of voluntary caregivers. The HIV and AIDS epidemic has put a heavy burden on communities and public health facilities especially in the global south, in countries like Zimbabwe, reducing effectiveness in providing standard health service delivery. In light of the above, caregivers have been trained in various skills and capacities for Palliative and Home Care. However, the impact of the training given to caregivers has not been fully assessed and evaluated to date. As a result, four key questions were posed in the survey:

1. To what kind of training have the care-givers, nurses and pastors been exposed?
2. How does the church work together with its public health institutions and faith-based organisations in reducing the impact of HIV and AIDS?
3. What is the impact of training on the work and personal lives of caregivers?
4. How has such training impacted on HBC volunteer retention?

The study builds on the hypothesis that palliative care and Home care training have made a positive impact on the work done practically by HBC givers, and even on their personal wellbeing and retention as caregivers.

Methodology

The study adopted the methodology framework of the Creative Associates International based on USAID's training impact evaluation methodology developed in 1991. It is a framework that defines impact as 'the economic, social and political change that results from an intervention altering the quality of life for a nation or a designated subset of the population'. In principle, the evaluating impact should measure or estimate the economic, social or political change induced by an intervention; determine the extent the change was attributable to the intervention; estimate the extent the intervention was critical to the change; reveal how and why the change occurred; and assess the role played by internal and external factors (USAID 1991). It is fundamental also to note that this theoretical framework builds upon the notion that 'impact or

induced change occurs at various levels from the individual trainee through the institution, sector, nation and occasionally, the region' (USAID 1991). Such levels can be interrelated. Also, when a change is identified, a link to the training intervention must be established to draw inferences that the training was related to the change – bearing in mind the question that 'can the change be attributed to the training received? Or is there any likelihood that the change would have occurred without the training?

Therefore, to establish the effectiveness of training and its impact on HIV programming, this study used mainly primary sources, with the questionnaire being the main instrument which was administered to a sample of 120 trained HBC givers and pastors. We did not manage to interview the nursing staff because of a lack of time to obtain the required Governmental approval of such communication from the district to provincial levels. Therefore, the analysis of the report on the biomedical response by the hospital was based on annual hospital reports from 2010 onwards. The hospital began to effectively engage in HIV management including the distribution of ARVs around 2009. Thus, the impact and change resulting from the trainings would be assessed based on the statistics documented in the annual reports, including for example, the percentages of condom uptake, voluntary medical male circumcision, response of male partners on PMTCT, and the total population of men, women and children on ART, to mention a few.

Also, FGD guides were used to gather some qualitative data from the caregivers, and Interview Guides were used to collect qualitative data from Key Informants such as church leaders and hospital administrators.

Six wards out of the 11 that Thusanang covers in Gwanda South were randomly selected for the survey. Twenty questionnaires were administered in each selected ward, where about 15 respondents were both practicing and retired caregivers, and at least 5 were both retired and practicing pastors of ELCZ and other partnering church denominations. The survey population was gathered using stratified random sampling in which was wards and zones. The individual interviewees were selected on the basis of their role in the church and or church-run institutions.

Data Analysis and Presentation

The data collected was processed and analyzed through editing, coding and

entry using Excel. We analyzed qualitative statements using matrices and tally sheets. The statistical data was analyzed and evaluated qualitatively.

Literature Review on HIV and AIDS and Lutheranism in Practice – Towards the End of a Witch-hunt in a Lutheran Way!

HIV and AIDS around the Globe: A Scourge against Humanity – A Wake-up Call for Holistic Action!

HIV and AIDS continues to cause a complex development crisis – with social and economic consequences felt widely in health, education, industry and agriculture, to mention a few. The epidemic poses a threat to health and life – with an estimated sixteen countries in Africa having more than a tenth of their adult population aged between 15 and 49 being infected with HIV, with the highest prevalence rate recorded in Sub-Saharan Africa (UNAIDS 2012). As a result, AIDS continues to be a key threat to human life especially in Sub-Saharan Africa. Life expectancy has fallen, the number of orphans continues to escalate, and family or community structures are weakened or destroyed. Increasing financial costs for caring for both the sick and affected cause a strain on already struggling national economies. Some have argued that the pandemic is much more deadly than war itself – in 1998, 200,000 Africans died in war, but more than 2 million died of AIDS (Regan 2002; Jackson 2012).

The United Nations once predicted about a decade ago that about 9 million people would be infected by HIV, while about 5 million would die of AIDS. A more current version of the global statistics (UNAIDS 2015) on HIV and AIDS is summed up as follows: 17 million people were accessing antiretroviral therapy, 36.7 million people globally were living with HIV, 2.1 million people became newly infected with HIV, 78 million people have become infected with HIV since the start of the epidemic and 35 million people have died from AIDS-related illnesses since the start of the epidemic.

The information provided by UNAIDS indicates that AIDS will remain more of a pandemic than a simple epidemic – which therefore challenges actors like the Church to strategize on how to keep on track in the quest for zero new HIV infections, zero discrimination and zero AIDS-related deaths. UNAIDS Research data has exposed us to the realities of the impacts of the pandemic as felt differently along and across gender lines, and also

among children. It, therefore, calls for an engendered approach to HIV and AIDS management and programming. This Lutheran community has to address critical issues such as domestic violence, child abuse and human rights abuses into context as these detrimentally affect decision making of the victims and result in an even greater risk of HIV infection. It is also fundamental for the church to consider the effect of the mobility of youths within countries and across national borders as research has shown that migration exposes the youth to promiscuity and sexual abuse in the quest for a better life (Jackson 2012; UNAIDS 2015).

HIV and AIDS in Zimbabwe

Zimbabwe has the fifth highest HIV prevalence in Sub-Saharan Africa, at 15 % (UNAIDS 2016). There are about 1.4 million people living with HIV in the country, including 170, 000 children, equating to 4 % of the global total (UNAIDS 2014; AVERT 2016). New infections dropped by 34% between 2005 and 2013, with behaviour change communication and ART Adherence thought to be responsible for the decline. However, there were still about 69, 000 new infections in 2013; about 64, 000 deaths due to AIDS-related illnesses; and about 89, 000 children being orphaned due to the AIDS pandemic (GARPR Zimbabwe Country Progress Report 2014). Of the most affected populations by HIV in Zimbabwe are the homosexuals (though homosexuality is illegal in the country), the sex workers (with around 50-70% found in Victoria Falls, Hwange and Mutare), and women (about 720, 000 of whom 70, 000 are pregnant) (ZIMSTATS, 2012; UNAIDS, 2014; AVERT, 2016). Research has also shown that the patriarchal society in Zimbabwe has helped in explaining women's greater vulnerability to HIV (UNAIDS 2016). As for the young population (aged 15-24 years), 41% are living with HIV; and only 52% of young women and 47% of young men do have comprehensive knowledge about HIV, thus limiting their ability to engage in safer sex (UNAIDS 2014; AVERT 2016).

In response to the Good News of God's unconditional love for all people the church is called to respond with compassion to the desperate situation of women and children in Sub-Saharan Africa and beyond, who are affected by the HIV and AIDS pandemic – As companions in God's mission, organizations like LUCSA, the Church of Sweden and the Evangelical

Lutheran Church in Zimbabwe, support each other in responding to the epidemic.

The Identity and Role of the Church of Sweden

The Church of Sweden is an Evangelical Lutheran faith community with the task of holding services of worship, teaching, and carrying out Diakonia and mission activities (CoS 2013). The Church is a place for reflection and communion, and also for social and spiritual support. Therefore, in its international work, the Church of Sweden is a highly recognized actor in humanitarian activities and development cooperation. The Church's international work has special responsibility for tackling the global challenges of our time, including HIV and AIDS, in cooperation with other churches and ecumenical organizations (CoS 2013). This is done on the basis of the belief in a God who takes the side of those who are oppressed or live in a vulnerable situation and in which faith, life, burdens and experiences are shared. In principle, the work done by the Church of Sweden is based on the theology that is responsive towards what people need, inspiring the world to tackle the challenges affecting humanity. This means taking a stand for the promotion of human life and creation of hope for the future. Therefore, it is on the basis of such attempts the Church has facilitated the establishment and running of both Faith-Based and Community-Based Organizations like Thusanang HIV and AIDS project in Gwanda South, Zimbabwe.

The Identity and Role of the Lutheran Communion in Southern Africa (LUCSA)

LUCSA is a voluntary non-profit making fellowship of 15 autonomous and independently constituted Lutheran churches in 10 countries of Southern Africa, namely, Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. The organization understands itself as a sub-regional expression of the global communion of the Lutheran Church within the Lutheran World Federation (LWF). It supports and initiates diaconal programmes and projects that seek to alleviate human need and to promote justice within member churches and assist them to act jointly to achieve common tasks. LUCSA is an instrument of the member churches

for coordination and support – with its task of fostering reconciliation, promoting social and economic justice and human rights and responsibility for Creation (LUCSA Constitution).

LUCSA and HIV and AIDS Programming: Putting THOUGHT and VISION into PRACTICE from both a Theological and Biomedical Approach!

In 2003, the LUCSA Council mandated the LUCSA Communion Office to coordinate and build the capacity of all member churches for effective strategic planning, implementation, monitoring and evaluation of their responses to the pandemic. The development came as a result of the Campaign held by the LWF in 2002 to ‘Break the silence on HIV and AIDS’ and the need for Care and Support for PLHIV mainly in the church. In response to the mandate, the LUCSA AIDS Action Programme (LAAP), was launched in 2003 to address various social problems resulting from the HIV and AIDS pandemic. One of the notable achievements of the LAAP was to ensure that all of the LUCSA member churches have HIV and AIDS desks and have broken the silence surrounding the pandemic (LUCSA HIV and AIDS Programme 2014). This has been evidenced by a number of Faith-Based Programmes and Projects that are engaged in the quest to reduce the strain caused by the pandemic through Orphan Care and Home Care for AIDS patients.

LAAP also seeks to work with church leaders, individual practitioners and organizations actively engaged in HIV and AIDS programming. This is done in line with the Strategic Plan (2013-2017), which requires results-based management of pandemics (LUCSA HIV and AIDS Programme 2014). The programme realizes and encourages the need for the mainstreaming of HIV and AIDS in word, action and deed. After the adoption of the mainstreaming concept, LUCSA ensured the improvement of the personal wellbeing of PLHIV and those affected by the pandemic through encouraging practitioners and actors within the scope of LUCSA’s work to cater for their spiritual, physical, psycho-social and economic-livelihood needs (LUCSA Statements of Needs 2013).

LUCSA is a vital arm of the Lutheran Communion operating as a Pan-African and global organization. LUCSA appreciates the role played by church leaders and the few mission hospitals run by the Lutheran Church, as it

also considers the importance of collective, inclusive and consultative approaches to HIV programming as no single country or organization can respond in isolation to HIV and AIDS programming. LUCSA encourages the Lutheran community to interact with other relevant stakeholders, including their national governments in response to the pandemic. The Lutheran church responds to HIV and AIDS through its mission hospitals who pursue biomedical initiatives like Voluntary Male Circumcision, PMTCT, STI or Opportunistic Infections Control and Management, ART Adherence and Compliance, and VCT. The church and its institutions played a major role in advocacy and lobbying the government in order that the church institutions and hospitals become roll-out points to increase access to ARVs. However, Faith Based Organizations and Parishes under the Lutheran Church need to scale up their efforts regarding pastoral and spiritual care and support, Home Based Care, Psychosocial Support for youths and OVCs and nutritional support for PLHIV. LUCSA has engaged pastors and leaders of HIV programmes or projects in workshops and training on capacity building, strategic planning and Clinical Pastoral Care.

The Identity of the Evangelical Lutheran Church in Zimbabwe (ELCZ)

The ELCZ has three Dioceses, namely, Central, Eastern and Western, each under the administration of a Bishop. The position of a Presiding Bishop rotates from one Diocese to another over a period of five years. Within the Dioceses, there are two Deaneries, each headed by a Dean. All the church parishes within a Deanery report to the office of the Dean, who in turn reports to the Bishop. The Bishops, Deans, Pastors-in-charge of Parishes, the General Secretariat and Management of the ELCZ Head Office, administer all the church institutions from a tripartite approach, offering Evangelism, Health and Education to the Zimbabwean communities and beyond (ELCZ Constitution). Each Diocese has a right to develop medical and Education policies for their institutions.

One of the broad aims of the ELCZ is to take care of the sick and suffering and exercise the ministry of the helping hands of Jesus (Diakonia). It is in this regard that the ELCZ derives its responsibility to participate in and complement the efforts of National Government in the provision of effective public health to the communities in question. The ELCZ runs and administers

faith-based HIV programming and the hospital health service delivery, including for example, Thusanang HIV and AIDS Project and Manama Mission Hospital in the Western Diocese; Betseranai HBC project and Mnene Hospital in the Central Diocese, and Tariro HIV and AIDS Project in the Eastern Diocese.

Research findings

Research Demographics

Of the respondents who participated in this study, the majority were females (90%) and (10%) males, with most of them falling between the 19 and 55 year age bracket. Those aged between 40 and 55 years constituted a larger percentage of the total number of respondents (88%). The respondents above 55 years of age constituted 12% of the total respondents. A closer analysis of this statistical demographic distribution indicates that fewer young people pursue care work, as they are very active with other priorities including taking care of their own children and are occupied with studies, work and business. The male percentage representation is lower than that of their female counterparts because of aspects relating to culture and tradition, among others. This means that a lot has to be done by the church to lobby and encourage male involvement in HIV and AIDS.

In terms of marital status, most of the respondents were married (60%), and of these 95% were female and 5% male. 30% of the respondents were widowed, and 6% were single while 4%) were divorcees and 98% of these were female. This data implies that many women in the research area are widowed most probably because of AIDS-related deaths. This has resulted in many women joining the HBC program in larger numbers.

The church has to do a lot to have its ministers practically engaged in HBC programming, by conscientising the women and men of the clergy that HBC is more of a call and tool for effective pastoral ministry and the growth of the church. This implies that the HBC concept has been voluntarily pursued by those with low literacy levels, a situation which challenges our church today to lobby and campaign for more engagement and participation of the literate population in HBC programming. It is critical to note that those who are educated often seek better paying jobs therefore much more needs to be done to enlighten the Christian community about the true essence and nature of HBC

as more of a calling than anything else. The disparities noted in terms of gender and literacy levels point to the effects of traditional and cultural ideologies that suppressed the progress of females in the context of educational attainment and job pursuits.

Most of the respondents' households had over three persons (85%). The majority of the households (80%) had 2 and 5 household members aged below 18 years. This indicates a higher degree of dependence ratios among most of the households, with an adverse effect on the economic wellbeing of the households. Also, the study found that at most each household supported 3 or less orphans (60%). This also points to the fact that the household heads are burdened with the challenges of caring and supporting the OVCs.

The study also established that farming, especially growing of crops and animal husbandry, constituted the major source of income among the respondents (75%), followed by informal trading (15%), menial or piece jobs (6%), and salaried jobs (4%) as the smallest category. The implication here is that the area in question is an agrarian region which takes an agro-based response through subsistence means. Zimbabwe's economy has of late become more informal with increased engagement of its citizens in small businesses. The country's unemployment rate has continued to escalate. The fact that only a few HBC givers earn a salary to sustain their lives is a challenge to the church when it comes to motivating more volunteers who are not on a salary to join HBC. Also, the study discovered that most of the respondents' income per month was below US\$100 (98%), pointing to the fact that it is really hard for the respondents to cope with the daily needs for themselves and their families. More has to be done to motivate and retain caregivers despite their low monthly incomes.

Pastoral Response to HIV and AIDS by LUCSA: A Case Study of Thusanang HIV and AIDS Project

The Background Role of Thusanang HIV and AIDS Project

Thusanang HIV and AIDS Project was initiated in 1993 with funding from Church of Sweden (CoS) as a programme of the ELCZ Western Diocese. The project envisions a society that is free of HIV and AIDS, through its commitment to capacity building for its membership, partners, local communities, and PLHIV – through motivating them to respond positively

towards the pandemic. The name of the project sums it all – ‘THUSANANG’ – a Sotho version of ‘HELP EACH OTHER’. Thusanang seeks to lobby and motivate individuals, communities and other stakeholders to work together in the face of HIV and AIDS and other adversities. The Project covers two neighbouring districts of Gwanda and Beitbridge in Matabeleland South province, and is being implemented in 11 wards in Gwanda District and 3 wards in Beitbridge.

The Thusanang Project focuses on three thematic areas, which are:

- i. Home Based Care (HBC);
- ii. Care of Orphans and Vulnerable Children (OVC); and
- iii. Information, Education and Communication (IEC) about HIV.

Thusanang does management of HIV and AIDS through Home-Based and Palliative Care is done in a consultative, inclusive and holistic way. Communities have been capacitated in the caring and support for chronically and terminally ill clients, through training community volunteers on HIV and AIDS Management, and basic HBC concepts. The project has also advocated for attitudes of acceptance regarding PLHIV among community members with the view of reducing HIV and AIDS related stigma, shame, denial and discrimination. Through community volunteers (caregivers), and in partnership with relevant stakeholders including AIDS Service organizations, the Church (ELCZ and other denominations), and also government structures, have encouraged the formation and running of PLHIV Support groups and Income Generating Projects (IGPs) such as keeping of poultry, goat rearing and nutritional gardening.

Under ‘Care and Support for OVCs’ the project has largely focused on the provision of basic needs such as education, health, shelter and birth registration. Thusanang has also been engaged in livelihoods development initiatives and Psychosocial Support Services (PSS) for youth. Thusanang has placed youth at the forefront of a holistic response to HIV and AIDS, considering the fact that the youth are very mobile, and the ELCZ Western Diocese is geographically located close to the borders of Botswana and South Africa. Many of the youth move to these neighboring countries in search of jobs, which is not always found to be the case! Research and reality have shown that many return home either pregnant (girls), sick, or even dead!

Through IEC, Thusanang has disseminated vital information using various channels in the Church, the Local Authority and the community at large. A number of platforms such as community meetings, training workshops, roadshows, and also participation in AIDS Awareness activities like World AIDS Day, have been used to ensure more effective IEC programming on HIV and AIDS.

Thusanang HBC Program realizes the growing need for caring for ailing patients suffering from AIDS-related illnesses, and also support for the OVCs and the elderly. The holistic approach to HIV and AIDS programming and management through voluntary caregiving by Thusanang includes: Psychosocial support, Youth Peer Education, Nutritional counseling, Spiritual counseling and support, Adherence and Compliance to ART, PMTCT and Referral mechanisms and other related services.

It is important to mention that much of the work done by Thusanang largely depends on the funding provided by the Church of Sweden. LUCSA has also played a significant role in capacitating the Thusanang Project Administration staff, and also the Church Leadership through Pastoral Clinical Training, training of carers as well as the youth OVC peer educators.

HIV and AIDS Programming at Thusanang Project

The Nature and Frequency of Training Provided within the Church and Thusanang

The study found out that there is a plethora of HIV-related training activities and initiatives, mostly pursued and done under Thusanang. These include Home Care (100%); Palliative Care (90%); Counseling (85%); ART Adherence (80%); Hygiene (65%); Nutritional Support for PLHIV (60%); and Life Skills Development (55%). The above data indicates that Home Care is the most predominant course that respondents have undergone. 100% of the respondents confirmed that they have been trained on Basic Home Care for ailing patients, and the affected. It proves therefore that the church, through its HIV projects like Thusanang, pursues the fight against the pandemic through HBC programming, which holistically addresses the issues affecting humanity. This is done when spiritual and psychosocial needs of the affected are contextualized, including giving attention to the bio-medical response to the pandemic.

Degree of Uptake of Training by HBC Givers and Pastors

The data provided by the respondents showed that HBC givers do attend training in large numbers, with 88% indicating that they have, since their engagement in voluntary HBC programming, attended every training session offered by Thusanang in a month. For those who indicated that they have failed to attend all the trainings offered (12%), the most predominant reason they gave is that of bad timing of the training sessions (90%); followed by the training being too basic and not challenging at all (8%). The shortage of transport facilities to ferry them to the workshop venues (2%) played a lesser role. It is fundamental for projects like Thusanang to improve the education and training which they offer to the caregivers, to avoid repetition of the same teachings to veteran caregivers. More has to be done to provide research-informed programming.

Impact of Training on the Work of Caregivers and Pastors

In the light of application of acquired skills from the training offered to the caregivers and pastors, the study discovered that most of the respondents had put into practice what they learnt from the training workshops. 90% of the respondents reported that they have applied what they have learnt to a great deal, especially in the context of Home Care and Palliative Care. Even the qualitative data collected through FGDs and interviews indicated that most of the respondents (85%) have managed to put into practice what they learnt. This is an indication that the caregivers are highly motivated to pursue their work, and that this church is therefore challenged to consider such good work done by both those who train the caregivers and the caregivers themselves. The study further investigated why some could not be able to put into practice what they have acquired from training. Most of the respondents (98%) indicated that they were not so sure why they failed to apply the skills. 2% reported that they have no adequate time to practically engage on full-time HIV programming since they are new recruits in the programme. This therefore gives the impression that the seriousness of a task pursued largely depends on intrinsic motivation of the one pursuing the task, regardless of the training acquired, a person can still underperform.

A number of pastors (85%) interviewed reported that they have been more involved in counseling of the sick and affected than with Basic Home

Care, owing to the training they acquired under the concept of Clinical Pastoral Care. The remaining percentage (15%) of pastors reported that they have not been able to practically engage on HIV programming. Such a distribution gives the impression to say a lot has to be done by the church and partnering actors to motivate pastors to do more with what they acquire as training and skills development. They have to go beyond counseling and practically engage on HBC programming. It is interesting to note that of the pastors who reported that they have put what they learnt into practice to a great deal, most of them (75%) were retired pastors. This indicates that caregiving from a pastoral point of view is currently a duty after retiring from full-time ministry. This church is therefore challenged in this regard to create awareness among pastors to realize that caregiving starts from within the individual Christian, right through the church as a community, and goes beyond the pulpit!

When asked whether the improvement of work and practice was resulting from the acquired skills, an overwhelming positive response was noted (98%), with the respondents indicating that they could not have done what they have done if they were not taken through skills development training sessions. Of these respondents, most of them (95%) reported that their attitudes towards HIV programming, the HBC concept, PLHIV and OVCs have greatly improved as a result of the training and skills acquired. This is an indicator that change occurs as a result of the training acquired, pointing to the vitality of skills training in service delivery, especially in HIV management and programming. It means that training is critical for performance improvement.

The study also established that most respondents (96%) have benefited from the trainings they undergo in HIV programming. The greatest benefit cited by most of the respondents was an increased understanding about the pandemic (100%); increased awareness of the importance of voluntary community work (85%); and improved self-confidence (60%). This implies that the trainings have contributed largely to the work of the caregivers through knowledge gain and societal networking with active stakeholders. It means the training also boosts the presentation skills of the caregivers as they get exposure and build communication links with other practitioners in public health service delivery.

When asked about the limiting factors in practicing caregiving after training, the respondents reported that performance after training has been halted by cultural and religious factors (100%); economic actors (65%); behavioral attitudes and biases (52%) and government policing and legislation

(15%). Cultural and religious factors were identified by all the respondents as the major limiting factors that constrain the application of skills acquired by caregivers and pastors. It means that the cultural and religious beliefs of the different communities are key in affecting the realization of the impact of training on the performance of caregivers. Partners and other Civil Organizations have to put into context the role played by HBC projects in HIV management and avoid biases and disturbing attitudes towards such projects like Thusanang. During the FGDs, most respondents pin-pointed the poor working relations between caregivers and Village Health Workers, a situation that requires intensive awareness of the public health sector to address because the two parties play a significant role within the communities. Hospitals, clinics and Thusanang have to work together for a single goal of redressing the strife placed by the epidemic upon human livelihoods.

On the question of recommendations for the trainings offered through Thusanang, half of the respondents (50%) recommended that the programme should offer more advanced training. They strongly believed that advanced training would improve public health care service delivery through the HBC concept. The respondents also recommended that the stakeholders and Thusanang should provide transport allowances for caregivers (25%); offer monetary incentives (15%); and refresher courses (10%). This implies that the church has to do more to improve the training offered to caregivers, and more funding has to be made available for such activities. Also, more has to be done to cater for the caregivers, especially ensuring that they attend the training sessions in big numbers by ferrying them to and from the workshop venues. In principle, caregivers have to be motivated to get more active on HIV-related programming, and by so doing the impact of training on their work performances would be realized.

Impact of Training on the Personal Lives or Well-being of Caregivers and Pastors

The study found out that training has impacted positively on the personal lives and wellbeing of most of the caregivers (98%). All of the respondents reported that they have gained knowledge about HIV and life in general. 90% of the respondents reported that they have gained respect within the communities they work in and beyond. Also, 85% of the respondents reported an increased general wellbeing of living. However, in the light of the improvement of

household income, most of the respondents (85%) reported that they have experienced stagnant or declining income levels since they acquired training. The distribution of the above points to the fact that training impacts positively on the personal lives of caregivers, implies a greater need for training as it improves the lives of individuals. It is critical though to note that training negatively impacts on the household incomes of the caregivers, in some cases causing the income to diminish or even remain stagnant. This challenges this church to consider the plight of the caregivers and even to motivate volunteers with better or stable incomes to join HBC. More income-generating projects have to be provided by the funding agencies and the church to cater for the socioeconomic lives and wellbeing of the caregivers.

The study also established that training was very effective in the management of stress-related personal experiences of the caregivers. Most of the caregivers (90%) reported that they have applied the skills they have acquired from training in dealing with stress-related experiences. 6% of the respondents reported that they have never applied any of the skills in dealing with stress management, and 4% indicated they are not sure about whether they have applied the skills or not. This distribution implies that training is fundamental to management of stress by individual caregivers, and hence the greater need of engaging the caregivers on training that is relevant to their personal lives and life skills development. Also, caregivers have to be encouraged to apply what they have learnt to personal life experiences, as this can motivate the communities to realize the vitality of HBC to life in general. This can result in improved uptake of the HBC concept and more people can even join HBC voluntarily.

On the question of the impact of training on personal performance and upkeep, 70% of the respondents reported they have had their personal care and upkeep improved; 15% indicated they have had their attitudes towards voluntary work improved; 10% reporting they have improved family time and friends; and 5% having a lower temper and mood swings. This implies that the courses and learning outcomes acquired through HBC training are fundamental in that they provide the caregivers with relevant exit profiles that give them dignity and societal relations as they actively engage and participate in their communities. This means they can be societal resource persons that people can consult over a variety of issues. If the caregivers are formally presented before the people, they can talk to the people who will listen to them if they have faith in them as life resource persons.

Impact of Training on the Retention of Caregivers and Pastors

Research data revealed that most of the respondents (70%) have agreed that the training they acquired broadens the future employment opportunities for caregivers to a great extent. 15% reported that the training exposes the caregivers to employment opportunities to some moderate level; 8% reported the training opens up employment opportunities to a lesser extent; while the remaining 7% indicated that the training does not broaden in anyway the employment opportunities of the trained caregivers, both the practicing and the retired. This provides evidence that effective training is relevant and applicable in the caregivers' search and access to employment opportunities beyond voluntary care work. There has to be a life after HBC for the exiting caregivers.

When asked whether they are aware of any caregiver who left voluntary caregiving after being offered paid employment, 98% of the respondents said they did not know of any, with only 2% reporting they knew of someone who left HBC for paid work. In a more practical sense, such a distribution would mean that cases of caregivers dropping out of voluntary HBC for paid work are not that much common in the areas in question. It implies that most of the caregivers are determined to do voluntary work and this has to be applauded by our church. Drop-outs by caregivers for paid employment could only be possible in cases where an individual is made to rise from daily care work to office and field work from an administrative point of view, as supported by the evidence gathered from the FGDs and Key Informant interviews where examples of such individuals who left caregiving to join Thusanang office full-time were cited. The contention to be upheld here is that the caregivers who leave caregiving for paid work rise within the church administrative channels. The study did not document any case of an individual who left for other organizations outside the Lutheran domain. This means the spirit of Lutheranism still influences and holds the commitment of those who leave HBC for paid work.

The study discovered that an average of about 52% of the respondents thought that training contributed to their continued work as caregivers. 25% percent believed that training has contributed to a moderate level; 13% indicated that it has contributed to a lesser extent; while 10% reported that training has not at all contributed to their continued work as caregivers. One key informant argued during an interview session that there is nothing like retirement in caregiving – a caregiver is on duty for the rest of his or her life.

Caregivers have to continue practicing care work even after full-time voluntary caregiving. They should remain societal advocates and resource persons within their localities and beyond. Most of the respondents (99%) felt that there were no negative issues to raise and discuss regarding their attendance and participation in trainings. This suggests a positive and commendable impact of training on the retention of caregivers.

Biomedical Response to HIV and AIDS by LUCSA: A Case Study of Manama Mission Hospital

The Background Role of Manama Mission Hospital

Manama Mission hospital belongs to the ELC). The institution is situated about 85 km south of Gwanda town, the Provincial capital of Matabeleland south Province (Manama Hospital Annual Report 2010). Manama Hospital follows and is guided by the WHO universal principles for the management and the administration of HIV-related programming. The hospital falls under the administration of both the ELCZ and the Zimbabwe Government, under the Ministry of Health. The Ministry of Health holds the primary responsibility for the daily running of the hospital. Most of the HIV-related programmes and activities, including the trainings on HIV management undertaken by the nursing staff, are from the Government and its partners rather than directly from the ELCZ. The Church owns the Health facility, but the Ministry of Health and Child Welfare and the National AIDS Council (NAC), runs and implements the HIV programming activities on the ground. Manama Hospital has embraced the need for mainstreaming HIV and AIDS in the quest for improved human health and service delivery. This has been evidenced by the running of a vibrant Opportunistic Infection (OI) clinic, Antenatal Care (ANC) at Maternity and Prevention of mother-to-Child Transmission (PMTCT) facility.

As argued by UNAIDS (2008) in Mzezewa (2015), the involvement and participation of the church in HIV prevention remains minimal, especially in countries like Zimbabwe, Lesotho, Swaziland, South Africa and Botswana. In addition, Mzezewa (2015) has opined that there has been limited research on the possible impact of personal perceptions of church leadership, their beliefs, norms, values and attitudes on the importance assigned to their participation in HIV-related programming. Research has indicated that the

majority of the Lutheran churches in Southern Africa were more involved in the provision of care and support than HIV prevention activities (LUCSA 2008; LUCSA 2012) and in Mzezewa (2015). It implies therefore that the church, through its hospitals, has responded to some degree to biomedical means of HIV management, than from a pastoral perspective which puts more emphasis on care and support for people living with HIV.

HIV & AIDS Programming at ELCZ Manama Hospital (2010-2015 Annual Reports)

This study discovered that AIDS has remained among the top five diseases resulting in the death of patients at Manama Hospital. HIV and AIDS remains amongst the top five reasons for medical admissions and remains one of the top five reasons for the admission of children under five years of age (Manama Hospital Annual Report 2015). This implies that the epidemic remains a central issue affecting the Church and society at large. It has exacerbated the mortality and morbidity levels within the hospitals and the surrounding communities. Children (under 5) are greatly affected, as they are admitted to the hospital in large numbers.

According to the information gathered through discussions with the Hospital Medical Superintendent and a selection of Pastors of the ELCZ, who would have been in some HIV-related programming with the hospital, it appears that the ELCZ has responded to the management of the epidemic in various ways. This includes having its pastors engaged as Hospital Chaplains who are officially appointed and deployed at the health institution. All of the pastors who were interviewed regarding the relationship between the church and the hospital, especially in the light of HIV programming, agreed that through the service of chaplaincy pastors play a crucial role, which includes conducting prayers for the hospitalized patients with chronic illnesses including those related to AIDS, counselling both the patients and those taking care of the bed-bound patients. The study also discovered that the pastors often go the extra mile and engage with the nursing staff to encourage them spiritually as they care for the terminally-ill patients. 80% of the pastors indicated that they have talked to nurses to understand how the work of taking care of patients with AIDS-related illnesses might negatively affect them. Some of the issues encountered included fatigue due to the heavy and

emotionally draining work load, stress, stigma, alienation, and discrimination by other members of the staff or the community at large. The pastors reported that in some cases they could find one or two nurses, especially in the wards with terminally ill patients and those that work with PLHIV who attend Opportunistic Infection clinics, complaining about the job as being too strenuous. In such cases, the pastors have spiritually supported the staff and counselled and motivated them to keep up the good work and do it to their best. When asked about where and how they could have acquired the counselling skills to motivate the staff as well as relatives and friends taking care of the patients, 90% of the respondents indicated that this was the result of the good job done by LUCSA through its workshops and trainings in Clinical Pastoral Care and Counselling.

Even though the ELCZ may not have done enough in terms of bio-medical response to HIV management, as has been argued by the Hospital Medical Superintendent, still commendable work has been noticed through the Pastoral Clinical Care pursued under LUCSA. All of the pastors interviewed reported that they also advise both patients and care givers on the importance of ART compliance. The pastors also indicated that they advise and give encouragement regarding the significance of nutritional support for the patients especially when they start on ART. The implication of this observation would be that the ELCZ, through LUCSA's programming on HIV and AIDS in the context of workshops and trainings geared towards the skills capacity development of the Clergy, complements to some extent the work done by the government and its partners in reducing the negative impact of the epidemic. This means therefore that the Church should continue supporting and implementing more training for pastors through LUCSA to reduce the detrimental effects of the epidemic. Pastors are significant players in this work as they have constant direct contact with communities.

Information gathered from the annual reports pointed to the fact that the hospital has engaged in a variety of HIV-related activities since 2010 such as: Pre and Post Test Counselling, ART follow-ups, Dispensing of ARVs and Ordering of ARVs (Manama Hospital Research Data 2016).

The study also found that the hospital nursing staff have also been engaged in HIV-related training. The study found that the hospital has engaged in frequent Antenatal Clinic (ANC), PMTCT and ART activities since 2010. The following is a summary of the activities, staff trainings and services provided to those affected and infected by the pandemic:

Pastoral and Bio-medical Responses to HIV and AIDS

HIV Patients		YEAR				
	2010	2011	2012	2013	2014	2015
Total patients pretest counselled		958	779	696	876	1312
Patients tested for HIV	749	958	779	696	876	1312
Tested Positive	339	316	202	160	138	164
Positivity rate	45,26	32,99	25,93	22,99	15,75	12,5
Patients on cotrimoxazole prophylaxis		4081	4221	4372		
Pre ART registration	956	408				
Patient on ART	377	1855		4361	969	994

Antenatal Clinic						
First ANC visits	263	179	144	137	180	126
ANC pretest counselling (Extras from RHC)	353	179	155	137	180	126
ANC women tested for HIV	263	185	155	137	178	126
ANC women positive	51	26	23	26	19	8
ANC women post test counselled	263	185	155	137	178	185
Positivity rate	19%	14%	15%	18%	10,6%	6,50%
ANC women dispensed Tenolom						627
ANC women dispensed NVP+ATZ		20	27	13	2	
ANC women dispensed NVP	63					
Total number of deliveries	641	607	411	396	578	675
Deliveries by HIV positive	138	116	77	68	89	99
Mothers swallowed NVP	121					
Exposed infants swallowed NVP	121					

Infants tested at 18 months	6					
Exposed infant tested positive	1					
Male partners tested	4	9	7	9		
Male partners positive	1	4		2		

STAFFING						
Midwife	0	0	2	3	2	2
RGN	1	0	2	4	4	9
PCN	3	4	4	1		
Nurse Aides	3	3	3			

PMTCT						
Nurses trained in rapid HIV testing	5	5	3	6	3	
Nurses trained in PMTCT	3	3	2	4	6	17
Nurses trained in MER	3	4		4	4	4
Nurses trained in CD4 count	4	4	1	3	4	3
Nurses trained in early infant diagnosis	2	4	2	3	2	8
Nurses trained in RPR	3	3	4	4	3	5

SOURCE: Manama Hospital Research Data, 2010-2015

The above data gives a picture as to how training could have impacted on the work done by the nursing staff in the hospital. It concurs with the theoretical perspective by USAID (1991) that training does result in change. It shows therefore that the hospital's engagement and commitment towards addressing the effects of the pandemic have impacted well upon the improvement of human lives, behavior change and responsiveness of the communities towards HIV and AIDS. The above statistics show that the trainings that the staff have received have improved service delivery as they address the effects of the epidemic.

The study further found out that some activities at Manama Hospital have been crippled by some critical challenges in its quest for the implementation of HIV-related programming. As documented in the Annual Reports from 2010-15, the challenges in order of importance were as follows: Delay in Dried Blood Spot (DBS) results; Inadequate equipment for effective HIV management/ control; Poor male participation in PMTCT, counselling and testing programmes; Lack of adequate knowledge on PMTCT and RPR by all nurses in maternity ward/ clinic – (RPR is a blood test used to screen for syphilis infection); Lack of adequate space / room for practical PMTCT sessions or services and No PCC to conduct counselling sessions.

A brief summary of the improvements or achievements since 2010 in light of HIV and AIDS management is as follows: Received a CD4 count machine, Use of serial testing instead of parallel testing, Ability to collect DBS specimens for Early Infant diagnosis, Nursing staff development through training on HIV-related programming and Introduction of extended nevirapine (NVP) in PMTCT.

Collaborative Work between the Faith-Based Project, the Hospital and the Church at Large

It is useful at this point to give a brief outline of the collaborative work and practical activities that Thusanang Project and Manama Mission Hospital have engaged in as a joint structure and venture, under the administration of ELCZ. Thusanang Project is situated within Manama Hospital grounds.

The study found that through the discussions held with the administration of both Thusanang and Manama Hospital, the hospital has responded positively towards HIV and AIDS management and programming through initiatives such as Voluntary Medical Male Circumcision, PMTCT, ART Adherence, Opportunistic Infections Management, Voluntary Counselling and Testing (Manama Hospital Research Data 2016). The question here is how then does the hospital engage Thusanang in pursuit of such programmes or initiatives? The research information gathered through the discussions with both Thusanang Programme Coordinator and Manama Hospital Medical Superintendent, suggested that both the parties invite some members of staff to be facilitators on HIV-related topics during workshops, where Thusanang would cater for the spiritual, emotional, psychosocial teachings and the hospital largely focus on the bio-medical issues.

This is essential as it also highlights the importance of cooperation between the Church and the Government. The hospital is an entity that falls under the political administration of the Ministry of Health, while the Church remains the Responsible Authority of the Mission Hospital. It therefore implies that most of the initiatives and activities that Thusanang and Manama Hospital could have jointly engaged in are not always those that are initiated and sponsored by the Church or LUCSA. Some of the most significant activities are run and sponsored by the Government and its partners in public health like UNICEF, Population Services International, USAID and the Global Fund, to mention a few (Manama Mission Hospital Medical Superintendent 2016). In this way Thusanang receives exposure and accessibility to the government's work and practice through the hospital connection, and therefore it is fundamental to strengthen the links between Faith-Based programming and the Health Institutions like hospitals. At present the link between the Government and FBOs like Thusanang is very weak. There is no direct collaboration between the two especially regarding the funding or mobilization of funds for initiatives such as the HBC concept by the Government (Thusanang Research Data 2016). We are obliged therefore as the Lutheran community today to do more in ensuring good and effective collaborative work between our FBOs and the Mission Hospitals, as the hospitals are in a better position to access funds for effective public health programming through the Ministry of Health. There is also a need to continue lobbying our governments to realize the importance of FBO programming through HBC and related programmes in HIV and AIDS management – we need more mutual support as a Church from our governments towards meeting our goals of reducing the strain caused by the pandemic upon humanity. Let us not operate in isolation, let us join hands with the government and the community and ensure a fruitful collaboration between church, state and society.

Conclusion and Recommendations

The study began with the hypothesis that training in Home Based Care and related issues has positively impacted on the work, personal lives and retention of caregivers. Thus, the analysis in this report supported the hypothesis, with some notable critical factors that impact negatively on the lives and retention of caregivers being cited and evaluated. There were noticeable disparities in terms of gender, literacy levels and representation and uptake of the HBC

concept in the selected wards. This suggests that more has to be done to ensure an improved male involvement and participation in HIV programming; and also motivation of formally educated individuals to join voluntary care work. Pastors have to be encouraged to be actively involved in caregiving. Members of the church have to realize and consider that home based care work is more of a calling than a job, which gives the church a unique and distinctive role and identity within the society. With evidence of positive changes in the performances of the care givers resulting from the trainings clearly more training opportunities are needed. Also, the current viability of projects like Thusanang largely depends on the funding mobilized and provided by partners such as LUCSA and Church of Sweden. More has to be done to go beyond these partners to source funding support from other interested parties and role players especially in the context of livelihoods development.

In the light of the foregoing discussion, the study therefore recommended that:

- More advanced training that exposes the caregivers to practical work should be provided to the caregivers;
- More emphasis on Practical Research and Innovation, to pursue community development thought and practice from a more informed and evidence-based position;
- More focus on livelihoods improvement programming that is more relevant and responsive to issues affecting community development today;
- More involvement and participation of LUCSA in Faith-Based programming through effective resource mobilization and financial support for HBC;
- More relevant and realistic trainings to be offered to the caregivers to give them a fruitful exit profile for community engagement and retention as caregivers. Caregivers should be capacitated with skills that even go beyond HIV programming, that is, to expose and train them in income-generating programming e.g. clubs, petty businesses, hand work, for them to be self-reliant. Involvement in care work should be sustainable. This means to provide the caregiver with a full package to assist the individual as he or she exits voluntary work or even when still engaged as a caregiver – a package that addresses the socioeconomic challenges faced by the caregivers in their daily lives;

- Capacity building of field officers at Thusanang to be sources of knowledge in community development initiatives including HIV programming, especially the bio-medical response to the pandemic. The Thusanang staff has to be capacitated to become trailblazers and think-tanks in the field of participatory community development;
- More funding for the HBC concept and related issues like incentivizing caregiving. Funds should be released in time to ensure effective service delivery;
- More advanced pastoral involvement in caregiving. Let it be mandatory to all the Lutheran parishes and congregations that HIV management through HBC is fundamental and each and every pastor has to implement the HBC concept in their Evangelical Ministry programmes. We encourage the church to use the offerings gathered through tithing and thanksgiving also to fund and support HBC programming at congregational and parish levels;
- Motivate and engage more youth towards joining voluntary care work
- Motivation and recruitment of caregivers with stable incomes. We argue that volunteerism is an opportunity to serve that comes in addition to what the individual is fully engaged in – HBC should not be viewed and understood as a job or stepping stone for those who are desperate, but as a calling and challenge for true discipleship and stewardship in God's mission that all might have life and life in its fullness (John 10:10).

References

- AVERT 2016. *HIV & AIDS in Zimbabwe*. AVERT. Brighton, United Kingdom.
- Church of Sweden 2013. *Strategic Plan for the Church of Sweden's International Work 2014 – 2017*. Uppsala, Sweden: International Department.
- GARPR 2014. Zimbabwe Country Progress Report. Harare, Zimbabwe: Ministry of Health.
- Jackson, H. 2002. *AIDS AFRICA: Continent in Crisis*. Zimbabwe: Avondale. (SAFAIDS.)
- LUCSA HIV and AIDS Programme 2011. *Taking LUCSA into the Future: Making the Links: LUCSA Mainstreaming TB – HIV & AIDS, Gender and Development Principles*. Zambia: LUCSA.

Pastoral and Bio-medical Responses to HIV and AIDS

- LUCSA 2013. *Statement of Needs 2014 -2016*. Bonaero Park, South Africa: LUCSA.
- Manama Mission Hospital Research Data 2016.
- Manama Hospital Annual Reports 2010, 2011, 2012, 2013, 2014 and 2015.
- Mzezewa, V. 2015. *An Analysis of the Attitudes and Perceptions of Church Leaders towards their Perceived Leadership Roles in HIV Prevention in the Matabeleland Province of Zimbabwe*. Pretoria: UNISA.
- National AIDS Council 2016. HIV/AIDS National Statistics.
- Regan, C. 2002. *80:20 Development in an Unequal World*. Wicklow, Ireland: 8020 Educating and Acting for a Better World and Tide.
- Thusanang Annual Report 2015.
- Thusanang Research Data 2016.
- UNAIDS 2012. *The GAP Report*. UNAIDS.
- UNAIDS 2013. *The GAP Report*. UNAIDS.
- UNAIDS 2016. *2030 Ending the AIDS Epidemic*; Fact Sheet 2016. UNAIDS.
- USAID 1991. *The Framework of Change*. USAID
- Zimbabwe National Census 2012. *ZIMSTATS*. Harare, Zimbabwe.
- Zimbabwe Country Analysis Report 2014. Harare, Zimbabwe.
- ZIMSTAT 2014. *Zimbabwe Multiple Indicator Cluster Survey*; Final Report. UNICEF.

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