

FAITH IN THE SYSTEM

The impact of local HIV responses on strengthening health systems in Malawi and Chad



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Acknowledgments

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Executive summary

Background

There has been an ongoing debate as to whether the significant investment in HIV and AIDS programmes has diverted funding from other areas of health programmes, and whether such direct (vertical) HIV funding has an impact on the strengthening or weakening of health systems. The debate raises the question of whether funding vertical HIV and AIDS programming or integrated horizontal approaches is more appropriate.

The focus of this research is the role of faith-based organisations – which to date have been largely unacknowledged in the discourse on HIV funding and health systems strengthening – to see if and how local faith-based responses to HIV strengthen health systems. Commissioned by Tearfund, the research aims to contribute to the growing literature on health systems strengthening by adding the experiences of faith-based responses.

The findings in this report emerge from a qualitative research process with a range of stakeholders in two African countries: Chad and Malawi. The research focuses on Tearfund partner organisations, Christian organisations and national- and local-level stakeholders. The participating individuals and organisations were identified as having a key role in the HIV response and/or health systems strengthening. Local community members who participate in projects of the Tearfund partner organisations in each country were also consulted.

Research overview

The qualitative research used three methods: desk review, semi-structured interviews and focus group discussions. The desk review made use of a wide range of documentation, including Tearfund literature, web-based information, and data gathered directly from international and national faith-based organisations. The report of the literature review is itself a significant contribution to the goals of the research.

The participants in the research included Christian faith-based organisations, Tearfund personnel, Tearfund partner organisations and collaborative stakeholders (government, donors, participants in programme activities in projects visited, religious leaders and networks of people living with HIV and AIDS).

The research findings in general support the conclusions in existing literature that faith-based organisations make a significant impact on and contribution to the health sector, particularly in relation to managing hospitals and health centres and reaching remote populations where there may be low or no coverage of government-provided health facilities. Significant work is carried out by faith-based organisations at community level that work with government health facilities and religious groups in the response to HIV and AIDS.

For example, implementing home-based care programmes, facilitating support groups for people living with HIV and conducting information, education and communication (IEC) activities, are frequent responses by faith-based organisations. At a national level, there are examples of effective coordination between faith-based organisations, ministries of health and secular bodies. Challenges for faith-based organisations in terms of maximising their impact include the need to strengthen coordination and monitoring and evaluation at a local and national level. In some instances certain religious beliefs can have a negative impact on the work of the health services, depending on the context and how they are managed, and can influence the work of the faith-based organisation itself.

In relation to the WHO criteria for defining the components of a functioning health system, the work of faith-based organisations particularly supports the criterion of a well-performing health workforce. For example home-based care programmes can reduce the number of patients that attend hospitals, as they

are treated at home. Support groups for people living with HIV and AIDS provide counselling and advice to their members. Both of these approaches reduce demands on already over-subscribed health services and therefore reduce the demands placed on health workers. Faith-based hospitals and health centres support efforts for equitable access to essential medical products, vaccines and technologies in relation to HIV and AIDS. For example, in Malawi, the faith-based organisation CHAM receives equipment and drugs for providing voluntary counselling and testing, anti-retroviral therapy and prevention of mother-to-child transmission in their hospitals for free in the same way as the government-run health facilities.

On issues of leadership and governance, faith leaders are involved with interfaith and multi-sectoral collaborations to promote and increase access to testing, care and treatment. At the same time, some faith-based organisations do not always agree fully with national HIV and AIDS policies because of key issues, particularly around the role of condoms in HIV prevention. Not all faith-based organisations promote or supply condoms as a means to prevent HIV transmission. As sexual transmission remains the key driver, this is an area which may in some places have a negative impact on the work of the health services.

Certain aspects of the WHO criteria are difficult to analyse in relation to the role of faith-based responses. For example, health systems require a well-functioning health information system and a good health financing system. Faith-based agencies do not always see themselves as having a direct role in contributing to these areas of focus.

In several key areas faith-based organisations play an important role: faith-based hospitals and health centres are often located in remote areas where there are no other health services. Those that provide voluntary counselling and testing, anti-retroviral therapy and prevention of mother-to-child transmission services in these areas can be considered as direct contributors to scaling up provision of these services. Those faith-based organisations that implement outreach work in remote areas are reaching populations that are possibly missed by other secular organisations and government facilities. In this way faith-based organisations are increasing service uptake.

Faith-based organisations at community level have direct impacts, for example, where they train government health workers in Malawi, and indirect impacts, for example, in outreach programmes to raise awareness and refer people to government hospitals for voluntary counselling and testing in Chad. At a national level health responses are strengthened, for example in Malawi where interfaith HIV umbrella organisation MIAA supports national health policy development, and where the government has used MIAA's structures to respond to other health issues such as cholera.

Some key findings

Faith-based responses to HIV can help strengthen health systems, because:

- interfaith HIV awareness programmes and services can be delivered that cut across the traditional barriers between different religions and make HIV services available to all
- HIV services can extend the reach and coverage of health systems by carrying out local education and awareness raising, and referring people to existing clinic programmes
- faith-based organisations can provide HIV services in difficult-to-reach rural areas where there is weak health infrastructure
- faith-based organisations can influence and empower religious leaders to discuss HIV and AIDS in the communities where they are based and thereby support the local health service responses
- HIV services can relieve pressure on health systems by carrying out home-based care and palliative care and by delivering medicines.

There are barriers to overcome if the full potential of faith-based organisations to contribute to health systems strengthening is to be realised.

- A lack of coordination at the local and national levels means that government health facilities and faith-based responses are sometimes unaware of each other's work. This can result in ineffective or no referral systems, and the possibility of services being duplicated unnecessarily.

- Faith-based organisations need to ensure good practice and improve monitoring and evaluation of their programmes to measure the impact and draw out the learning.
- Attitudes towards people living with HIV and AIDS by some religious leaders and a reluctance by some to promote comprehensive services (including condoms or antiretroviral therapy) can create challenges for health workers implementing HIV and AIDS programmes.

The following recommendations in relation to increasing the contribution of faith-based HIV responses to strengthening health systems have emerged from the findings of the research, the literature review and the institutional knowledge of Tearfund.

Recommendations to faith-based organisations

- Increase internal capacity to develop proposals, and to deliver and support effective HIV prevention and care programmes following national HIV and AIDS policies and guidelines with a special focus on HIV prevention.
- Seek interfaith responses, collaboration with health services and following best practices in HIV and AIDS programmes.
- Empower and build the capacity of religious leaders to give them sufficient resources, technical assistance and finances to maximise their potential to work on HIV and AIDS issues in the communities where they are based.
- Partner with existing faith-based networks of people living with HIV and AIDS such as ANERELA+ and support them to expand their work and form stronger linkages with religious leaders.
- Include health systems strengthening as an objective in HIV and AIDS programmes to support closer collaboration with government-run health services.

Recommendations to donors and governments

- Recognise the direct and indirect existing contributions of faith-based and interfaith responses, and their potential to increase their impact on health systems strengthening.
- Facilitate the meaningful inclusion of faith-based organisations in health systems strengthening by ensuring they are part of health service coordination mechanisms.
- Support faith-based organisations to increase the quality and technical capacity of their service provision through funding, training and skills initiatives, and integration into national priorities and policies.
- Increase funding and programmes to support religious leaders, networks and faith-based organisations to develop HIV and AIDS strategies which follow national HIV and AIDS policies and guidelines.
- Support the ongoing work to strengthen the capacity of religious leaders to work on HIV and AIDS and to align responses with national HIV and AIDS guidelines.
- Develop policies which promote collaboration between local clinics, hospitals and faith-based organisations, and which encourage mutual recognition and coordination between government services and faith-based programmes. This should include ensuring strengthening effective mutual referral mechanisms.
- Support faith-based organisations to increase their monitoring and evaluation capacity to increase the quality and maximise the potential of faith-based HIV and AIDS programmes.
- Continue to emphasise the importance of following a single national monitoring and evaluation framework among secular and faith-based organisations, encouraging them to contribute to these national-level processes irrespective of funding requirements.
- Document good practice of faith-based and secular coordination, and ensure that lessons learned in HIV and AIDS programming are disseminated at national and international levels.

- Encourage and strengthen collaboration between faith-based organisations and national and local health authorities by developing strategies for joint programming to ensure a comprehensive HIV and AIDS programme is provided for all people.

Recommendations to donors

- Encourage faith-based agencies to specifically include health systems strengthening as an objective in their programme and organisational strategies.
- Continue to fund integrated and vertical programmes for HIV and AIDS within the specific country context, ensuring national priorities and policies are referred to and international guidelines considered.
- Encourage government and secular organisations to include the responses of faith-based organisations in their monitoring statistics.
- Support research into further analysis of the impact of the HIV and AIDS work of faith-based organisations, for example on health systems strengthening and on religious leaders, and how this impacts on HIV and AIDS programmes delivered in the communities.
- Provide support to faith-based partners, religious leaders and networks to challenge stigmatising attitudes towards people living with HIV and AIDS.

Recommendations to governments

- Continue to support and fund existing coordination structures such as MIAA in Malawi to strengthen the coordination of the faith-based response to HIV and AIDS.
- Promote compliance with and contributions to national HIV and health guidelines and priorities among donors and faith-based organisations.
- Recognise and emphasise the importance of faith-based and interfaith leadership in the national response to HIV by increasing dialogue with faith-based national networks of people living with HIV and AIDS, such as MANERELA+.

It is intended that this report and its findings will contribute to the literature looking at whether faith-based organisations have an impact on health system strengthening and give some suggestions for the way forward.

Acronym list

ACT	Assemblées Chrétiennes au Tchad (Christian Assemblies in Chad)
ADP	Area Development Programme (World Vision terminology)
ADT	Assemblée de Dieu au Tchad (Assembly of God in Chad)
AIDS	Acquired immune deficiency syndrome
ANERELA+	The African network of religious leaders living with or personally affected by HIV and AIDS
BAC	Bureau d'Appui Conseil (Support Council Office)
CCAP	Church of Central Africa Presbyterian
CEVIFA	Centre d'Education à la Vie Familiale (Family Life Education Centre)
CHAM	Christian Health Association of Malawi
CHARMS	Core HIV and AIDS Response Monitoring System (Système de suivi des réponses au VIH et SIDA)
CIFA	Centre for Interfaith Action on Global Poverty
CNLS	CNLS: Conseil National de Lutte Contre le SIDA (National AIDS Commission)
DED	Deutscher Entwicklungsdienst (Service Allemand pour le Développement, German Development Service)
EAM	Evangelical Association of Malawi
EEACT	Eglise Evangélique de l'Afrique Centrale au Tchad (Evangelical Church of Central Africa in Chad)
EEFT	Eglise Evangélique des Frères au Tchad (Evangelical Church of Brethren in Chad)
EEMET	Entente des Eglises et Missions Evangéliques au Tchad (Covenant of Evangelical Churches and Missions in Chad)
EEMT	Eglise Evangélique Missionnaire au Tchad (Missionary Evangelical Church in Chad)
EET	Eglise Evangélique du Tchad (Evangelical Church of Chad)
EFLT	Eglise Fraternelle Luthérienne au Tchad (Lutheran Brethren Church in Chad)
EPJ	Ethique, Paix et Justice (Ethics, Peace and Justice)
FOSAP	Fonds de soutien en matière de population et de lutte contre le SIDA (World Bank Fund for AIDS)
GFATM	The Global Fund for AIDS, Tuberculosis and Malaria (also referred to as the Global Fund)
HIV	Human immunodeficiency virus
HLSP	The HLSP institute (Health and Life Sciences Partnership), an international professional services firm specialising in the health sector
HSA	Health surveillance assistant

IEC	Information, Education and Communication
INERELA+	The international interfaith network of religious leaders living with or personally affected by HIV
LISAP	Livingstonia Synod AIDS Programme
MANERELA+	The Malawi network of religious leaders living with or personally affected by HIV
MCC	Mennonite Central Committee
MIAA	Malawi Interfaith AIDS Association
MoH	Ministry of Health
OFC	Organisation des Femmes de l'EET (Women's Department of the Evangelical Church of Chad)
PCAR	Programme Chrétien d'Animation Rurale (Christian Programme for Rural Development)
PEDC	Projet Evangélique pour le Développement Communautaire (Evangelical Project for Community Development)
SCOM	Student Christian Organisation of Malawi
SEM	Service d'Evangelisation et Mission (Evangelisation and Mission Service)
SWAp	Sector-wide approach
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
WHO	World Health Organisation

1 Introduction

The prevalence of HIV and AIDS in Africa has been the focus of international development agencies globally for the last 20–30 years. Significant progress has been made in stabilising and reducing national HIV prevalence levels in many countries, as the annual monitoring reports by UNAIDS show. However, there has been ongoing debate as to whether the investment in HIV and AIDS has diverted funding from other areas of health programmes; and whether it is appropriate to continue the focus on vertical HIV and AIDS programming and funding or to focus on more integrated horizontal approaches. The focus of this research is the role of faith-based organisations in this debate: to see if and how local faith-based responses to HIV strengthen or otherwise impact on health systems.

The findings of the literature review show that the debate over vertical and horizontal approaches to health programmes has been ongoing for the last 50 years.¹ It has become more of a focus within the HIV and AIDS field, predominantly because of the high levels of funding that have been channelled into the sector. This has often resulted in parallel systems being set up to manage, implement and monitor HIV- and AIDS-specific programmes. There is a general consensus on the need for both horizontal and vertical approaches, as each complements the other.^{2,3,4}

However, there is little analysis or research about the impact that faith-based organisations have on health systems through their HIV responses. Faith-based organisations have an established history of working in the health sector. WHO estimates that between 30 and 70 per cent of health services in Africa are operated by faith-based agencies.⁵ Documentation of the faith-based response has been improved through efforts such as the Capacity Project.^{6,7} One of the outcomes from a recent CIFA-WHO meeting from 2009⁸ addresses the issues around the lack of documentation on the impact that faith-based organisations are having on health systems, including in the HIV response. Various initiatives have begun the process of mapping the faith-based response in a systematic way. The findings of this research will contribute to this growing literature on the impact that faith-based organisations are having within the HIV response and in relation to strengthening health systems.

The findings from Malawi and Chad are presented in the report as examples of the work of faith-based organisations and reflected upon within the theme of the central debate. The aim is to show how faith-based organisations impact on health systems and some of the challenges that are faced within the contexts of Malawi and Chad, and to draw on these experiences for broader discussion.

The work of faith-based organisations will be discussed through the lens of whether the HIV programme has a direct or indirect impact at a national and local level. The research gives an insight into the issues but is not an exhaustive report and mapping of the response of all faith-based organisations. Further research and analysis are necessary for a comprehensive understanding of the work of faith-based organisations and their role in the HIV response and the strengthening of health systems.

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- 1 Atun R et al (2008) *When do vertical (stand-alone) programmes have a place in health systems? Policy Brief*, WHO
 - 2 WHO (2009) *Initial summary conclusions: Maximising positive synergies between health systems and Global Health Initiatives*
 - 3 ITPC (2008)
 - 4 Dhaliwal M (2008) *HIV and Health Systems Strengthening: Opportunities for achieving universal access by 2010*, Stop AIDS Campaign
 - 5 Karpf Rev Canon T (2007) *Community Realities in Africa Show FBO Partnership Key to Global Scale-Up*, *AIDSLink*: Issue 103 / 1 June 2007, WHO
 - 6 Capacity Project (2009) *Human Resources-Geographical Information Systems Data Development and Systems Implementation for the Christian Social Services Commission of Tanzania: Final Report*, May 2009
 - 7 Capacity Project (2009) *Capacity Project knowledge sharing, technical brief*, November 2009
 - 8 WHO and the Centre for Interfaith Action on Global Poverty (CIFA) (November 2009) *Consultation: NGO Mapping Standards Describing Religious Health Assets*

1.1 Background

The World Health Organisation (WHO) defined the components of a functioning health system as service delivery, health workforce, information, medical products, vaccines and technologies, financing and leadership and governance.⁹ WHO in its report on health systems strengthening details each of the different components. While this research does not address in detail each component of the WHO criteria, it is clear that faith-based organisations are working in diverse ways with health services, ranging from managing hospitals and health centres to implementing a range of activities that may have an indirect or direct impact on health service provision in the specific locality.

Some general comments can be made regarding the different WHO components for a functioning health system which can be viewed in the context of the research findings. The findings are also considered in line with the work of the HLSP¹⁰ Institute, which examined AIDS services and common health system constraints in countries with weak health service infrastructure.¹¹ This is in order to consider to what degree faith-based organisations might contribute to the scaling up of the HIV and AIDS response.

1.2 Definitions

VERTICAL PROGRAMMING

WHO¹² defines *vertical programmes* (also known as *stand-alone*, *categorical* or *free-standing programmes*) as instances where 'the solution of a given health problem [is addressed] through the application of specific measures through single-purpose machinery',¹³ for example, as in the case of HIV-specific interventions.

HORIZONTAL PROGRAMMING

Integrated programmes (also known as *horizontal programmes*, *integrated health services* or *horizontal approaches*) seek to 'tackle the overall health problems on a wide front and on a long-term basis through the creation of a system of permanent institutions commonly known as "general health services"'.¹⁴

DIAGONAL PROGRAMMING

In the WHO framework for action 2007,¹⁵ the *diagonal approach* to health system strengthening is defined as:

- taking the desired health outcomes as the starting point for identifying health systems constraints that stop effective scaling up of services
- addressing health systems bottlenecks in such a way that specific health outcomes are met, while system-wide effects are achieved and other programmes also benefit
- addressing primarily health systems and capacity issues

9 WHO (2000) *Health Systems: Improving Performance*, *The World Health Report 2000*

10 Health and Life Sciences Partnership

11 Druce, Dickinson (2008) *Making the most of the money? Strengthening health systems through AIDS responses*, p8, HLSP

12 Atun R et al (2008) *When do vertical (stand-alone) programmes have a place in health systems? Policy Brief*, p3, WHO

13 Msuya J (2005) *Horizontal and vertical delivery of health services: what are the tradeoffs?* Washington, DC, World Bank

14 ibid

15 WHO (2007), *Everybody's business – strengthening health systems to improve health outcomes. WHO's framework for action*

- encouraging the development of national health sector strategies and plans, and reducing investment in isolated plans for specific aspects of health systems
- having robust monitoring and evaluation frameworks

This is based on the building blocks that make up a health system, as defined in the WHO 2000 report: service delivery, health workforce, information, medical products, vaccines and technologies, financing and leadership and governance.

HEALTH SYSTEMS STRENGTHENING

The Global Fund for AIDS, TB and Malaria (GFATM or the Global Fund) describes health systems strengthening within the context of the Global Fund's mandate as 'activities and initiatives that improve the underlying health systems of countries in any of the six areas [of the WHO building blocks for a health system]¹⁶ and/or manage interactions between them in ways that achieve more equitable and sustainable health services and health outcomes related to [HIV, malaria and tuberculosis].'¹⁷ Core functions or essential 'building blocks' are variously defined, but include governance and leadership, organisation, planning, financing, the workforce, information management, supplies and infrastructure. Communities, clients and the non-state sector are important but often forgotten players in the system.¹⁸

FAITH-BASED ORGANISATIONS

Faith-based organisation is used as a broad term in the research to include all such organisations that are faith-based, including church networks, religious groups, religious leaders and faith-based health service providers.

1.3 Objectives of the research

One of Tearfund's organisational priority areas is HIV and AIDS. Tearfund supports many local churches and faith-based organisations around the world, some of which are key players in the response to HIV and in tackling health issues more broadly. Through this research Tearfund aims to explore a variety of local responses to HIV by faith-based groups and explore ways in which they may be building up health systems or, conversely, taking resources away from other health responses.

The overall aim of the research is: **to understand whether local faith-based responses to HIV can also help to strengthen health systems.**

In particular, this study has four main objectives:

- to explore the role of the faith-based responses in strengthening health systems at national and local level
- to seek evidence and collate case studies which show whether HIV responses have strengthened health systems, or whether they have diverted resources away from tackling other health concerns
- to analyse this data to develop policy messages on how faith-based responses to HIV help to build health systems, and how best to support them in this work (as well as ways in which they themselves may need to change), and subsequently to influence the policy, planning and practice of decision makers at international level and influence policy and practice at national and local level

16 ibid

17 GFATM (2008), *Fact Sheet: The Global Fund's approach to health systems strengthening*

18 Druce, Dickinson (2008) *Making the most of the money? Strengthening health systems through AIDS responses*, p8, HLSP

- to investigate good and bad practice and suggest ways in which donor responses could tackle HIV and strengthen health systems simultaneously.

1.4 Research approach and methodology

To meet these objectives, a literature review was carried out, looking at the current existing literature regarding faith-based HIV responses and health systems strengthening.¹⁹ Interviews were carried out with Tearfund UK personnel, and field research took place in Chad and Malawi. This section outlines the approach and methodology adopted to achieve this.

The interviews with Tearfund UK personnel placed the research – especially the visits to Tearfund partners – in the context of the organisation’s approach to HIV and AIDS.

Qualitative field research was carried out in Malawi and Chad with the aim of discussing with different stakeholders, at a national and local level, the role that faith-based organisations are playing to strengthen health systems in the HIV response.

The research took place over a two-week period in February and March 2010 in Malawi and Chad. Semi-structured interviews were carried out with key stakeholders at a national and local level and were modified according to the context and stakeholders involved.²⁰ In each country a visit was made to a rural area to see the programme activities of a Tearfund partner that is implementing an HIV programme.

Focus group discussions were held with key groups of beneficiaries, participants and local stakeholders, such as religious leaders and health facility personnel, in the localities of the projects that were visited. A local translator was used at the field sites so that the people involved in the focus group discussions and interviews could speak in their mother tongue. The groups were invited to participate by the local faith-based organisation which was implementing the relevant programme activities.

The research did not seek to compare the experiences of faith-based organisations with those of secular organisations. Neither did it seek to evaluate the effectiveness of the faith-based or secular programmes or services. Instead it sought to gain a better understanding of the impact of selected faith-based responses to HIV on broader health systems. The findings from the research were analysed within the country context and the overall research topic.

1.5 Malawi: key national and local stakeholders

PARTICIPANTS

The participants in the research in Malawi were as follows:

- National Tearfund office
- Tearfund partners: EAM, LISAP, Scripture Union and SCOM
- National-level stakeholders: MIAA, MANERELA+, UNAIDS, National AIDS Commission, Ministry of Health
- International faith-based funders: Norwegian Church Aid, Danish Church Aid

During the field visit focus group discussions were held with health centre personnel, people living with HIV and AIDS, youth groups and home-based care groups.

19 Ward N (2010) *Can, and how, do local faith based responses to HIV help to strengthen health systems? A Review of the Literature*, Plurpol Consulting

20 *ibid*

LOCAL ORGANISATIONS

- **MIAA** – the Malawi Interfaith AIDS Association – is an interfaith service agency composed of different faith members. The main aim of the secretariat is to facilitate a united commitment of faith communities in the response to HIV. Under each faith member body's secretariat there are different faith-based organisations.
- **MANERELA+** – the Malawi Network of Religious Leaders Living With or Personally Affected by HIV – is part of a network of organisations of religious leaders all over Africa called ANERELA+, which was created in 2003. It exists to equip, empower and engage religious leaders living with or personally affected by HIV to live positively and openly as agents of hope and change in their faith communities and countries.
- **EAM** – the Evangelical Association of Malawi – is an umbrella body for evangelical and Pentecostal churches and Christian organisations joined together in the common task of improving the spiritual and social well-being of all people in Malawi. As a secretariat, EAM serves 53 church denominations and 51 Christian organisations, building their capacity to improve the lives of the poor and marginalised people in the area of their mandate. EAM has three major intervention areas: church mobilisation and training; food security; HIV and advocacy. EAM is a Tearfund partner.
- **LISAP** – Livingstonia Synod AIDS Programme – focuses on HIV and AIDS programmes in the five districts of the northern region and Mzuzu city. It is part of the Church of Central Africa Presbyterian (CCAP). Activities include home-based care, care and support for orphans and vulnerable children, youth outreach, information, education and communication, prevention of mother-to-child transmission and mobile HIV testing. LISAP is a Tearfund partner.
- **Scripture Union** has two main aims: to make God's good news known to children and young people and to encourage people of all ages to meet God daily through Bible reading and prayer. There are five main ministries (Bible, youth, children, family and women); HIV activities take place mainly in the youth, children and family ministries. Scripture Union is a Tearfund partner.
- **SCOM** – Student Christian Organisation of Malawi – addresses the spiritual needs of students at college level between 12 and 16 years. This is achieved through a range of programmes, one of which includes HIV and AIDS awareness. SCOM is a Tearfund partner.

1.6 Chad: key national and local stakeholders

PARTICIPANTS

The participants in the research in Chad were as follows:

- National Tearfund office
- Tearfund partners: PCAR, PEDC and EPJ
- National-level stakeholders: UNAIDS, National AIDS Commission, National network of people living with HIV
- Religious leaders (ACT and EEMET), EPJ head, SEM head
- National faith-based organisations: CEVIFA
- International faith-based organisations: World Vision Chad.

During the field visit focus group discussions were held with people living with HIV, project personnel, religious leaders and hospital staff.

LOCAL ORGANISATIONS

- **CEVIFA** – Centre d'Education à la Vie Familiale (Education Centre for Family Life) – is a faith-based organisation that is not linked to one denomination, and works from within the philosophy of how Christians can have an impact on society in their HIV response. There are two main aims: to provide

education and information on HIV and reproductive health and to care for those who are living with HIV and AIDS.

- **PCAR** – Programme Chrétien d'Animation Rurale (Christian Programme for Rural Development) – works under ACT and implements agriculture programmes, income generation activities and HIV and AIDS activities. PCAR is a Tearfund partner.
- **PEDC** – Projet Evangélique pour le Développement Communautaire (Evangelical Project for Community Development) – works under EET and is mainly involved in food security and agriculture. It also takes opportunities to discuss HIV issues. PEDC is a Tearfund partner.
- **EPJ** – Ethique, Paix et Justice (Ethics, Peace and Justice) – works under EEMET in southern Chad and Ndjamena and is the ministry that implements most of the community HIV and AIDS activities and advocacy against injustice and poverty. EPJ is a Tearfund partner.

RELIGIOUS NETWORKS

EEMET – Entente des Eglises et Missions Evangéliques au Tchad (Covenant of Evangelical Churches and Missions in Chad) – is the Covenant of Evangelical Churches and Missions in Chad. EEMET is an umbrella organisation and oversees work carried out through autonomous departments:

- EPJ – Ethique Paix et Justice (Tearfund partner – see above)
- SEM – Service d'Evangelisation et Mission (Evangelisation and Mission Service) organises the missions and evangelism
- Organisation des Femmes de l'EET (Women's Department)
- Bureau d'Appui Conseil (Support Council Office)

EEMET includes seven denominations:

- Eglise Evangélique du Tchad
- Assemblées Chrétiennes au Tchad
- Eglise Fraternelle Luthérienne au Tchad
- Eglise Evangélique des Frères au Tchad
- Eglise Evangélique de l'Afrique Centrale au Tchad
- Assemblée de Dieu au Tchad
- Eglise Evangélique Missionnaire au Tchad.

2 Research findings by country

Findings from each country present the direct and indirect impacts of the local faith-based HIV response on health services. Coordination and funding issues are considered at a national level in relation to the different stakeholders who participated in the research.

National coordination of the HIV response has been a focus for the last decade, including initiatives to strengthen national AIDS councils and multi-sectoral collaboration led by the Ministries of Health. Many of these efforts for coordination have included faith-based responses. The World Council of Churches has documented many of the declarations and policy statements on HIV and AIDS by churches and faith-based organisations between 2001 and 2005.²¹ This demonstrates the international commitment from the faith-based community to strengthen faith-based work in response to HIV and AIDS and improve coordination. In practice improvement in these areas has been uneven, and this is reflected in the varying degrees of coordination and implementation at a country level found by this research in parts of Malawi and Chad.

At community level in Malawi and Chad different faith-based organisations respond in a variety of ways to HIV and AIDS. Some have a direct and positive impact on the health system, while others have an indirect impact. Activities implemented by faith-based organisations include home-based care, peer support groups, voluntary counselling and testing, and awareness raising. Each of the faith-based organisations has differing levels of engagement with local health facilities.

2.1 Malawi

In 2008, among Malawi's population of 14 million approximately 11.9 per cent of adults aged 15–49 were living with HIV.²² Although the national HIV prevalence has decreased since 2005, Malawi still has one of the highest rates in sub-Saharan Africa. There are an estimated 91,000 children aged 0–14 living with HIV and 560,000 children aged 0–17 who have been orphaned by AIDS.²³ There has been significant progress in reaching the universal access targets.²⁴ For example, two-thirds of Malawians who need antiretroviral therapy are now accessing this treatment. This is an enormous leap, from approximately 3,000 in 2003 to 184,000 in 2009 and from having nine antiretroviral therapy distribution sites to having 236,^{25,26} though there is still much to be done to achieve universal access.

The research took place in the capital city Lilongwe and in the Kamwe area, which is within the district of Mzimba in the northern region of Malawi. Semi-structured interviews were conducted with national stakeholders, including Tearfund partners the Evangelical Association of Malawi (EAM), the Livingstonia Synod AIDS Programme (LISAP), the Student Christian Organisation of Malawi (SCOM) and Scripture Union. National coordinating bodies were interviewed, including the National AIDS Commission, the Malawi Interfaith AIDS Association (MIAA), the Malawi Network of Religious Leaders Living With or Personally Affected by HIV (MANERELA+), UNAIDS and the Ministry of Health (MoH). Two faith-based donor agencies were interviewed: Norwegian Church Aid and Danish Church Aid. Focus group discussions were carried out with home-based care groups, support groups for people living with HIV and AIDS, youth and local health centre personnel.

21 www.oikoumene.org/en/documentation/documents/programmes-du-coe/justice-diakonia-and-responsibility-for-creation/ehaia/declarations-et-prises-de-position-sur-le-vih sida-par-les-eglises-et-les-organisations-religieuses-2001-2005.html

22 UNAIDS (2008) *Fact Sheet Malawi*

23 *ibid*

24 UNAIDS (2008) *Progress towards Universal Access* http://cfs.indicatorregistry.org/country_factsheet.aspx?ISO=MAL

25 www.dfid.gov.uk/Media-Room/News-Stories/2010/Advice-to-developing-countries-on-paying-for-healthcare/Malawi/

26 MoH (2009) *Quarterly report anti-retroviral treatment programme in Malawi, Sept 2009*

FAITH-BASED HIV RESPONSES: DIRECT IMPACT ON HEALTH SYSTEMS AT COMMUNITY AND NATIONAL LEVELS

At a community level faith-based organisations can be said to have a direct and indirect impact on health services through their HIV and AIDS programmes, depending on the types of programmes being implemented and how closely they work with government health facilities and authorities.

For example, the Christian Health Association of Malawi (CHAM) manages 171²⁷ health facilities in mainly remote rural areas across the country. This makes up 37–40 per cent of all health facilities in Malawi and particularly responds to the need for health facilities in some remote areas with little government coverage. As of December 2008, CHAM provided HIV voluntary counselling and testing in 134 facilities, antiretroviral therapy in 66 health facilities and prevention of mother-to-child transmission services in 127 facilities, and nine health facilities offered paediatric antiretroviral therapy.²⁸ HIV counselling and testing, antiretroviral therapy and prevention of mother-to-child transmission are provided free of charge through funding provided by the Ministry of Health. Treatment of opportunistic infections is not necessarily free, except for tuberculosis treatment, which is also provided through government services and funding.

CHAM runs training centres which train the majority of nurses in Malawi. Funding was provided by the government in the past, and more recently by the Global Fund. This training contributes importantly to health system strengthening because it directly increases the number of qualified health workers in Malawi.

Faith-based organisations also work directly in the community, delivering home-based care programmes and support groups for people living with HIV. For example, LISAP works in the five districts of the northern region and Mzuzu in Malawi. In addition to providing home-based care, LISAP's HIV and AIDS programmes include responses to orphans and vulnerable children, youth outreach, information, education and communication initiatives, prevention of mother-to-child transmission and mobile HIV testing. A visit was made to Kamwe in the district of Mzimba to meet participants involved in the HIV programmes run by LISAP.

There are seven home-based care groups operating in the Kamwe area, whose members were trained through government-provided home-based care training. Each carer visits and cares for patients in their homes and promotes HIV testing to members of the community. One member of the home-based care group visits around three to seven people in his area. He visits them twice a month if possible and more often if they cannot leave their house.

The home-based care programme has made a significant impact on the communities where it is implemented. Comments made during the focus group discussion indicate that it has reduced the frequency of hospital visits and the length of people's stays in hospitals. Because people can be treated and cared for in their homes, there is a reduced workload on the staff of the local health centres and hospitals. The carers believe that people cared for in their homes seem to spend less time being ill, and were able to become healthier and more active faster. LISAP works closely with the local government health facilities by inviting government health surveillance assistants to contribute their knowledge and skills to relevant training initiatives and by negotiating replenishments of medications distributed by carers with local health providers. Local health centres have officially agreed to exchange medication supplies that pass their expiration dates.

As the health of patients improves and they no longer need carers to visit, they are referred to support groups, which LISAP helped to strengthen. The research included discussion with some of the groups from the Kamwe area in the district of Mzimba.

Fourteen people (six female, eight male) from six different support groups in the district participated in the focus group discussion, ranging in age from 32 to 50, the majority in their 40s. Most had tested for HIV in the last two to three years at their local clinic, which subsequently referred them to the support group. The members of the support groups meet monthly and the groups also meet jointly at intervals. They visit each

27 CHAM (2008) *HMIS Status report 2008*

28 *ibid*

other where possible if someone is unwell, or refer people to the hospital if needed. Each support group has a home-based care kit. As a group they counsel each other and some have vegetable gardens where they may grow, for example, soya to make porridge. They encourage others to go for voluntary counselling and testing. Referrals take place between the support groups and the health centres, hospitals and the LISAP home-based care group.

Members of the support group find that being linked to different church denominations can present difficulties, as sometimes a church will only support members of its own denomination. For example, LISAP programmes are aimed at CCAP members; and people of other denominations sometimes feel sidelined.

BOX 1

The impact of support groups for people living with HIV and AIDS

The chairman explained the history of the group. He was the first among the members to have a positive HIV test result in 2003. The following year his wife died. That same year antiretroviral therapy became available in his area and he began a treatment regime in April. He made the decision to be at the forefront of mobilising his fellow community members. He found four other people and suggested starting the group.

'At first when we started the support group, we were only four in 2004. After starting our campaign, up to date, we have 285 members and are now so happy that have reduced deaths in the villages.'

One of the group members attributed their very survival to the chairman's actions: 'Because he came out openly we are here today.'

The support group has provided a safe place for its members: 'At first I used to fear; these days I don't. We are also learning a lot from the support group and sharing experience. We don't fear anything and are very open. We encourage them if we find people at home, and we assist them.'

The members no longer feel isolated: 'We have seen the stigma and discrimination that was there at first is not there; this used to distance us.'

The support group members discussed how they could increase the effectiveness of their work. Their suggestions to each other included appointing a person living with HIV to the church consortium committee. Other ideas included support to increase income-generating activities and nutritional support for those in need. They also suggested closer collaboration with the health surveillance assistants and expressed a desire to be able to provide data on their groups to the health centres. They propose to do advocacy with the local health authorities to make antiretroviral therapy and nevirapine available in health centres.

It is clear that LISAP has worked to support the group, and challenges remain: they need further support to increase their effectiveness. The support group has made a positive and significant impact on the members and communities where its members live; people are supporting each other and not needing so much support from health services.

INDIRECT IMPACT ON HEALTH SYSTEMS

EAM (the Evangelical Association of Malawi), a Tearfund partner in Malawi, carries out activities including advocacy, food security, evangelism and mission, and response to HIV and AIDS. It works within a consortium structure to encourage different evangelical churches to work together. It facilitates support groups for people living with HIV and AIDS, vulnerable children and home-based care. An example of a well implemented multi-stakeholder project is the Circle of Hope project, which focuses on 'fighting HIV/AIDS stigma through gender and rights based approaches'.²⁹

29 EAM (2009) *Fighting HIV/AIDS Stigma and Discrimination, Biannual report*

The Circle of Hope project in Ntchisi district in the central region is an integrated approach supporting people living with HIV and AIDS through support groups, home-based care, HIV counselling and testing in churches and mobile clinics, and prevention of mother-to-child transmission promotion. There are strong links to the local health facilities through these activities and referrals. One of the objectives of the programme is to work with religious and traditional leaders to influence them regarding 'risky religious and cultural attitudes, beliefs, values and practices that promote stigma and discrimination'.³⁰ Some members of the support groups also deliver spoken testimonies in their churches on 'HIV positive Sundays', when services specifically focus on HIV and AIDS awareness. Such projects have the potential to have an important impact on religious leaders within the community setting. With an integrated approach to implementing a range of activities in the community, the projects can significantly reduce the pressure on the health facilities and support the work they are doing.

COORDINATION WITH GOVERNMENT, NATIONAL AND INTERNATIONAL AGENCIES

At national level there are different key faith-based organisations and religious bodies and networks which have influence in Malawi in relation to HIV and AIDS and health services. These organisations are involved in coordination efforts, advocacy, capacity building and national programme responses. There are differing levels of interaction with government, which include:

- involvement and consultation in developing national HIV policies
- advocacy work on key issues with religious leaders (for example reducing stigma and discrimination towards people living with HIV and discussing the role of condoms in prevention)
- monitoring and supervision of faith-based activities
- developing official memorandums of understanding with the health authorities to provide health services.

The Ministry of Health in Malawi leads the response to HIV and AIDS and is responsible for managing health systems in order to effectively deliver HIV testing, treatment and care services to the population. It recognises CHAM as a strategic faith-based partner and works together with CHAM to manage the health facilities.

In interviews with local health personnel in Kamwe in the same location as Tearfund partner LISAP, there was clearly a link between the local health centre and LISAP project activities and groups. Collaboration existed to the extent that the health centre replenished drugs for home-based care kits, medication supplies could be exchanged if they approached their expiration dates, and sometimes health personnel were involved in training. The senior health surveillance assistant, however, did not always know of the activities being implemented and did not receive monitoring reports about the programme.

It is within the UNAIDS mandate to work with faith-based organisations and religious leaders as part of its overall secretariat coordination role. UNAIDS in Malawi specifically acknowledges the importance of the faith-based contribution to the HIV response in Malawi and considers religious leaders to be an important target group for collaboration at a national level.

The National AIDS Commission in Malawi plays an important role in the overall coordination of the HIV response and works closely with the Ministry of Health.³¹ Faith-based organisations are viewed as integral players in the HIV response. The work of Christian (both Protestant and Catholic) organisations was noted, and the National AIDS Commission explicitly mentioned its work with networks of faith-based organisations such as MIAA. MIAA led the development of the mutual faithfulness strategy, which was a turning point for faith-based organisations and religious leaders in Malawi: the strategy resulted in increased emphasis on HIV and AIDS programmes by faith leaders and faith-based agencies.

30 *Fighting HIV/AIDS Stigma and Discrimination, Biannual report 2009 EAM*

31 National AIDS Commission (2008) *Malawi HIV and AIDS Monitoring and Evaluation Report 2007–2008*

The National AIDS Commission recognises that one of the main contributions of faith-based organisations in relation to the HIV response and health systems strengthening is their ability to reach people in remote communities. In rural areas there is a lack of government capacity to run health facilities, and so organisations such as CHAM deliver much-needed antiretroviral therapy, voluntary counselling and testing, and prevention of mother-to-child transmission programmes. Other faith-based responses include home-based care programmes, support groups for people living with HIV and AIDS, income-generating activities and cash transfer programmes. The National AIDS Commission would like to see faith-based organisations increase their focus on HIV prevention in the community.

National networks of people living with HIV and AIDS are vital stakeholders in the HIV response at local and national levels and help increase coordination, advocacy and programme quality. In Malawi these networks

BOX 2

Faith-based coordination: case study

MIAA is an example of an initiative to coordinate the HIV response of faith-based organisations and religious networks in Malawi. MIAA facilitates and coordinates the faith activities.

MIAA was formed in 2003 after the preceding World AIDS Conference, whose theme was 'Breaking the Silence'. MIAA applied this message directly to the faith community. Stakeholders recognised that faith-based organisations were implementing much work in HIV prevention, care and support but that there was a lack of coordination among them. As a result the Malawi Council of Churches, the Evangelical Association of Malawi and the Episcopal Conference of Malawi created a task force. They then invited the Muslim Association of Malawi to participate and formed the secretariat for MIAA. The National AIDS Commission recognises MIAA as representing the faith community HIV response in Malawi.

MIAA carries out activities such as research, advocacy and capacity building of faith-based organisations, particularly in developing funding proposals and in HIV programming. It also has a regulating and monitoring role. MIAA has contributed at a national level to the HIV strategy, the national AIDS plan and the HIV law, and on an annual basis is asked to input into the National AIDS Commission implementation plan. MIAA has a structure at the community level working through the district interfaith AIDS committees, although at a district level it is the district AIDS coordination committee that is the forum for interaction with the health authorities. MIAA is also part of the Malawi Equity Health Network, an advocacy organisation monitoring drug procurement and health service provision in Malawi.

Staff at MIAA believe that faith-based organisations have made a significant contribution to health system strengthening in Malawi, notably the work of CHAM. Progress has been made on the issue of promoting condoms in HIV prevention, although it still remains a sensitive topic. Discourse has progressed from condoms being a confrontational issue to one that can be summarised as follows: 'The faith community will promote what they know best and not castigate others.' MIAA has researched topics such as HIV- and AIDS-related stigma and discrimination with the faith community in Malawi, and the acceptability and use of condoms among faith-based communities.³² One of the conclusions of this study was that 'the persistent impression was that the faith community is not in favour of condoms as a method of family planning. The major reason was that the condoms have always been associated with illicit sexual liaisons since their introduction in the country, and as such it was not a method that was associated with family planning in the house.' However, only 3 per cent of respondents cited religious prohibition as the reason that influenced them not to use a condom. Most reject the condom because of personal dislike and misconceptions about condoms rather than religious prohibitions.

MIAA led the development of the mutual faithfulness strategy. The strategy has led to an increase in the faith-based response to HIV prevention. The strategy and other publications can be found on their website: www.interfaithaids.mw/publications.htm

The MIAA network has also been used by the Ministry of Health to promote other health issues, such as the cholera campaign, and both organisations are in the process of working with WHO to consider how to collaborate on TB issues. When the Ministry of Health or National AIDS Commission are developing HIV policies, MIAA is always involved in consultations on behalf of the faith communities along with representatives from the parent bodies of the religious groups.

32 MIAA (2006) *Acceptability and use of condoms among faith based community*

are at differing stages of establishment at both levels. There are several national networks of people living with HIV and AIDS, including MANERELA+.

In the religious communities the religious organisations and leaders have a role in coordinating the work of local faith-based organisations. This presents opportunities and challenges, as discussed below. Religious leaders can directly influence large segments of the population, and therefore their messages on HIV and AIDS need to be well informed and comprehensive. In Malawi MIAA has the role of coordinating the different religious groups (see box 2). For each religious group there is a parent body which works with its respective groups and faith-based organisations.

While not all religious groups participate in MIAA,³³ it remains an important initiative which attempts to coordinate the faith-based response in order to improve mapping of faith-based activities, to influence religious leaders and to strengthen the capacity and quality of faith-based responses to HIV. As MIAA has strong links with the Ministry of Health and is involved in various consultations with them, it provides an opportunity to further strengthen the collaboration between faith-based organisations and health authorities and ultimately to work towards strengthening health systems.

The Ministry of Health, National AIDS Commission and UNAIDS in Malawi all recognise the importance of the faith-based response to HIV and the potential for strengthening health systems. In practice collaboration between faith-based organisations and health personnel varies according to the context.

FUNDING FOR HIV PROGRAMMES

It is difficult to determine whether faith-based funding spent on HIV programmes is diverting resources from faith-based spending on broader health programmes. What is clear is that significant levels of funding are being invested in HIV programmes at a national level in Malawi and also in faith-based organisations for HIV and AIDS programmes.

In Malawi there is a Sector Wide Approach (SWAp) to funding in the health sector. It is a pooled funding mechanism for funding health and HIV programmes. All money that is allocated to national government health programmes from bilateral or multilateral donors goes through the SWAp, which determines how the collective funds are spent. Funding for HIV programmes comes from this common pool. It is a unique funding system, and in relation to HIV and AIDS programmes all donors follow the priorities of the National AIDS Commission. Funding for HIV programmes is disbursed by the National AIDS Commission, while the rest of the funding for other health programmes is disbursed by the Ministry of Health. For example, there has been significant financing from the Global Fund for health systems strengthening which has been channelled through SWAp. CHAM has been selected as a recipient of the Global Fund grant. Through this funding, CHAM has continued its health worker training facilities for nurses and directly reduced the health worker shortage in Malawi. CHAM also uses these funds to strengthen its health service infrastructure and to pay salaries. The Global Fund grant enables antiretroviral therapy to be bought for 300 facilities in Malawi. These include private, state and faith-based facilities (including CHAM).

In Malawi, there is an estimated total of 13.5 billion Kwacha for HIV and AIDS programmes. An estimated 10 per cent of this is spent on institutional funding, 50 per cent on antiretroviral therapy and the remaining 40 per cent on prevention activities, research, monitoring and evaluation, and policy development. Within the HIV funds about 80 per cent come from external donors while 20 per cent come from the Ministry of Health. The majority of the overall health budget in Malawi is external donor funded.³⁴

Funding for religious networks comes from church networks, faith-based donors and secular donors. One faith-based donor, Norwegian Church Aid based in Malawi, receives its funds through NORAD, the Norwegian embassy, church fundraising and private individual donors. The majority of the funding is spent

33 Tearfund (2009) *The Potentials and Perils of Partnership*, p20

34 These figures are approximations provided by the Ministry of Health representative during the research interview.

on health programmes, including HIV and AIDS. Norwegian Church Aid also funds CHAM through its maternal and child health programmes. Norwegian Church Aid focuses primarily on funding and building the capacity of (mainly Christian) faith-based organisations, although it has a policy of supporting all faith-based and secular organisations. It is engaged at national coordination and policy level, for example, as part of a faith-based donor group who coordinate their funding streams among partner organisations, and participate in policy discussions with the Ministry of Health and in SWAp meetings.

Norwegian Church Aid promotes both integrated and vertical approaches to funding HIV and AIDS programmes. HIV is mainstreamed into its health programme, while there is also a separately funded vertical HIV programme. In 2009, 50 per cent of funds were spent on HIV programmes and 50 per cent on other health programmes. Norwegian Church Aid recognises that there is a need for strong community interventions in HIV to support health facilities and that faith-based organisations have a role to play in this, particularly because supporting churches is sustainable since they remain as permanent structures in the community.

Danish Church Aid focuses on three main areas: food security, HIV and AIDS and good governance. Its main health focus is through HIV and AIDS programmes. It funds faith-based organisations and secular organisations.

While HIV is often a significant part of funding or programme work for both faith-based organisations and government organisations, in the case of the National AIDS Commission, which focuses exclusively on HIV, its spending is determined in relation to broader health priorities at a national level through the common pool of donor funds. This approach allows for clarity in the distribution between HIV and other health spending. It also allows for national health priorities to be addressed, as in effect there is discussion as to how the funding will be allocated before expenditure is agreed. The introduction of the SWAp programme, which was specifically designed to strengthen the health system, demonstrates that relying on vertical HIV funding alone was not enough to build the capacity of Malawi's health sector as a whole.

However, the resources mobilised for SWAp did not seem to displace HIV-designated funds, as HIV funding through the Global Fund and other donors has not abated. Faith-based organisations such as CHAM have become integral and significant parts of the national health system. Importantly CHAM helps build the capacity of the national system, especially through training new health workers. Malawi's health system is in a particularly precarious situation and there is also a high level of HIV prevalence. These factors mean that funding is needed for both HIV and health systems strengthening. It seems as though the HIV programmes are – or have the potential to be – most effective at supporting the capacity of the health system where there is greater coordination between faith-based organisations and the health authorities. In the case of HIV-focused programmes, if they are, in practice, a coordinated part of the health system, then arguably the health system directly benefits given the high demand for HIV services.

2.2 Chad

Chad remains in a difficult humanitarian situation as a result of civil unrest in neighbouring countries and clashes between rebel groups. There are more than 280,000 Sudanese refugees and 180,000 internally displaced people living in and around camps in eastern Chad.³⁵ This impacts on the country's capacity to have accurate HIV statistics and a comprehensive HIV response. The latest UNAIDS and WHO report from 2008³⁶ estimates that 3.5 per cent of adults aged 15–49 are living with HIV (low estimate = 2.4 per cent and high estimate = 3.4 per cent). Sentinel surveillance of HIV among pregnant women in Moundou in the south of Chad is in the range of 10–24 per cent, and is in the 5–9.9 per cent range in three areas: Ndjamená,

35 www.fco.gov.uk

36 WHO/UNAIDS/UNICEF (2008) *Epidemiological Fact Sheet of HIV and AIDS, Chad 2008 Update*

37 www.cia.gov/library/publications/the-world-factbook/geos/cd.html

Bongor and Sarh (and an estimated 85,000 children orphaned by AIDS: the low estimate is 42,000 and the high estimate is 270,000. Chad's estimated total population was just over 11 million in 2009).³⁷

The research in Chad took place in Ndjamena city and Bousso district. Semi-structured interviews were conducted with key stakeholders. These included Tearfund partners the Christian Programme for Rural Development (PCAR), the Evangelical Project for Community Development (PEDC) and Ethics, Peace and Justice (EPJ). Other faith-based organisations involved were World Vision Chad and Family Life Education Centre (CEVIFA). Key national players that were interviewed are UNAIDS, the National AIDS Commission and the national network of people living with HIV and AIDS. Religious leaders and church networks who participated are the Covenant of Evangelical Churches and Missions in Chad (EEMET), the Evangelisation and Mission Service (SEM), EPJ and Christian Assemblies in Chad (ACT).

Focus group discussions were also carried out with key participants in a PCAR programme area, including religious leaders, project personnel, people living with HIV and AIDS and local health personnel. Findings from the research in Chad are presented, looking at the indirect and direct impact of faith-based organisations in the HIV and AIDS response and health systems strengthening at a community level and then looking at some coordination and funding aspects at a national level.

FAITH-BASED HIV RESPONSES: INDIRECT IMPACT AT COMMUNITY LEVEL

Faith-based organisations are involved in working in remote rural areas, carrying out information, education and communication (IEC) activities and supporting the work of the local health facilities. This has an indirect impact on the health facility, as although it may not be directly influencing the work of the health facility it is doing important outreach awareness work that the hospital does not have the capacity to do and in this way is increasing the uptake of the health services. For example PCAR in Chad, working through ACT, implements agriculture, income-generation activities and HIV and AIDS activities.³⁸ It carries out information, education and communications activities in the community and gives people a health card if they are interested in doing an HIV test. The hospital recognises these cards, and when they are presented staff know that the person has already received a certain amount of counselling before coming for a test and that the person will also be supported by the faith-based organisation on their return. The health personnel commented that the work of PCAR through the information, education and communication programme and the introduction of the health cards has assisted the hospital in encouraging more people to come for HIV tests. Faith-based organisations working in such communities also assist in making referrals to the hospital for people to receive tests and further treatment.

PEDC (Projet Evangélique pour le Développement Communautaire) is another example of a faith-based organisation which has an indirect impact on the health services. PEDC is mainly involved in food security and agriculture. It uses its interactions with communities as opportunities to discuss HIV issues. The area it works in is predominantly Muslim and it has sought permission from imams to implement the programme in the villages. It is now possible for community members to take an HIV test in the health centre and to access condoms and anti-retroviral therapy in the hospital. The staff of PEDC have noticed that the level of HIV and AIDS awareness in the communities where they work has increased but feel that there is a need for much more HIV work to take place.

DIRECT AND INDIRECT IMPACT

Some faith-based organisations carry out comprehensive HIV programmes involving prevention and care activities and have a direct and indirect impact on health services, for example CEVIFA (Centre d'Education à la Vie Familiale). CEVIFA started its activities in 1998 but these have been interrupted by civil war. It works through a Christian philosophy of how faith can create a positive impact in society in relation to HIV. Since 2004 CEVIFA has been a national NGO. It has two main aims: to give education and information on HIV

and reproductive health and to care for those who are living with HIV and AIDS. It has noticed a change in attitudes over the last three years in terms of people starting to talk more about HIV. It organised a television programme in 2008 in which one person spoke openly about living with HIV and AIDS.

CEVIFA partners with different churches and is not linked to one specific church; it is inter-denominational and aims to remain neutral and open to all people of all faiths. People come to its centre through the information that is given in different churches, through word of mouth or through the radio programme. A nurse at the centre provides voluntary counselling and testing and treats opportunistic infections. It is funded by MCC, DED and FOSAP. In addition to voluntary counselling and testing, CEVIFA provides follow-up support for antiretroviral therapy and treatment of opportunistic infections. It also provides HIV awareness-raising programmes at the centre and in the community for youths and others. It supports children affected by AIDS through school fees where possible. It provides information about living positively with HIV, raises awareness of the importance of nutrition, and provides cooked meals at the centre (see box 3). It is strongly supported by the Ministry of Health, which pays the salary of various key staff in the centre. Four hundred people are registered at the centre at the moment.

BOX 3**The impact of CEVIFA****Eric Mbaigoum**

'I am 26 years old, the father of one child. I am sero-positive. For some time I suffered often from fever which never stopped and I had persistent diarrhoea. I visited several health centres and hospitals in Ndjama but without any results. I was weakened by the diarrhoea, and was admitted to the National General Reference Hospital, where they discovered I was sero-positive. After leaving the hospital, I started to worry. I went to EEMET (Entente des Eglises et Missions Evangéliques du Tchad) where I was advised to go to CEVIFA. After having discovered CEVIFA, I was welcomed with open arms. I was cared for psychologically and medically, and my child was equally cared for. He is now going to school, fed and cared for by CEVIFA thanks to the support from MCC to CEVIFA which continues up until now. I have gained a little more than five kilos of weight and my child is educated, cared for and fed, although I am unemployed and I don't have a job.'

Julpa Nekoimbaye

'I am a widow and 32 years old, I am sero-positive. After the death of my husband, people found out that my husband died of AIDS. I took the decision to go and do a test and it was positive; I hid my illness. One of my friends who used to come to CEVIFA invited me to go with her; after praying they asked for those who had come for the first time to stand up. That was when a team was given the responsibility to care for me and to follow up and visit me at home. After their visit to my house, I received advice and I spoke about being positive with my brothers, my sisters and other people that I knew. Thanks to their psychological care and medication, I was able to start to work in the market again where I sell food, and I am in good health, and my child, who had missed two years of school, now goes to school. God bless the centre and the sponsors who support it.'

The example of CEVIFA highlights some important points:

- The effectiveness of interfaith approaches to faith-based HIV and AIDS programmes.
- How faith-based responses are able to help relieve the pressure on hospitals, releasing beds for others.
- The impact that small faith-based organisations can make when given technical support and assistance and when the faith-based organisation is also open to implementing such programmes following national HIV and AIDS guidelines and best practice models.

World Vision is an example of an international faith-based organisation which supports religious networks in Chad. One programme that it is implementing is the Core HIV and AIDS Response Monitoring System (CHARMS). This programme works with both communities and religious leaders. The overall aim of the programme is the well-being of children, and in that way all community-based organisations and structures within a community are involved in the programme. It is a model for working on prevention, care, advocacy and capacity building activities. There are 14 area development programmes (ADPs) in Chad, with over 400,000 beneficiaries. Congregational HIV and AIDS task teams aim to train church leaders to speak openly

about HIV and AIDS. There are strong links with the local health facility in the programme which makes referrals for HIV testing, counselling and antiretroviral therapy. This example emphasises the importance of a comprehensive community approach to working on HIV and AIDS issues that places the role of church leaders within the community context.

BAC (a ministry within EEMET) in Chad manages four hospitals and 101 health centres. These health facilities work within the policies of the Ministry of Health. Some of the nurses and doctors in the health facilities are paid by the government and the health centres receive subsidised drugs. In relation to the management of health facilities, if the largest hospital in a district is faith-based then it will assume the management role of the health facilities in that district. They also supply anti-retroviral therapy, voluntary counselling and testing and prevention of mother-to-child transmission services. BAC contributes to strengthen health systems by providing health services in remote rural areas where there are no state health facilities. This strengthens health systems and HIV and AIDS programmes if they are also following national health and HIV and AIDS guidelines.

COORDINATION WITH GOVERNMENT, NATIONAL AND INTERNATIONAL AGENCIES

National-level coordination of the HIV and AIDS response in Chad is led by the Ministry of Health in partnership with the National AIDS Commission and other key players such as UNAIDS, FOSAP, CCM and the national network of people living with HIV and AIDS. There are also faith-based organisations and religious bodies and networks which have influence in Chad in relation to HIV and AIDS and health services. Involvement of such faith-based organisations includes coordination efforts, capacity building and national programmatic work. Interaction ranges from involvement and consultation in developing the national HIV and AIDS policies, and monitoring and supervision of faith-based activities, to official memorandums of understanding with the health authorities to carry out key health services.

UNAIDS in Chad acknowledges the importance of the faith-based contribution to the HIV response and considers religious leaders to be a key target group for collaboration at a national level. The National AIDS Commission considers faith-based organisations to be integral players in the HIV response and works with networks of faith-based organisations and churches such as EEMET. The main faith-based organisations working on HIV and AIDS were noted by the National AIDS Commission to be the Catholic response (through LINAP) and the Protestant response (through EPJ). It considered the main contribution of faith-based organisations to be their extended reach into remote rural areas. The National AIDS Commission worked most with networks of churches such as EEMET.

In interviews with local health personnel at a district level in a remote rural area, it was apparent that the only organisation doing work on HIV and AIDS in the area was the faith-based organisation PCAR. The usefulness of the health card system, which encourages people to come to the hospital for HIV testing, was noted, but there were insufficient HIV prevention activities and home-based care programmes. The local health personnel discussed the need to do further work with religious leaders so that the local community accepted and understood HIV and AIDS. The hospital was funded by the government and offered free antiretroviral therapy and voluntary counselling and testing services. It seemed that there was recognition of the progress the National AIDS Commission had made in Chad but that this particular region had been neglected.

National networks of people living with HIV and AIDS are key players in the HIV response at local and national level for coordination, advocacy and programme quality. In Chad they exist to differing degrees of development at both levels, but there is not a direct link to religious leaders. The vice president of the national network of people living with HIV and AIDS commented that the health system in Chad is very weak. He is on the Global Fund country coordinating mechanism committee, and recently a Global Fund proposal has been developed which recommends health systems strengthening and through that increasing coverage of HIV and AIDS programmes.³⁹ He also mentioned that they have started to work with specific

priests and pastors who have agreed to do funerals for families where members have passed away from AIDS-related illnesses. They do advocacy work with religious leaders to increase the understanding of HIV and AIDS.

In the religious communities the parent bodies and leaders for the different religious groups are important in the coordination of the work of local faith-based organisations. This presents opportunities and challenges, as discussed below. Different religious leaders of groups within EEMET such as EPJ and ACT were interviewed.

EEMET is the Covenant of Evangelical Churches and Missions in Chad. BAC is a department of EEMET and responsible for developing the capacity of churches, monitoring activities, and evaluating and designing projects. It is also responsible for the management of the hospitals and health centres under EEMET.

Another department of EEMET is Ethics, Peace and Justice (EPJ), which works in southern Chad and Ndjamenana and implements most of the community HIV and AIDS activities. These include home-based care for people living with HIV and AIDS and support for orphans (school fees, food, healthcare, feeding, uniforms). More than 100 people living with HIV and AIDS are supported through small credit programmes, and support is given for medication and to access antiretroviral therapy. There are links with the health authorities in relation to using the hospital to deposit funds which the hospital then uses to care for the orphans. Very poor children (currently numbering 595) are identified through the church and cared for in the health facilities in eight different communities.

SEM is EEMET's department of evangelism and missions. The head of this department regards HIV as a cross-cutting issue and the main health issue that the church deals with. He mentioned that the church works with ACDF (Planned Parenthood Federation) to give presentations on HIV and AIDS, including the role of condoms in HIV prevention. Although such collaboration exists with non-governmental secular organisations, he also stated that the position of the church is that condoms can only be used in discordant couples. He did feel, however, that there is now a registered commitment to address the issue of HIV and AIDS and not to spiritualise it. EPJ has developed a booklet that has been used in the HIV and AIDS education programmes. He feels that one significant change he has noticed is that people cannot joke any more about HIV prevention, as people have seen their own friends become sick and die, as well as church leaders.

The importance of coordination between faith-based organisations, religious leaders and the national coordinating bodies in the HIV response is recognised in Chad even if coordination mechanisms appear to be not as well established as in Malawi. Religious leaders have a strong influence at a national and community level, and further collaboration could result in more comprehensive and effective HIV and AIDS programmes being implemented by faith-based organisations, building on the existing good examples such as CEVIFA.

FUNDING

It is difficult to determine whether faith-based funding for HIV programmes is diverting resources from faith-based spending on broader health programmes in Chad. What is clear is that significant levels of funding are being invested in HIV programmes at a national level and also in faith-based organisations for HIV and AIDS programmes.

Funding for religious networks varies, for example EEMET in Chad receives funding from MMC, the World Bank, UNICEF, the government, Tearfund and World Vision. Most of this funding is allocated for HIV and AIDS programmes and a small amount for malaria programmes.

The Global Fund proposal for Chad focuses on key areas for a comprehensive HIV programme to be implemented nationwide and on the need to strengthen health systems. International donors are encouraged to follow the guidelines set out in the Global Fund proposal when considering funding HIV programmes in Chad.

3 Reflections and challenges

The focus on HIV through vertically funded programmes has been important in the global response to HIV and AIDS and has resulted in significant advances and progress in making HIV and AIDS health services available to all. It is difficult to say whether this has diverted funding away from health systems strengthening, as donors seem to apply both vertical and horizontal funding for HIV and AIDS. For example, Norwegian Church Aid in Malawi has horizontal and vertical funding streams for HIV and AIDS programmes. They support integrated approaches where HIV services are part of the health services and specific HIV programmes which address a specific need.

In Malawi the presence of SWAp re-emphasises the need for much closer programming to strengthen health systems and ensure comprehensive coverage for HIV programmes. The vice president of the national association of people living with HIV and AIDS in Chad is also part of the Country Coordination Mechanism committee for the Global Fund. He commented that it would be most efficient if donors could support the existing Global Fund proposal that addresses HIV programme and health systems strengthening. There is a clear need to strengthen health systems in the presence of weak health infrastructures to ensure a comprehensive response to HIV and AIDS. To complement this there is also a need for specific funding for HIV to meet the need for HIV services.

There is complexity in assessing whether a faith-based HIV programme contributes to or detracts from the health system as a whole. In the case of CHAM in Malawi, the organisation responds to HIV as part of a wider health remit. It provides almost 40 per cent of the healthcare in the country and partly uses government funds to deliver its services. In this context it can be argued that CHAM is a significant part of the national health system. Where organisations provide an integrated range of HIV and broader health services they can more clearly be seen as strengthening the national health system. Therefore CHAM's programme can also be seen as a partly diagonal approach because it specifically addresses capacity issues through training nurses. CHAM hospitals and clinics exist in place of government-initiated infrastructure, and therefore their HIV services are not parallel duplicative services that divert funding away from the health system.

There remains justification for vertical HIV-specific services because of the needs expressed by community members. Existing community organisations may begin responding to HIV, or new groups can be formed. However, these vertical programmes need not undermine the broader health system. The services that these community organisations provide may focus on linking people with existing medical health services, providing peer support to people living with and affected by HIV, and doing outreach that is often outside the capacity of formal health facilities, such as home-based care and awareness raising. Some of these community organisations may be faith-based.

From these perspectives, faith-based HIV responses reduce the overall demand on health systems and therefore their work can be seen as factors that do not contribute to the weakening of health systems. It is difficult to quantify whether faith-based organisations are contributing to strengthening health systems for many reasons. One of the reasons is that strengthening health systems may be an unintended outcome of their work, and it is explicit neither in their objectives nor in their monitoring and evaluation.

In some cases, faith-based responses to HIV may have only a weak positive impact, for example, providing a limited amount of referrals and giving little information about the health facilities with no formalised relationship between the faith-based organisation and the health clinic, and no follow-up with patients by the faith-based organisation. In other cases, the faith-based programmes themselves may be of low quality because of weak infrastructure, lack of monitoring and evaluation processes, low awareness of HIV and AIDS issues and limited programme activities by religious leaders and staff. These may result in a restricted range of services being provided, discrimination against people of other denominations, and increased stigmatisation of people living with HIV. In these contexts, individual faith-based organisations, whether implementing horizontal or vertical programmes, may unwittingly increase the burden on health systems and therefore contribute to weakening them.

Despite some of the challenges that faith-based organisations face, it is clear from the programmes that were the subject of this research that as a whole these faith-based organisations are contributing significantly to both the HIV response and the broader health responses in Chad and Malawi.

Faith-based organisations play a key role in managing hospitals and health centres. This can be used as an opportunity to ensure that HIV prevention, treatment and care reaches the most remote populations where often there is no other access to healthcare services. It is also an opportunity to directly contribute to health systems strengthening by ensuring open collaboration between faith-based health facilities and the Ministry of Health, and other key players could strengthen this (eg CHAM).

Faith-based organisations may be working in areas where there is a government health facility. Links between local state-run health facilities and faith-based organisations could be strengthened to ensure the communities receive the maximum possible from their health services (eg LISAP in the field example from Malawi). Close collaboration and effective cooperation create a diagonal approach, as seen in LISAP's response, which aims to reduce bottlenecks and create a continuum of care for patients.

Faith-based organisations have an important trust relationship with church leaders and have access to them in a way that other secular organisations may not. This opportunity can be maximised in working with faith-based organisations to develop their HIV technical capacity, advocacy and influencing capacity to work with religious leaders in a way that can have long-lasting influence on the HIV prevalence in the communities where the religious leaders are based. This may also influence the levels of stigma and discrimination around HIV and AIDS (eg some of the religious leaders' views in the communities where partners are working and also at a national level in Chad). Religious leaders are very influential and vocal, particularly in the two countries visited.

In some communities faith-based organisations may prefer to work with faith-run health facilities. Further work could take place between state-run and faith-run health facilities to work to the same health policies and standards of work so that certain health facilities are not preferred over others.

The capacity of faith-based organisations to write proposals, develop good-quality HIV programmes, and carry out monitoring and evaluation and accurate targeting should be increased to enable them to access funding, to implement quality projects and to document and share their experiences.

The capacity of faith-based organisations should be increased to enable them to implement quality HIV programmes, as faith-based organisations reach some of the poorest and most remote communities that sometimes other secular organisations do not reach.

3.1 Impact of religious beliefs

As already discussed, faith-based organisations provide a significant proportion of healthcare services in Africa. To overemphasise the negative impacts of a minority of specific religious beliefs would do a disservice to the many people and organisations who are motivated to provide care and support for others as a direct result of their faith and religious beliefs. Equally, it is important to discuss the areas where religious beliefs can or do have a detrimental impact in order to begin to address them.

The religious leader who coordinates MANERELA+ is a pastor living with HIV. It is apparent that the network exists in part because of the need for further work to be carried out with religious leaders because of sensitive or controversial areas of policy and discourse, such as church responses to HIV prevention (ie focusing more on care and support than on prevention) and the role of condoms within prevention.

Programmes run by faith-based organisations which focus on youth life skills and pre-marriage counselling often include elements around HIV and AIDS (eg Scripture Union and SCOM in Malawi, and PEDC in Chad). These may focus on issues such as faithfulness within the marriage, pre-marriage HIV testing, and abstinence. While these can be valid strategies, the impact of programmes depends on the quality of delivery, and also the comprehensiveness of key HIV and AIDS messages.

Where being HIV positive is wrongly considered a sin, this has fuelled stigma and discrimination in communities. For example, in Chad, one person living with HIV commented, 'The religious leaders won't pray for us in our homes.' This was a major concern for the small group who participated in the research, and such attitudes of faith leaders continue to fuel stigma and discrimination against people living with HIV in the community. It is not surprising that in the same group there were comments such as, 'Sometimes people call us names or do not want to use the toilet after we have used it.'

There was evidence that one Christian group in Malawi had encouraged people to stop taking antiretroviral therapy because it believed that God would directly heal someone from HIV. This does not strengthen the scale-up of antiretroviral therapy and unfortunately can have serious consequences for people who interrupt their treatment or never go for testing if they do not believe in the importance of accessing antiretroviral therapy.

In Malawi, there was a comment from one member of the support groups, that sometimes it is difficult to receive the support and training aimed at people living with HIV, as often they are focused on specific members of a specific church. A suggestion was made that it could improve access to services for people living with HIV (eg home-based care, psychosocial support) if support groups were independent and strengthened through different or multiple churches and others who wished to support them.

The work of organisations such as MANERELA+ is extremely important in strengthening the faith-based response to HIV and AIDS. MANERELA+ is part of a network of organisations of religious leaders living with or affected by HIV and AIDS all over Africa called ANERELA+, created in 2003. They exist to equip, empower and engage religious leaders living with or personally affected by HIV and AIDS to live positively and openly as agents of hope and change in their faith communities and countries.

In Malawi MANERELA+ has around 1,000 members; having started in 2004 with only ten. It is one of the largest networks of its kind in Africa and the world. The majority of its members are Christian (75 per cent) and the rest mainly Muslim. They follow the SAVE prevention model which is promoted by ANERELA+. ⁴⁰

The SAVE approach provides a holistic way of preventing HIV by incorporating the principles of the ABC (Abstinence, Be faithful and Condom use) approach, as well as providing additional information about HIV transmission and prevention, providing support and care for those already infected and actively challenging the denial, stigma and discrimination so commonly associated with HIV.

MANERELA+ acts as a support system for religious leaders living with and affected by HIV and AIDS, and carries out significant capacity building and advocacy with the faith community and beyond. It links people to health service providers in the communities where they are present, for example by promoting testing, creating support groups such as in Pedze district in Malawi, carrying out home-based care programmes, making referrals and carrying out follow up for treatment adherence.

There are significant challenges in working with religious leaders from different faiths on issues such as HIV prevention. However, as INERELA+ (the international network of religious leaders living with HIV) notes in relation to its members, it is vital that religious leaders are 'empowered to use their positions of respect within their faith communities in a way that breaks silence, challenges stigma and provides delivery of evidence-based prevention, care and treatment services'.⁴¹

3.2 Monitoring and evaluation and quality programmes

Monitoring and evaluation is crucial irrespective of whether a programme is implemented by a faith-based or secular organisation, and there is a noticeable lack of consistent and rigorous approaches among the faith-based community, including the faith-based organisations which were interviewed. If there is a lack

40 www.inerela.org/english/save-prevention-model

41 From the INERELA website

of clear targeting in programmes based on programmatic criteria and a lack of a monitoring and evaluation framework that is followed, it is very difficult to decipher whether the programme is having an impact or not. It is important that HIV and AIDS programmes are working within the national programmatic and policy guidance and using the nationally identified monitoring indicators.

There is clearly some disparity in both countries between the national HIV and AIDS policy and what different faith-based organisation and religious networks are following in practice, particularly regarding condom use. The main religious bodies and networks were consulted in both Chad and Malawi when the respective HIV and AIDS policies were developed in both countries, but they did not necessarily agree and adhere to all parts of the policies. It is apparent that there is a certain degree of consultation in both countries with religious leaders, which is important for coordination at an implementation level even if there are disagreements.

Implementing quality programmes that address the key areas of the HIV epidemic is vital, and there is a wealth of experience showing what programmes work. Combining this with the influential role that religious leaders have in a community makes a powerful approach when considering key strategies for reducing the HIV prevalence in a country.

3.3 Coordination at a local and national level

LOCAL COORDINATION

Local coordination can be more effective than national coordination, as it may be activity-specific. For example LISAP, a faith-based organisation in northern Malawi, has a home-based care programme in a community and works with the local health facility to run the home-based care programme, in supplying or storing home-based care kits and training health surveillance assistants who are then involved in the programme. However, it was discovered that home-based care monitoring reports are not submitted to the health centre on a regular basis, so it is difficult for the health centre to track the activity and clients. It would enable better patient care if there were more local coordination.

In Malawi there is a reliance on health surveillance assistants at a community level who are often the only health personnel present running health centres. This results in the assistants being overburdened and overworked, yet also not always fully informed about health activities happening in districts where work is taking place. If the assistants were more informed of district activities this would support the overall health response in a more efficient way. Both youth groups and support groups for people living with HIV and AIDS stated they would appreciate more support from the assistants.

NATIONAL COORDINATION

There is coordination at a national level between key players, for example between UN bodies, the National AIDS Commission, the Ministry of Health, the private sector, civil society, faith-based organisations and religious leaders to varying degrees. An example of coordination with the faith-based community is MIAA in Malawi, as described above.

Coordination at a national level for MIAA could be strengthened. One of the roles of MIAA is to monitor the faith-based response. MIAA does not receive reports from all faith-based organisations. This is mainly due to the fact that organisations tend to report on work on the basis of funding received from a specific donor. These are the same challenges that the National AIDS Commission experiences from civil society and faith-based organisations. MIAA receives reports from the religious mother bodies which may or may not cover all of the activities linked to that specific religious body. MIAA has begun a mapping exercise to create a better picture of the number of faith-based organisations that exist and are operating in different communities nationally, as there is currently no database of faith-based organisations in Malawi.

The Malawi National AIDS Commission reported similar challenges to MIAA, as reporting tends to be linked to the funding demands of specific donors. Organisations are unwilling to provide information on activities unless they are receiving funds from that body. It is then difficult for any central body to collect accurate data on what activities are taking place, especially from faith-based organisations if they are not receiving funds from the National AIDS Commission.

Coordination of existing HIV and AIDS plans is another well known challenge in the HIV and AIDS response, not only for the faith-based community. In Malawi, MIAA has attempted to coordinate the HIV plans and align them with the national policy and plan, but because of disagreements between religious groups this proves challenging. Even at the level of MIAA, there is a MIAA HIV plan and one for each of the different religious parent bodies. The National AIDS Commission also commented on the lack of capacity of many faith-based organisations to design effective HIV programmes and proposals and to meet the criteria of donors in order to receive funding and technical support. Part of the role of the National AIDS Commission and MIAA is to develop further the capacity of faith-based organisations to do this. As competition for funds is high, faith-based organisations need to be able to present competitive proposals and bids in order to access funding or support to improve their programmes.

In Chad, coordination between different faiths has been initiated through the creation of the Alliance, but this body has not held recent meetings. Each parent body coordinates activities with its members and there is little dialogue between, for example, the different religions at a national and local level.

Coordination at national and local level is important. This has been recognised and steps taken to address this Africa-wide through the UN, national AIDS councils and other institutions. There is still a need to continue the emphasis to improve coordination, particularly in the context of faith-based organisations and the contribution they are making to delivery of health services.

3.4 Collaboration

In each interview, participants were asked about the level of collaboration they have with health authorities, local health facilities, faith-based organisations and secular organisations. Results are subjective but there are some general trends.

National-level faith-based organisations, funders and religious groups had less collaboration with secular than with other faith-based organisations. At the level of Tearfund partners and locally in the field there was even less collaboration with secular organisations. Sometimes there was increased collaboration if funding had been received from a secular organisation. Generally collaboration between the health authorities at a national level and the national-level faith-based organisations and religious leaders was rated quite high on both sides, whereas at a local level it varied very much in terms of the level of collaboration with local health authorities or health facilities.

These findings were reinforced by the Tearfund UK office, showing that where collaboration with other faith-based organisations may be good, in the field it was significantly weaker with secular and health authorities. At headquarters level, relations with secular organisations were rated as being much higher.

This indicates the need for ways to be found to increase the collaboration between faith-based organisations and key players and further ways for possibly initiating joint programming.

4 Conclusions and recommendations

Through the literature review and the research conducted, findings show the successes and challenges of the faith-based response to HIV and AIDS and give some insight into how it may strengthen health systems. At a community and national level, faith-based organisations have contributed significantly to health services indirectly and directly. It is also evident that there are barriers to overcome in relation to religious beliefs around HIV and AIDS in particular impacting on HIV prevention services and also linked with stigma and discrimination against people living with HIV and AIDS. Through better cooperation, collaboration and joint programming between faith-based organisations, health authorities and facilities and secular organisations such barriers can be overcome, faith-based responses to HIV can be more effective, and health programmes can be strengthened to have a stronger impact on health services.

The following recommendations are applicable to both Chad and Malawi and potentially other contexts in Africa where faith-based responses to HIV exist alongside secular health service provision.

4.1 Recommendations to faith-based organisations

- Increase internal capacity to develop proposals, and to deliver and support effective HIV prevention and care programmes following national HIV and AIDS policies and guidelines with a special focus on HIV prevention.
- Seek interfaith responses, collaboration with health services and observance of best practice in HIV and AIDS programmes.
- Empower and build the capacity of religious leaders, giving them sufficient resources, technical assistance and finances to maximise their potential to work on HIV and AIDS issues in the communities where they are based.
- Partner with existing faith-based networks of people living with HIV and AIDS, such as ANERELA+, and support them to expand their work and form stronger linkages with religious leaders.
- Include health systems strengthening as an objective in HIV and AIDS programmes, to support closer collaboration with government-run health services.

4.2 Recommendations to donors and governments

- Recognise the direct and indirect existing contributions of faith-based and interfaith responses, and their potential to increase their impact on health systems strengthening.
- Facilitate the meaningful inclusion of faith-based organisations in health systems strengthening by ensuring they are part of health service coordination mechanisms.
- Support faith-based organisations to increase the quality and technical capacity of their service provision through funding, training and skills initiatives, and integration into national priorities and policies.
- Increase funding and programmes to support religious leaders, networks and faith-based organisations to develop HIV and AIDS strategies which follow national HIV and AIDS policies and guidelines.
- Support the ongoing work to strengthen the capacity of religious leaders to work on HIV and AIDS and to align responses with national HIV and AIDS guidelines.
- Develop policies which promote collaboration between local clinics, hospitals and faith-based organisations, and which encourage mutual recognition and coordination between government services and faith-based programmes. This should include ensuring strengthening effective mutual referral mechanisms.
- Support faith-based organisations to increase their monitoring and evaluation capacity in order to increase the quality and maximise the potential of faith-based HIV and AIDS programmes.
- Continue to emphasise the importance of following a single national monitoring and evaluation framework among secular and faith-based organisations, encouraging them to contribute to these national-level processes irrespective of funding requirements.

- Document good practice of faith-based and secular coordination, and ensure that lessons learned in HIV and AIDS programming are disseminated at national and international levels.
- Encourage and strengthen collaboration between faith-based organisations and national and local health authorities by developing strategies for joint programming to ensure a comprehensive HIV and AIDS programme is provided for all people.

4.3 Recommendations to donors

- Encourage faith-based agencies to specifically include health systems strengthening as an objective in their programme and organisational strategies.
- Continue to fund integrated and vertical programmes for HIV and AIDS within the specific country context, ensuring national priorities and policies are referred to and international guidelines considered.
- Encourage government and secular organisations to include the responses of faith-based organisations in their monitoring statistics.
- Support research into further analysis of the impact of the HIV and AIDS work of faith-based organisations, for example on health systems strengthening and on religious leaders and how this impacts on HIV and AIDS programmes delivered in the communities.
- Provide support to faith-based partners, religious leaders and networks to challenge stigmatising attitudes towards people living with HIV and AIDS.

4.4 Recommendations to governments

- Continue to support and fund existing coordination structures such as MIAA in Malawi to strengthen the coordination of the faith-based response to HIV and AIDS.
- Promote compliance with and contributions to national HIV and health guidelines and priorities among donors and faith-based organisations.
- Recognise and emphasise the importance of faith-based and interfaith leadership in the national response to HIV by increasing dialogue with faith-based national networks of people living with HIV and AIDS, such as MANERELA+.



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