Informed Decision Making: Partner Perspectives

Research commissioned by Cordaid

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Executive Summary

Cordaid supports Catholic partner organisations that provide health and HIV related services. For many of the organisations, services related to family planning and HIV prevention may cause dilemmas as their service delivery is influenced by conflicting messages and expectations from sexual morality teachings of the Church, Catholic social ethics tradition, government regulations, and the needs and requests of their clients. Cordaid undertook this research in order to address potentially challenging theological issues surrounding its partners' perspectives on facilitating informed decision making among clients of HIV and sexual health related services. The research aimed to illuminate the influencing factors on the ability of men and women to make informed decisions. The key influencing factors that were presumed to exist include religious teachings, policies, structures and communication styles at different levels of the Church, and further factors included secular government policy, the personal religious views of health care workers, the training and capacity levels of health workers, and the attitudes of clients.

Additionally the research used a framework designed by Engender Health (2003) as a basis for discussion with partner organisations and for analyzing the partners' abilities and constraints in facilitating informed decision making. The Engender Health model articulates five key areas that are necessary for facilitating informed decision making:

1. Service options are available
2. The decision making process is voluntary
3. Individuals have appropriate information
4. Good client-provider interaction, including counselling, is ensured
5. The social and rights context support autonomous decision making

Among the nine key contributing partners to the research from DRC, Malawi and South Africa, the practices and views about sexual and reproductive health were varied. Among the most religiously conservative partners, condoms were acknowledged as HIV prevention strategies but applicable only in non-Catholic service provision contexts. No partners condemned the use of condoms outright, but many believed that providing them was in conflict with Church teachings. Only one partner took a public health approach and openly promoted the supply and distribution of condoms as part of HIV prevention. Five of the partners supplied condoms discreetly to clients in the privacy of the consulting room, despite having a public image of not promoting condoms, and one of these partners provided condoms to discordant couple only. The three remaining partners do not provide condoms under any circumstances but do refer clients to other services.

Among most of the partners family planning services are avoided by the partner organisations altogether. The three South Africa partners provide ART delivery and support services, while the partners in DRC and Malawi are health clinics with a broader remit. Because of the Church teachings on the inappropriateness of artificial family planning methods, most of the partners had effectively ruled out any kind of family planning services and instead make referrals to other services. Individual health care workers among some of the partners provide information on natural family planning methods, and some provide some information on artificial methods but again need to refer clients to access other services.

Good practice among partner organisations in facilitating informed decision making were recorded against each of the five necessary areas of the Engender Health framework. To ensure that service options are available, **referrals** are crucial and all the partners were aware of services that were available to clients, including their own and those of other service providers in the area. **Providing related services**, such as treatments for sexually transmitted infections or TB treatment benefits clients because it reduces the number of referrals and staff can accompany clients through their diagnoses and treatments. Three of the partners used the standards set out in the **national policy on HIV prevention** to legitimize their provision of condoms.

The second necessary area focuses on ensuring that the decision making process by the client is voluntary. One partner explicitly referred to emphasizes the promotion of the **rights of the client** by explaining them, and two partners both had confidentiality policies to ensure the privacy of their clients as part of facilitating decision making process and to encourage uptake of services. Other good practice included **supporting clients to make decisions** by helping them involve their family members or a friend. Partners also emphasized regular **training and support** for staff members to manage their stress and their ability to facilitate their clients' decision making.

All partners strive to ensure that individuals have appropriate information through **facilitating peer support groups for people living with HIV**. The members of these groups importantly act as resource persons for new clients to the facilities. **Outreach** to provide information also featured among the clients in different formats including visiting community meetings, providing outreach clinics and advocacy campaigns. To maximize access to information some of the partners provide IEC materials in multiple languages and hire translators for communicating effectively with migrants.

Good client-provider interaction was defined for two of the partners as providing **individualized care** for each client and building relationships with them. As part of this strategy they strive to make attendance at the clinic as stress-free as possible by reducing waiting times and providing a welcoming environment. Pre and post test **counselling** was the key mechanism for partners to interact with clients to build trust, impart information, and importantly listed to the needs of the client. Some of the partners emphasized the need to ensure that clients understand the information they are receiving and encourage clients to ask questions openly and candidly. Two partners ensure that their staff training explicitly includes counselling skills to help clients make decisions.

The fifth area in the framework focuses on whether the social, religious and rights contexts support autonomous decision making. This was perhaps the most challenging area for the partner organisations, as they often felt that external factors were outside their influence. Additionally working to change external factors often lay outside their remit as health service providers. However, one of the DRC partners has initiated **training with bishops and priests** on HIV. This strategy has contributed to these leaders having much greater awareness of HIV and AIDS and the needs of communities.

The research sought to understand some key issues for faith-based partners such as how they perceive their Catholic identity, and what challenges in providing sexual and reproductive health related services are specific to them. All partners expressed the importance and significance of their Catholic identity. In particular, Catholic values (love, solidarity and respect) strongly motivate partner organisations to respond to the communities they work in. This perspective was largely echoed by clients who, whether Catholic or not, articulated their appreciation of their welcoming experiences at the facilities, and staff's commitment to accompanying them through their diagnoses and treatments. The impact of these positive aspects of Catholic identity should not be underestimated. Facilities and staff are often seen as safe and trusted places for clients to seek information and support. There is no denying, however, that a health facility with a Catholic identity may deter people from entering the clinic. The research surveyed current clients of the partners without seeking out local community members to find those who choose not to attend Catholic health facilities.

How partners Catholic identity manifested in their service delivery was somewhat influenced by the wider role of religion in society and its perceived and actual relationship with the government. For example, in Malawi there seemed to be a high interaction between religion and the state as evident in the agreement between the Catholic Bishops Conference and the government: according to the research participants, the Bishops Conference state the range of health services that Catholic organisations will provide, which excludes the provision of family planning services and condom distribution. While this may seem as if religion can have a stronger influence than the government in Malawi, the South African governments does not require religious organisations to implement secular national policy on sexual and reproductive health. In DRC the government strongly promotes compliance with national policy but has no means of monitoring or penalizing organisations that do not conform. Therefore in all three countries religious organisations are at liberty to express their faith-based priorities through their service provision.

The main limiting factors of having a Catholic identity relate to the practicalities of not distributing condoms and providing family planning services. There are several consequences to this situation. While providing condoms does not guarantee their consistent and correct use, clients are a step closer to having the means to protect themselves from HIV transmission compared to those individuals who are provided with information but not the condoms themselves. Similarly for family planning services, clients who are not provided with contraceptives at the time of their enquiry at a Catholic health service, are forced to delay their access to these commodities while they take up referrals to other services. This delay often becomes indefinite because clients do not seem to have the time, financial resources or decision making ability to take up the referrals. Partner staff expressed dismay at seeing clients return pregnant or with STIs after seeking advice from them on sexual and reproductive health.

For communities in urban and high density areas there are usually more options of service providers compared to those in rural areas. However, even in cities, partner organisations cited seemingly low referral take-up by clients. In countries like Malawi, health facilities can have long distances between them, so a Catholic health service may be their only choice without travelling long distances. In this situation referrals are virtually ineffective as clients simply cannot take them up even if they wanted to.

Official Church messages on sexuality sway partners to provide services in the context of marriage. Most partners do not discriminate against unmarried clients in general. While it may seem unjust to provide condoms

only to married couples, the partners who distribute condoms to discordant couples should be seen as moving towards full service provision because they come from a previous context of not providing condoms at all. Among the DRC partners there was frustration expressed that effectively family planning services are only available to married couples in practice. And while the Malawi partners do not deny access to their services based on marital status neither do they offer family planning services to anyone.

The impact of Catholic identity on health service provision caused dilemmas for some partners as they attempted to reconcile seemingly opposing Church and public health messages. Others did not seem to feel any conflict as they were confident that clients could access the full range of services between themselves and the government services, or they discreetly provide condoms for HIV prevention (but no family planning services). Only one partner in South Africa openly provided condoms and justified this from a Catholic perspective of saving lives. The partner staff experienced no conflict as a result of this stance, and instead receive recognition from other service providers for delivering a holistic approach. However, the partner acknowledged that the Bishop of the diocese acts as a buffer from opposition and criticism that comes from higher levels of the Church.

Some of the partner organisations expressed a desire to offer both condoms for HIV prevention and family planning information, at the very least in natural methods. Those that would like to offer more services felt that they were providing an inadequate service because they do not offer the full range of services. Among the more conservative partners in Malawi, there was less willingness to provide comprehensive services because the Church messages were viewed as important moral stances that, if adhered to, would contribute to the reduction in risk taking behaviour. However, during the partner workshop held at the end of the research, staff debated ethics around decision making and whether clients are genuinely able to implement their decisions. One of the partner staff concluded by questioning whether health services should be provided on the basis of religious views, noting that the facilities also receive government funding, so perhaps should be taking into account government policy.

For informed decision-making among clients to take place, it is clear that a number of other factors must also be present. The research asked the partners to consider five key areas. The first is whether all the service options are available. This is most problematic for the Malawian partners rather than the DRC and South African partners. This means that for the Malawian partners, particularly, a strategy needs to be developed which is designed to support clients to access the full range of HIV prevention and family planning services. This could be through placing higher expectations on the partners to provide more services themselves, but it could also be through finding partnerships with other services providers: for example, by working with the government to provide complementary services, or by working with mobile health service providers to visit the areas where the partners are based.

The second factor important in facilitating informed decision making is that the decision making process is voluntary. On the whole it seemed that partners did their best to ensure that clients made the decision for themselves, but again external factors influenced the process. In particular the opinions of (potentially less informed) relatives and family members seemed to be significant, either because of their direct input into the decision making process, or conversely because the patients made decisions which would ensure their relatives would not discover their HIV positive status. One of the partners provide clients with information about their rights as a patient, and patient-service provider charters could also help re-enforce the role of the client in decision making.

The third factor is that individuals have appropriate information. As much as possible partners strived to provide as much information as they could to clients. This often took place over a longer period of time than one visit as there is a lot of information about HIV treatment particularly that is not possible to convey in a short consultation. One of the challenges, however, for some staff was the fact that information without practical examples of commodities to show clients potentially limited the effectiveness of their efforts to explain options.

Partner staff also raised an important point which is linked to both this factor and to the fourth factor which is about good client-provider interaction. It is equally important for the information between the client and the service provider to be two-way. Staff need to ensure that they facilitate an environment of openness and honesty between themselves and their clients in order to ensure that they are providing the most appropriate information given the patient's circumstances. Another issue around counselling clients, is that partner staff also need support and their own version of peer and other kinds of counselling to ensure that they are managing the demands of the work and their patients. Organisations to varying extents provided forums for carers and counsellors to socialise and recuperate from stress. This is an important aspect of staff support that helps reduce burnout, protects staff from becoming overwhelmed, and also ultimately contributes to a more effective service for clients.

The fifth and final factor is that the social and rights context support autonomous decision making. This is the factor that is most external to the partners' service provision. In Western society the rights of the individual are

paramount, and most people have an awareness of their personal rights and a legal framework which they can exercise these within. People may or may not choose to exercise their rights but nevertheless there are expectations that people can, if they choose to, make their own decisions regardless of the views of other family members, Church leaders and government officials. In all three countries that took part in the research, the rights of the individual are much less present in everyday conceptual thinking. Beyond this, clients and patients seem to be influenced by a range of external factors including church groups and leaders, and especially family members and relatives. The influence of small and local churches was cited several times by South African partners because some leaders encourage the use of alternative treatments instead of ART. In Malawi medically unproven beliefs about contraceptives prevail (e.g. such as wearing certain beads around the waist to prevent pregnancy).

The research identified strategies to enhance partners' ability to facilitate informed decision among clients in five thematic areas. The first area has three recommendations relating to promoting existing organisational policies related to sexual and reproductive health. This includes Cordaid's policies as a donor agency and the partners' own policies to ensure that current standards of service delivery are met, and training and materials are available to staff to help them fulfil the policy expectations.

1. Ensure clarity among partner organisations of Cordaid's existing policy on full and accurate information on HIV prevention and family planning

2. Ensure mechanisms and resources for ongoing training staff so they have the capacity to fulfil the existing policy on full and accurate information

3. Ensure that partner staff have access to appropriate IEC materials and examples of commodities to demonstrate them to clients

The second area is defining policy specifically on facilitating informed decision making in sexual and reproductive health services. Recommendations 4-7 focus on Cordaid's need to define its own policy on facilitating informed decision to be explicit about its expectations of partners, and work closely with its partner organisations to help them define their respective organisational policies.

4. Define Cordaid's policy on facilitating informed decision making

5. Support partner organisations to define their own policies and strategies to facilitate informed decision making

6. Work with partner organisations to examine whether the policy on full and accurate information is adequate to facilitate informed decision making among clients in practice

7. Support partners to define the rights of the client, and promote these among those who visit their facilities

Thirdly, recommendations 8-11 are aimed at helping Cordaid address some of external factors that impact on partners' abilities to facilitate informed decision making among clients. This is a broad and challenging area of work as many of the barriers to clients' ability to make informed decisions are affected by low literacy levels and gender inequality. These need to be addressed at individual and community levels without diverting partners away from their core areas of work. Some of the barriers are related to Church leaders, both Catholic and non-Catholic. Catholic Church leaders include clergy and layers of Diocesan and national Church leadership. Cordaid and its partners need to work towards raising awareness of sexual and reproductive health needs and realities of communities among these Church leaders. They may be able to do some of this work themselves, and they should also draw on existing initiatives that are aimed at religious leaders.

8. Support partners to address external barriers to facilitating informed decision making by increasing their capacity to dialogue with other stakeholders to contribute to: increasing awareness of patient rights, low literacy rates so that clients can read their appointment cards, low education levels, gender power imbalance in decision making

9. Help partners make links with traditional practitioners to increase their ART literacy and create mutual referrals where appropriate

10. Facilitate or provide HIV and AIDS awareness training for clergy, local community and religious leaders

11. Support partners to develop advocacy strategies to make changes with local government on issues such as health service access for people without ID papers and for immigrants (including illegal immigrants)

The fourth area is addressing internal capacity factors to facilitate informed decision making among clients. Recommendations 12-16 propose practical measures to ensure that partners have appropriate staffing with the appropriate training, and that their services are as accessible as possible to clients. Accessibility issues include providing translators, supporting partners to integrate family planning information and services where possible, and reviewing the opening hours and costs associated with attending the clinics.

12. Support partner organisations to ensure there are enough male and female staff so that clients have a choice of seeing a health care worker of the same gender if they prefer

13. Support partner organisations to ensure translators are employed where necessary

14. Support partner organisations to integrate family planning information and services

15. Support partner organisations to increase ability and confidence of partner staff to discuss condoms and family planning

16. Work with partner organisations to review the accessibility of the clinics including their opening hours, and how to reduce the cost of accessing the clinics' services

Finally, recommendation 17 urges Cordaid to lead theological discussion and analysis with partner organisations on effective approaches as many have expressed a desire to explore the interaction between health service provision, Church messages, and Catholic social teaching.

17. Facilitate a series of reflections and discussions with partner organisations including such issues as: the difference between providing information and promoting options; reconciling religion and science i.e. what role does faith have in motivating action, and in delivering services?; medical ethics and Catholic morality; the role of national guidelines and policies in Catholic service provision; rights-based and needs-based approaches; the effectiveness of referrals.

Acronyms

AIDS	Acquired immunodeficiency syndrome
ART	Anti-retroviral Therapy
ARV	Anti-retrovirals
FBO	Faith-based organisation
HIV	Human immunodeficiency virus
IEC	Information, Education and Communication
IPU	In-patient unit
OI	Opportunistic infections
STI	Sexually transmitted infections
TB	Tuberculosis
VCT	Voluntary counselling and testing

Introduction

Background

Cordaid supports Catholic health and HIV and AIDS service organisations in over 15 countries. The work of many of Cordaid's partner organisations includes HIV prevention, ART delivery and services related to family planning. Partners experience dilemmas in the issues of HIV prevention and family planning as part of broader work on sexual health and reproductive health. These dilemmas arise because of the disparity between some of the teachings of the church on sexual morality, Catholic social teachings, and secular public health policy. Within the Church and within faith-based organisations, people address these dilemmas differently. To document the differing opinions and approaches ("positive and negative") and to highlight some of the key influencing factors, Cordaid commissioned this research among nine partners in DRC, Malawi and South Africa.

The research hypothesised that informed decision making on HIV and sexual and reproductive choices by women and men is influenced by religious teachings, policies, structures, and communication styles at different levels of the Church, and a range of other factors external and internal to partner organisations. The research focussed on good practice and constraints among partners in facilitating informed decision making among clients of sexual and reproductive health services.

Prior to field research, a literature review surveyed over one hundred documents related to: informed decision making; HIV prevention; sexual and reproductive health; and faith-based responses. The full literature review is available as an annex. The literature review showed a recent and noticeable change in the perception of faith-based responses by secular development agencies, many of which have moved from a position of non-engagement to constructive dialogue with faith-based organisations. Criticism has often been quick to flow towards faith-based agencies based on actual and sometimes presumed conservative attitudes towards sexual and reproductive health. Similar areas of work pose challenges to both secular and faith-based agencies, however, including promoting rights and personal understanding of sexuality, and legal and cultural contexts that inhibit working with young people on sexual health.

The review of Vatican and other documents issued by Church hierarchies indicated that official Church messages focus on ideals in the context of marriage and contraception, and arguably do not have appropriate application to disease prevention and public health service provision. Praise and criticism levied at the Church's response to HIV assumes little or no distinction between the Church itself as a religious institution and the responses of hundreds of Catholic faith-based agencies. Critics therefore sometimes view what they see as "the Church's response to HIV" as contradictory when juxtaposed with official Church messages on marriage and contraception. In reality, most faith-based agencies draw on their faith principles to inspire action rather than on Church doctrine. Areas of importance in Catholic teaching which could impact significantly on debate, such as the role of the conscience, receives little if no mention in Vatican or Bishops' public communications about HIV prevention; neither do faith-based agencies often raise such issues in the debate on the use of condoms.

Church messages are frequently cited as having a negative impact on condom use. Looking at other regions of the world that are highly affected by HIV, the literature reported that condom use is often low for other reasons. The use of condoms in most Asian countries is very low among non-married partners, and even lower among married couples, and unpopular as a contraceptive option. In some cases (e.g. Thailand, Laos PDR and Indonesia) the aggressive promotion of condoms among sex workers has created a situation where condoms are synonymous with paid sex. It has become is a sign of grave mistrust to suggest condom use within a relationship. This may be the case in some parts of Africa too, but access to condoms appears to be hindered mostly by their lack of availability, their cost, as well as traditional values about fertility.

In many ways it is difficult to compare regions to identify transferable lessons because contexts vary considerably. For example, the high proportions of Catholic women in Latin America that access artificial contraceptives do so for many reasons, not least because of their availability. Additionally society's perception of the role of the Church and its leaders correlates with religious influence in people's daily lives – particularly in South America where liberation theology has a history of advocating for the rights of people in poverty. Its role, therefore, is one of promoting human rights and justice at national policy level, rather than influencing daily decision making among individuals. In North America and Europe the rights of the individual are culturally highly

valued. Therefore people perceive it as their right to follow a religion's rules or, alternatively, make decisions contrary to doctrine yet still remain committed to other aspects of their religion.

The literature review found well documented evidence and discussions on the impact of religion on individuals' ability to make choices. However, the competing and challenging demands on health workers providing sexual and reproductive health services seemed to receive very little research and analysis. The promotion of "informed decision making" by clients of health services takes place most obviously in Northern/Western industrialised countries. Research of investigates particular areas of health service provision (such as breast and prostate cancer treatments) including patients' views of their experiences. In developing countries research on facilitating informed decision making usually applies to helping medical staff, rather than clients, make decisions about good practice and patient care. Health workers themselves, in both developing and developed countries, seem rarely consulted about the challenging environments they work in.

What is clear is that the environments that health providers operate in, no matter which continent or country, contain a range of political, cultural and religious influencing factors. The field research sought to understand the impact of these factors for the participating partner organisations. The research aimed to examine the level of faith and religion (doctrine) that interacts with the programmes, and how health staff manage the (sometimes competing) demands placed on them by various hierarchies within and outside the organisations. At the same time, partner programmes were also engaged in discussions about "informed decision making" – how they facilitate this in the context of sexual and reproductive health provision.

Methodology

A Literature Review preceded the field research incorporating 103 documents relevant to informed decision making among clients. The document began by examining Cordaid's approach to sexual and reproductive health in order to set the context of the review to come.

The field research took place with three partner organisations in three African countries. In-country researchers spent approximately one week with the partners implementing a range of research tools to collect information from staff and clients and through observation.

The lead in-country researchers

South Africa	Hilde Bakker
DRC	Professor Munyanga
Malawi	Jesman Chintsanya

The nine partners that were the focus of the research were service delivery organisations. In addition a tenth partner, CIE in South Africa, participated in a one-day consultative meeting. In DRC and Malawi, the organisations were medical centres, while the three partners in South Africa were ARV treatment providers. The tenth partner, CIE, was an educational organisation that works with teachers and school children on HIV education. CIE did not operate in a similar service delivery format to the health centres so the research tools did not fit their approach. However, the views of staff were sought, particularly because of their experience in working with youth. The tools and their aims are summarised below.

Observation of the facility	A checklist was provided in order to understand the environment in which the staff work and its impact on the service that they are able to provide. It was also designed to understand the environment in which clients receive the service. The first set of indicators were observed directly, such as the privacy of the counselling rooms, and the public health messages displayed in waiting rooms. The second set of indicators on working conditions were observed and also required making enquiries over the course of the visit, such as the numbers and gender ratio of staff, their average working hours and ranges of responsibilities.
Questionnaire for clients	The questionnaire served two purposes: firstly to verify information about service provider-client interaction and secondly to collect data on the attitudes of clients to better understand the context that the staff provide their services in. Research assistants invited clients to complete the survey after their visit.

Focus group discussion with clients

The discussion with a group of clients allowed for the opportunity of finding out in more detail what the experience of clients at the service provider consists of; whether the clients hold religious views themselves; and whether they feel that the service provision is influenced (and should be influenced) by religious values.

Direct observation of client-service provider interaction

In order to record the kinds of information that staff provide, and how they facilitate informed decision making, consent was sought with clients (and staff) for the researcher to sit in on sessions. The researcher noted on a check list the reason for the visit, which information was provided, whether clients were supported to make decisions etc. This part of the research methodology posed some particular challenges because firstly, consent from clients may be difficult to obtain; and secondly the researchers were aware that such overt observation could affect the behaviour of both the client and the service provider. However, despite these potential biases the methodology provided some insight into the interaction, rather than no observation at all.

Interviews with senior staff/ head of partner organisation

A semi structured interview was held with senior staff to ascertain the views of the organisations' leadership. It was hoped that the head of the organisation had a wider view of the external influences on service provision. At the same time the views of the leadership could then be compared with the views of the staff members who interact with the clients to see if there is disparity or similarity between them.

Participatory workshop with staff

The workshop provided an opportunity for in-depth discussion with staff to understand the factors that allowed informed decision making to take place.

Session 1: Group discussion on enabling and challenging factors
This session took participants through the five key areas of informed decision making as defined by Engender Health:
A. Service options are available
B. The decision making process is voluntary
C. Individuals have appropriate information
D. Good client-provider interaction, including counselling, is ensured
E. The social and rights context support autonomous decision making
The participants were asked to discuss each element in detail, and consider each on three levels: personal/community; service delivery; and policy. Discussion of the five areas was intended to reveal what the views and practice of the service providers are, and the influencing factors, including religion but also legal, financial and social impacts.

Session 2: Self assessment exercise
The self assessment tool allowed the staff to assess their current strengths and identify their priorities for areas of action. It took each of the five key areas (A-E) which are needed for facilitating informed decision making, and suggested different levels of practice, from being aware of issues to systematising practice. Staff identified which level they are currently at, and where they would like to progress to by 18 months time. The format is based on the AIDS Competence analysis tool which allows responses to be compared across organisations in order to see where learning and skills exchange can potentially take place.

Session 3: Review session of main issues
The final session with staff was an opportunity to elicit from participants what the key determinants are for facilitating informed decision making in their faith based context.

After the field research had taken place with each of the partners, a one-day workshop was held in each country with all three partner organisations to feedback the data gathered and elicit further information about their views and practices. The workshop provided an opportunity to begin developing strategies for sharing good practice, particularly in the context of sharing the self assessment tool results.

There were differences in how the three in-country researchers conducted the field work. The nature of the partner organisation often dictated events. For example, the research aimed to interview one key member of staff from each of the partner organisation. The researcher in South Africa found she had the time and capacity

to interview more staff so interviewed 27 members of staff among three partner organisations. The reporting of information was also noticeably different between the researchers, with the Malawian researcher providing more aggregate data and summarised information. Not all the data from DRC and Malawi was presented disaggregated by sex and age.

The exercises in the partner workshops were subject to some interpretation by the researchers, and even broader interpretation by participants. Researchers were also severely constrained by time as it was often not possible for a significant proportion of staff to be away from their duties for an extended period.

Participants in the research

The participants in the research provided their time and knowledge for this research, and it is important to recognise and acknowledge their significant contributions.

	Women	Men	Gender unknown	Total
Interviews with key members of staff			33	33
Client provider observations	17	6	36	59
Client questionnaire	120	62	101	283
Focus Groups	24	13		37
Staff workshop			66	66
TOTAL*				**478**

*The above figures exclude information relating to the following data collection:

- The numbers of participants in the focus group sessions with Malawian and DRC partners
- The number of staff that participated in the partner workshop of ECC

Research findings

Summary

Among the nine key contributing partners to the research, there were a range of practices and views on sexual and reproductive health expressed within the context of religious conservatism and liberalism. All partners expressed the importance and significance of their Catholic identity. How they manifested this identity in their programmes seemed to be influenced by the role of religion in society and its perceived and actual relationship with the government. The influence of the Church seemed to set the tone for the attitudes of the partners as service providers. For example, in Malawi high interaction between religion and the state can be seen in the agreement between the Bishops' Conference and the government: according to the research participants, the Bishops Conference state the range of health services that Catholic organisations will provide, which excludes the provision of family planning services and condom distribution. While this may seem as if religion can have a stronger influence than the government in Malawi, neither governments in South Africa and DRC demand that religious organisations implement the secular national policies on sexual and reproductive health. Therefore in all three countries religious organisations are at liberty to express their faith-based priorities through their service provision.

The three partners in Malawi had relatively more conservative approaches to sexual and reproductive health compared to those in South Africa. None of the three Malawian partners openly distribute condoms, for example, and only one provides them discreetly to HIV sero-discordant couples. Malawian partners face an additional layer of complexity in that the public health system is known to be in a critical state in terms of resources, both human and financial. This means that the government cannot fully complement health services by providing those aspects that Catholic services decline to offer. In a high density city environment, clients and patients have a greater choice of service providers and therefore can choose to attend at one or more clinics in order to receive their preferred options. However, there are situations where the Catholic hospital or clinic is some distance from the nearest government provision. Ultimately the people living within the catchment area of these Catholic institutes cannot access alternative services without considerable time and cost implications.

During the workshop with partners from all three Malawian organisations, these issues were discussed at length. The participants discussed the role of religious beliefs in health service provision. From one perspective the partners do not discriminate against clients or patients: all are welcome and patients' religious denomination is not requested when they present at the clinics. However, some of the participants at the meeting felt that regardless of the denomination of patients, it was the responsibility of the staff to explain to them both medical information and Catholic religious values; the reason being that faith messages are as important as the medical messages. By providing religious values to all clients, this was viewed as a non-discriminatory approach. The discussion extended to the role of religion and state in health provision. Participants raised the point that the government provides financial resources to their facilities, for example in the form of paying some salaries, and if this is the case, participants asked themselves why they don't prioritise the government health messages over the religious messages. The question of whether religion and health service provision should be interlinked at all was also raised.

From the perspective of the partners in Malawi, there may have been feelings of scrutiny being placed on them by the research process, perhaps because of the conservative approach of the organisations and the Bishops' Conference. One participant expressed the view that they have fully embraced the Catholic faith, imported into Malawi, only to be told now that other Catholics (i.e. the donor being Cordaid and outside of Malawi) have "moved on". This raises an important point about donor expectations and partnerships between donors and partners. A partnership is not necessarily equal in terms of the resources and influence of each party on the other but in a meaningful partnership both parties should have a clear understanding of expectations of each other.

The South African partners operate in a very different environment where religion and state are more divided in terms of healthcare provision. Whilst under-resourced and under-staffed, the government health system is vastly more present than that of Malawi. Further, the context of the partners' work is also different from the partners in Malawi and DRC, in that they are largely ART services. This means that their core business centres around HIV treatment delivery, including VCT, and HIV prevention, rather than a broader remit of a general health clinic. Because of the treatment delivery nature of the service provision, none of the partners provide family planning services, and like the Malawian partners provide information only. It seems that patients are less

likely to expect these services from the partners; partly because they recognise that Catholic organisations are unlikely to provide artificial contraceptives, and also because these particular organisations focus on ART delivery. However, family planning, in addition to HIV prevention, is an issue that is raised by clients and patients, for those that want to have children and well as those that want to avoid pregnancy. Although government services are less popular with clients because of the perceived and sometimes actual lower quality of service, patients can usually access these alternative sources of information and services.

Among the three South African partners, only one openly and publically includes the distribution of condoms as part of its response. Although perhaps less visible than in Malawi, the influence of the Catholic Church in South Africa is still present and felt by Catholic organisations, none more so than this partner's Bishop, and specifically because of the its open stance on the distribution of condoms. The other partners do not attract similar levels of critique, not because they do not distribute condoms (which they do) but because their official and public messages do not contradict the official messages of the Church. For example, one promotes only the messages of abstinence and mutual fidelity in public, while in the privacy of the counselling room they both repeat these messages and provided condoms to some patients.

What the differing approaches reveal is a complexity about how HIV prevention services are implemented, and what kinds of approaches each organisation is prepared to admit to in the public sphere. It may well be that religion among the South African partner organisations is just as important as it is among the Malawian and DRC partners. However, it seems that religion may have less of an impact on clients and patients if certain services are omitted because of the availability of other government services.

The partners in the DRC expressed more variance between them than those in the other two countries. One partner seemed to take a conservative approach that was strictly in line with Church messages, while one took the view that public health messages were a priority and therefore took an approach more in line with secular expectations. The third partner seemed to be in between these two views and often discussed the challenges of trying to meet the expectations both Church and government. Overall the staff of the DRC partners find themselves in dilemmas about how to facilitate informed decision making. They wrestle with trying to balance their professional advice with the rights of the clients to make decisions. But they are also aware that they do not know whether their clients genuinely have access to all types of HIV prevention and family planning services that they make referrals for. Because they do not provide family planning services themselves, they are concerned about whether they have the most recent information on modern contraceptives. The rights of clients seeking HIV services are also affected by the influence of family members, and DRC partners often observe decisions being made by people other than the client, particularly those who are very sick and do not have the strength to assert themselves over dominate relatives.

Mbuji Mayi seems to be the only partner among the nine services who proactively promote natural family planning methods. While clients appear to appreciate this service provision, they commented that the partner was not as articulate and confident in discussing condoms and artificial contraceptives. However, the researchers noted that decisions about family planning seem to be made by individual clients rather than their family members, as was more likely the case in HIV treatment decisions.

The influence of the Church is strong in some areas, for example, there has been successful advocacy by the Church, to change national standards to stop uncontrolled entry of condoms and artificial contraceptives. At the same time Kananga felt that the Church is now under pressure from national policy which requires complete packages of HIV prevention and reproductive health services. This pressure also comes from international donors.

Whilst referrals are usually in place for clients to access alternative service providers, Kinshasa felt its own referral methods were lacking. Kinshasa also highlighted the lack of government monitoring of sexual and reproductive health services, which could encourage faith-based organisations to provide a wider range of services and increase access to family planning for young and unmarried people. For BDOM Kananga, however, additional external pressure does not seem necessary as the organisation has already taken the decision to prioritise public health messages over expectations of the Catholic Church.

Currently Cordaid's expectations of partners centre on their provision of full and accurate *information* about all methods of HIV prevention and family planning. By looking at whether partner organisations are able to facilitate informed decision making by their clients, another dimension to the impact of this full and accurate information comes to light. For the partners that do not provide the services directly (which is most in terms of HIV prevention, and all in terms of family planning), their ability to facilitate informed decision making among clients took place on a *conceptual* level. For it to take place on a *practical* level, external factors such as the availability of alternative referral services seemed to make the biggest difference.

For informed decision-making among clients to take place, it is clear that a number of other factors must also be present. The research asked the partners to consider five key areas. The first is whether all the service options are available. Clearly this is most problematic for the Malawian partners rather than the DRC and South African partners. This means that for the Malawian partners, particularly, a strategy needs to be developed which is designed to support clients to access the full range of HIV prevention and family planning services. This could be through placing higher expectations on the partners to provide more services themselves, but it could also be through finding partnerships with other services providers: for example, by working with the government to provide complementary services, or by working with mobile health service providers to visit the areas where the partners are based.

That said, however, in South Africa, where government services are largely available, partners discussed the fact that many clients and patients do not to access alternative services for family planning, as evident by the number of women who return to the clinics pregnant. This research did not undertake an investigation into the follow up rate and outcomes of referrals by the partner organisations but this could a potentially useful study in the future for the partner organisations to better understand the decision making processes of their clients.

The second factor important in facilitating informed decision making is that the process is voluntary. On the whole it seemed that partners did their best to ensure that clients made the decision for themselves, but again external factors influenced the process. In particular the opinions of (often ill-informed) relatives and family members seemed to be significant, either because of their direct input into the decision making process, or conversely because the patients made decisions which would ensure their relatives would not discover their HIV positive status. One of the partners provide clients with information about their rights as a patient, and patient-service provider charters could also help re-enforce the role of the client in decision making.

The third factor is that individuals have appropriate information. As much as possible partners strived to provide as much information as they could to clients. This often took place over a longer period of time than one visit as there is a lot of information about HIV treatment particularly that is not possible to convey in a short consultation. One of the challenges, however, for some staff was the fact that information without practical examples of commodities to show clients potentially limited the effectiveness of their efforts to explain options.

Partner staff also raised an important point which is linked to both this factor and to the fourth factor which is about good client-provider interaction. It is equally important for the information between the client and the service provider to be two-way. Staff highlighted the need to ensure that they facilitate an environment of openness and honesty between themselves and their clients in order to ensure that they are providing the most appropriate information given the patient's circumstances. Another issue is that partner staff need peer support counselling for themselves to help them manage the demands of the work and their patients. Organisations to varying extents provided forums for carers and counsellors to socialise and recuperate from stress. This is an important aspect of staff support that helps protect staff from becoming overwhelmed, and ultimately contributes to a more effective service for clients.

The fifth and final factor is that the social and rights context support autonomous decision making. This is the factor that is most external to the partners' service provision. In Western society the rights of the individual are paramount, and most people have an awareness of their personal rights and a legal framework which they can exercise these within. People may or may not choose to exercise their rights but nevertheless there are expectations that people can, if they choose to, make their own decisions regardless of the views of other family members, Church leaders and government officials. In all three countries that took part in the research, the rights of the individual are much less present in everyday conceptual thinking. Beyond this, clients and patients seem to be influenced by a range of external factors including church groups and leaders, and especially family members and relatives. The influence of small and local churches was cited several times by South African partners because some leaders encourage the use of alternative treatments instead of ART. In Malawi medically unproven beliefs about contraceptives prevail (e.g. such as wearing certain beads around the waist to prevent pregnancy).

Examples of Good Practice

Service options are available

Referrals

In terms of good practice, all of the partners in the three countries rely on referrals to provide their clients with opportunities to access the full range of services available. This is and should be standard procedure for health facilities given that most do not provide every service that a client may need. Referrals are not only from Catholic clinics but are also mutual between Catholic and government (or other) clinics. This works particularly well at Tapologo where staff take part in a monthly local NGO forum to share information, and refer patients to each other. Where regular dialogue does not take place between services provides misunderstandings can arise among staff regarding the reasons that clients are being referred. In St Joseph's case, referrals are made by some government clinics without dialogue between the organisations. Partner staff have no opportunity to discuss the government staff practices which often include referring the clients to St Joseph's after a HIV positive test result without explaining to the client the reasons for the referral or the test result.

Providing related services

Partners have found that providing additional and related services is of great benefit to clients because it reduces the number of referrals to other clinics. It increases the staff's ability to accompany them through more of their diagnoses and treatment processes. In addition to providing ART, Nazareth House provides TB treatment, which helps clients to access both HIV and TB services in one place. Both St Joseph's and Tapologo provide condoms to patients and mentioned their emphasis on HIV and STI education. While Tapologo specifically provides STI treatment and St Joseph's encourages women to get pap smears to ensure that cervical cancer does not go undetected.

Adhering to national policy on HIV prevention

BDOM Mbuji-Mayi feels that it has had its capacity around HIV prevention and care strengthened as a result of following the government's national health policy more closely. This seems to staff like a successful effort to "reconcile religion and science". Tapologo proactively provides condoms as part of its HIV prevention services. St Joseph's provides condoms at the discretion of staff in counselling sessions.

The decision making process is voluntary

Promoting the rights of the client

St Joseph's was the only partner to explicitly mention that they explain to clients their rights. They also provide role models for patients by employing staff living with HIV and facilitating former patients living with HIV to share their experiences and knowledge. Both BDOM Mbuji-Mayi and Nazareth House cited their *confidentiality policies* as key tools which ensure that staff are aware of the rights of the client to privacy. Equally importantly a confidentiality policy also contributes to the clients' confidence in their privacy being respected and therefore encourages take up of services. Nazareth House's clients are often alone without family or friends and living in dormitories, so the organisation focuses on providing confidentiality at the clinic rather than their place of residence. The partner also provides translators as much as possible in order to work with people who do not speak the local languages.

Supporting clients to make decisions

St Joseph's and Tapologo facilitate the involvement of family members or buddies in order to support patients. This process helps the clinics interact with a close member of the client's social circle and sensitise them to HIV prevention and ART adherence issues. Both partners also provide home visits in order to counsel families together in their privacy of their home to increase understanding and reduce stigma. These visits provide the opportunity to assess the clients' home situation and whether they have enough food and are accessing any social security they may be entitled to.

Staff training and support

It can be very challenging for staff to work with clients who decline to follow their professional advice. Nazareth recognises that staff need training and support to manage clients well, and to manage the stress of their roles,

particular that of counsellor. The partner ensures that all staff and volunteers involved in counselling are provided with regular opportunities for peer support.

Individuals have appropriate information

Raising awareness among communities of the services available

St Joseph's (Blantyre) promote outreaching to communities with information on HIV. In particular, the organization engages communities through conducting meetings in collaboration with village leaders. A second approach to reaching people is through supporting people living with HIV to share messages from personal experiences: both the risks of contracting HIV, and the message that positive people can live healthily and happily. All three Malawian partners also focus on increasing awareness through community outreach meetings and clinics, conducting trainings and encouragement of the establishment and use of community support groups for people living with HIV/AIDS to disseminate reproductive health messages.

Other approaches to ensuring that clients have information include: door to door campaigns; ongoing education and awareness raising; language classes for immigrants; providing translators and IEC material in multiple language; and involving families in home-based care activities so they also receive information. All partners facilitate peer support groups of people living with HIV meet regularly to listen to each other, support the most vulnerable. Importantly, members of these groups are able to provide other visitors to the clinic with information and encouragement to seek testing and counselling.

Good client-provider interaction

Individualised care

Both Nazareth House and St Joseph's place an emphasis on making clients feel as welcome and comfortable as possible at the clinics. Both of these partners said they promote the ABC HIV prevention messages and explain the importance of disclosure. All three partners promote adherence to and monitor ART adherence and these two organisations emphasised this as a key component to facilitating informed decision making among clients. Tapologo emphasised the importance of explaining how the medication works.

Nazareth House promotes the importance of building good relationships with clients, reducing waiting times at the clinic to encourage attendance and ensuring that patients understand the window period after a HIV negative result.

Pre and post test counselling

Counselling sessions provide valuable opportunities to share information with to clients, build trust, understand their needs, and play a key role in facilitating informed decision making. All three South African partners have a strong emphasis on counselling clients both pre- and post- test. They provide one-to-one counselling, and facilitate group and peer support. St Joseph's and Tapologo mentioned that their counselling training includes strategies to support clients make decisions. All three partners also promote education on health and healthy living.

The partners check that patients understand the information provided by asking them questions (Nazareth House) and by encouraging clients to ask questions of staff (St Joseph's). Supporting clients by respecting their decisions, even when they seem to be making choices not necessarily in their best interest, was emphasised by Nazareth House and Tapologo. Tapologo ensures it provides non-judgemental information on HIV and STIs, information on both male and female condoms, allowing the client to make their own decisions, and building women's dignity in sexual rights and choices. The partners stressed that their interactions with clients must be non-judgmental and accepting. It must be open, honest and frank. It must be two way.

The social, religious and rights contexts support autonomous decision making

Sensitisation of clergy to HIV prevention, sexual and reproductive health issues

BDOM Kinshasa feels that its training and workshops for bishops and priests has contributed to these leaders having greater awareness of HIV and AIDS and the needs and problems of communities. ECC's approach is to empower people with information so they can make informed decisions about their actions. The organization

works with church leaders to ensure they have the correct information and are able to share it with their congregations, particularly in their role as counsellors.

Catholic Identity

From the perspective of partners, staff find enormous strength from Catholic values such as love, solidarity, and respect. These values are strong motivational factors for people to respond to the needs of the community. All the partner organisations are proud of their Catholic identity and make it known to their clients and other partners and stakeholders. Part of the Catholic identity is to exercise a non-discriminatory approach to clients of all religions. This inclusive approach appears to be well-known among the clients that took part in focus groups.

The clients of all partners reiterated the warmth and quality of service that they have experienced at the facilities, and the trust that they have in them specifically because of they are Catholic.

> "When we come inside here or to the HIV testing and counselling that is where you feel you will be welcome because they do not make any rude remarks. They welcome you as a human being who should be assisted, they will check your weight, carry out whatever tests or anything you should be informed about they do it right there"
>
> Men FGD, Malawi

It is possible that the Catholic identity of the partners may deter some community members from seeking services. The research did not survey a sample of community members who have not accessed the services, so there is no data available on how the partners' Catholic identity is perceived by non-clients. The limiting factors of having a Catholic identity relate to the practicalities of not distributing condoms and providing family planning services. The result of not providing these services directly means that the partner staff are not continually updating their own knowledge and skills in these areas, so they cannot be sure that they are providing clients will all the information that is currently available.

All partners make referrals for family planning services, however, these referrals do not seem to be universally taken up by all clients. Sometimes the government services are simply not preferred by clients because they are less friendly environments. But importantly, some clients cannot afford the time or money to travel long distances if the referral clinic is a long journey away.

> "We feel helpless seeing our clients having unwanted pregnancies or contracting STIs"
>
> Participant at St Montfort

Overall, the partner organisations themselves reported that they do not face many challenges or criticisms from either inside or outside the health and development sectors. Health facilities are usually expected to make referrals to each other, with each providing different and complementary services. It is not unusual for the Catholic institutions to make referrals to government health clinics for family planning services, while government clinics make referrals to Catholic institutions, for example to Nazareth House to treat people without ID papers.

One of the questions that the literature review raised relates to a model of how organisations deploy faith through developmental or humanitarian objectives (Clarke 2005, referenced in the literature review). In relation to this model, all of the partners can be described as operating from an Active standpoint: "Faith provides an important and explicit motivation for action and in mobilising staff and supporters. It plays a direct role in identifying, helping or working with beneficiaries and partners, although there is no discrimination against nonbelievers and the organisation supports multi-faith cooperation."

Partner organisations in Malawi take their Catholic identity further: not in terms of Clarke's model which defines levels of faith-based perspectives largely based on the selection of beneficiaries, but in terms of the kind of service they provide which goes beyond health delivery. This scenario is not fully accounted for in Clarke's model: some of the staff feel it is important to impart Catholic values, or rather morals, about sexuality and sexual behaviour with clients and patients. This is not done in the context of proselytising with the aim of converting clients to Catholicism. Rather the staff felt that it is their responsibility to share these views with patients, and they equally felt it important to share them in a non-discriminatory manner, i.e. with all clients regardless of the clients' religious preferences.

During the national workshop in Malawi, participants began to discuss whether providing information alone is really enough to *enable* someone to make a decision and access their preferred service option, especially if the other clinics are effectively inaccessible. Participants also discussed the acceptability of providing "religious health" services. Conclusions were not necessarily reached, but participants reflected on the role of government public health policy and the fact that some staff positions are funded by government. This raised the question

among staff of whether their services should conform solely to the guidelines set out by the national Bishops' conference, rather than the national policy as well.

This seems to be an important and topical issue for the DRC partners, one of whom expressed several times how it would like to provide a service which reconciles the government and Catholic policies. Current HIV discourse among development organisations seems to place a strong emphasis on following the national guidelines on HIV prevention and sexual and reproductive health. It seems that the process for providing a Catholic service in the context of secular public health messages is not defined for partners, by the partner organisations themselves, the Catholic hierarchy in the country, government, or donors. One partner goes by the public health policy when it happens to have condoms in stock (provided to them by other agencies and services), one partner holds Catholic messages above public health messages, and the third partner seems to be in a quandary about what to do: it notes its obligations to the national policy but does not want to openly contradict the expectations of the Bishops' conference.

DRC

Kinshasa highlighted the values that the Church teaches, such as dignity, love, and solidarity and psychosocial support for people living with HIV and AIDS as affirmative and enabling influences in their work. The partner also cited the Church's promotion of non-discrimination in the fight against stigma as positive message. The staff mentioned the church's rejection of the beliefs and practices of sorcerers, presumably because of the misinformation that sometimes is perpetuated by uninformed traditional herbalists or spiritual healers. Mbuji-Mayi cited the fact that the church preaches abstinence, mutual fidelity and natural methods as positive aspects, and the fact that it rejects the use of condoms and artificial family planning methods, but did not elaborate on why. However, staff at Kananga were more explicit. Senior staff at Kananga thought that the overall Church messages around rejecting "sinful" behaviour can protect people from HIV infection (by abstaining and being mutually faithful) and high moral standards can have exponential impacts ultimately with the potential to lead the country towards sustainable development. This is perhaps an overoptimistic extrapolation of the values of individuals into positive national progress.

In relation to family planning, the staff interviewed at Kananga suggested that a reliance on artificial contraception can discourage people from their responsibilities. They drew a distinction between the negative consequences of artificial methods failing, and couple having to deal with an unexpected pregnancy, and the impacts of using natural methods: "If using natural methods, we accept what God gives, which has no adverse consequences." Although this is arguably a simplistic and optimistic view, the partner did explain further that with natural family planning, the couple is obliged to take responsibility and plan sex in order to get or avoid pregnancy. These views present challenges in the context of informed decision making among clients. The emphasis on the behaviour of individuals, seems to centre around a pre-conceived expectation about what the most appropriate actions are, and excludes the possibility that clients will make alternative decisions about their behaviours. The views expressed assume that clients will have the same attitudes towards sexual and reproductive health also therefore exclude the role of conscious among clients. While staff at Kananga felt that moral values associated with its Catholic identity are positive and enabling factors in their approach to facilitating informed decision making, their views may in fact reduce clients abilities to make decisions.

At Kinshasa staff were adamant that it was not appropriate to talk about limits: rather the values of the church should be upheld, for the long-term well-being of individuals. An emphasis was placed on understanding rather than opposing the church. Mbuji-Mayi staff believed that due to the aspects of HIV and family planning services that they cannot provide directly, there needs to be greater efforts to ensure that all staff have their capacity strengthened in order to fully inform clients. The organisation would like to explore more ways to reconcile science and religion. Kananga felt that the "extremism" of the church is somewhat limited or diluted by external factors such as globalisation and national policies advocating a comprehensive scientific package. The church risks marginalising itself if it continues to place itself outside the main current and refuses to acknowledge people's expression of sexuality. The pressures and expectations of donors creates a situation whereby the partner organisation risks the withdrawal of financial support if it does not adhere to conventional medical approaches to HIV prevention. at the same time, Kananga believed that the church must remain faithful to its primary mission to "promote human life and remove man from sin".

Malawi

St Joseph found that the respected reputation of the Church was important because community members feel safe visiting the facility. For people who have a strong faith, staff at St Montfort saw itself as the obvious and reassuring choice of health service for those who needed drugs for treatment as well as God to heal them. There

was an implication that clients may believe they will get the best treatment because the institution believes in God. The partners said they strive to provide information without being judgmental regarding the choices the clients made. They provide information on the client's choice of service and listen to the concerns of the clients. The clients are given an opportunity to ask questions and the service providers also ask questions to the clients.

> "They explain everything then they tell you that you should discuss. After discussing for some time they ask that do you have any questions on what I said. So you ask them questions. If you do not have questions you do not ask so they know that everything is understood. Sometimes when you do not ask when they ask you if you have any questions, when you say we do not have then they ask you questions for them to know that you have understood the issue"
>
> Women FGD, Malawi

The lack of comprehensive service provision at St Montfort means that staff need to make referrals and some staff are concerned that the very fact that they do not provide some options can discourage people from seeking them elsewhere. At St Joseph staff acknowledged that the organization's expression of its Catholic identity may put some people off from attending, such as starting some groups sessions with a prayer. Staff at St Joseph also discussed their need to strengthen their referral systems because they realize that they do not know how many of their clients actually take up the referrals, and neither do they know the reasons that these clients decline the referrals.

During the partner workshops, staff agreed by providing only information about modern contraception, they were limited in practice in their ability to facilitate informed decision making among clients. The services that clients are referred to are sometimes a long distance to travel and clients may simply not be able to access alternative health providers. In addition, some individuals within organisations feel constrained further and do not even give information on condoms and family planning because they think this goes against the organisation's policies. Either these staff are not fully and properly orientated in policies of the organizations or there is pressure or expectation from the heads of the organizations that disapproves of the official policy which requires full and accurate information be provided to clients.

Ultimately, not providing family planning services means that knowledge and skills among the majority of the service providers is limited as they do not stay abreast of the latest information on modern family planning technologies. This affects informed decision making among clients as the service providers may not have the confidence to provide adequate and updated information.

Clients in the focus group discussions indicated that the Catholic identity of the health services had little impact on them for two reasons. Firstly, they are well aware of the Catholic values of the service so there are no unexpected surprises about the range of services that the institution provides. Secondly, clients noted the service providers assisted the people to talk freely and openly about issues of sexual and reproductive health without being influenced by their own religious and personal values.

> "They are able to discuss with us very private and personal issues pertaining to our individual sexual and reproductive health matters and help us to make decisions and choose services of our liking"
>
> FGD young men, Malawi

South Africa

At Nazareth House the staff felt that being Catholic identified the service as available to all people regardless of their religion or legal status to be in the country. The organisation's Catholic identity ensures that people know they are here to help, not only with medical problems but social problems too. This sentiment was reiterated by St Joseph's where staff valued the holistic approach that the organisation took to working with patients. The partners provide food, toys, blankets and spiritual support if clients want it. There is a sense that Catholic organisations serve the whole community, and staff members give all they can and wholeheartedly to support people and bring them hope. Clients recognise this and view the service as non-judgmental and trustworthy.

> "We don't notice any difference between people of different faiths or beliefs. They all treat us with respect and don't try to push their values."
>
> "It is a Catholic organisation, they give bread and tea, and they take care of people. They do that because they are Catholic. But they never talk about religion or how they personally feel. They are who they are and do what they do. They don't do condoms, but tell you where to get them."

Focus group participants, South Africa

At St Joseph's the Catholic identity was also cited by a VCT counsellor as a reason that the facility is a place of respect and peace. At Tapologo the Catholic identity allows staff to interact with clients because they trust the Church and therefore trust the Church-based organisations which have credibility. The organisation was proud of its Catholic identity, the values of which motivated the staff to serve people. At the same time staff were careful not to aggressively promote the Catholic religion because it is a health facility and for people of all religions. The heads of the organisations were also very aware that their Catholic identities allow them to access much needed sources of Catholic funding.

Because certain services are omitted or left to government run facilities, ambiguity and confusion can arise among clients who arrive looking for family planning services particularly. At Nazareth House, however, to resolve this usually takes one explanation and referrals to other clinics where condoms and other contraceptives can be accessed. Clients are usually very understanding once they are given the reasons that these are not available at Nazareth House. Some staff felt that not providing condoms is a limitation, while others are content not to provide them because they believe that it encourages "bad behaviour".

At St Joseph's the inability to provide condoms puts them in a "bizarre" position for some staff who see divergence between the policy and people's realities. The Department of Health provides condoms which the staff clandestinely give out in one-to-one counselling sessions which they believe goes against the policy of the organization. On the whole staff do not think the moratorium on providing condoms affects their work a great deal because they are accessible at other places. Working with young adults and promoting abstinence and fidelity messages can be a struggle for some staff as they feel they are swimming against the public and popular tides.

Tapologo acknowledges that some people may be hesitant in coming to the clinic because of its Catholic identity. Some home based caregivers may be selective about the information they provide because of their personal beliefs, while more conservative Catholics might avoid the clinic because Bishop Dowling's stance on making condoms available is well known. For Bishop Dowling, he finds himself isolated, having to justify himself continually and being accused of breaking ranks within the Catholic Church. He firmly believes that "Thou shalt not kill" must supersede "Do not use condoms".

Challenges in providing family planning and sexual health options

In general, church messages on sexuality and family planning encourage partners to respond to people within the context of marriage. What is interesting is the interpretation of official church messages, which is influenced by the prominence of religion in the country. In all countries, the official church messages cause all the partners to provide information about family planning to lesser or greater degrees, and all partners refer clients to other services for more information and to access family planning services and commodities. The "promotion" of condoms within HIV responses and family planning services remains controversial and the research sought to identify the extent to which partner organisations discuss, provide, or make referrals to clients to access condoms in both HIV/STI prevention and in family planning.

All the partners, with the exception of Tapologo in South Africa, do not openly distribute condoms in HIV prevention. St Joseph's in South Africa provides condoms in a more confidential manner during private consultations and Mbuji-Mayi sometimes has condoms supplied to it by the Ministry of Health so distributes them in HIV prevention and family planning as and when they are available. The partners in Malawi seemed to most strictly adhere to not distributing condoms, although one partner did reveal it provides them to discordant married couples (to the surprise of some other research participants).

The influence of the official church messages has had an unintended effect on the provision of information about natural family planning methods. The partners in Malawi realised during the national workshop that in their commitment to upholding the messages around the prohibition of modern family planning methods, they have overlooked the role of natural family planning in their service provision. South African partners expressed a desire to become more skilled in family planning methods (both natural and artificial) which do date have played only a peripheral role in their service delivery because all three essentially provide ART. However, there are obvious links between ART, PMTCT and people's desire to have or not to have children after knowing their HIV status. Partners in DRC expressed frustration that their family planning services are effectively only available to people who are married. In Malawi there are echoes of the restricted practice in some staff's minds but in practice marital status does not define which services clients can access. In South Africa there are no parameters for accessing the partners' services.

DRC

Kinshasa does not see any challenges with providing information only about family planning and HIV prevention options because other providers are able to provide these services. Therefore clients do have all choices available to them. However, the staff noted the lack of participation of men in the services provided by the clinic and expressed the need to further educate and raise awareness among men on sexual health issues. Kananga would like to see some kind of harmonization between the various political trends in the Church, the desire of communities, and national policies. They felt that the organisation can continue to restrict its range of services but importantly effective referral systems must link clients with other government run facilities. Other parallel and complementary structures (OACS) must be strengthened and supported to provide family planning and HVI prevention commodities as they are managed autonomously. Alternatively, staff noted that HIV prevention and family planning would be successful globally if the values of the church were upheld but this would involve convincing all individuals and all service providers in the country (and the world) to ally with the church's principles – and this is unrealistic in practice.

Mbuji-Mayi finds the referral systems between services need more coordination. It seems that some clients that are referred to another clinic, do not return to Mbuji-Mayi and it is not clear whether these people access the services they were seeking or are deterred from visiting all health centres, or whether they are deterred from visiting the BDOM because they have been asked by the clinic to go elsewhere. The clinic also wonders whether it should provide a comprehensive package in line with the national government policy and guidelines. In the meantime, strong links between BDOM and state services are a must for clients to be able to access all HIV and family planning services. Secondly, staff must be well trained in those areas of services that the clinic does not provide in order to fully inform clients. Kananga noted that both the Church's principles and the national reproductive health policy are both influential on its services. The major challenges seem to be a lack of understanding and training among health providers of the role of the Catholic Church, and equally a lack of understanding and training among clergy about the medical side of HIV treatment and prevention.

During interviews with key members of staff Kananga explained that the government policy for HIV prevention consists for four key messages: abstaining from sex; being mutually faithful within a relationship; using condoms; and seeking VCT. Staff attempted to remain optimistic by pointing out that the exclusion of condoms means that there are still three possibilities in the fight against HIV, but equally they stated that VCT cannot be

effective without referring to condoms. They emphasised the duty of staff to provide all information about family planning to clients because the clients have the right to choose from all methods available, even if the service itself does not provide their preferred option. The ambiguous question arises, whether staff should provide information on artificial contraception, or can they *advocate* for its use among clients. Ultimately the clinic thinks that the quality its service is affected negatively because it cannot provide a comprehensive package for either HIV prevention or family planning.

Kinshasa noted the broader global external influences of donors and international organisations, which "impose" their views on condoms. Ultimately, the organisation felt that church organisations would be forced to comply with donor preferences if they want to access certain funding. Clearly the official church messages impact on Kinshasa in the sense that condoms and artificial family planning are not provided as part of service delivery. However, staff highlighted the fact that these restrictions means instead that they put an emphasis on other important aspects of HIV prevention and treatment such as educating youth and couples, providing psychosocial support, and giving hope to those who suffer. Mbuji-Mayi acknowledged that Catholic Church leaders reiterate the Vatican's positions on condom use and artificial planning methods, but did not say how this affected their service delivery. There seems to be some faith leaders that Mbuji-Mayi thinks have a poor grasp of confidentiality around HIV testing, such as demanding to see the results of pre-marital HIV tests. While this may not affect the clients' interaction with the clinic, it may create challenges in the clinics' negotiation and advocacy with these church leaders. Mbuji-Mayi staff are very clear that the confidentiality of the patient is paramount and the decision to disclose one's HIV status must be with the person living with HIV only.

Mbuji-Mayi took the view that it tries to reconcile science and religion, but ultimately feels that not providing condoms has a negative effect on service delivery. The fact that family planning options are not integrated into the rest of the service makes it impossible to evaluate the relationship between family planning and other services. Minors, adolescents and unmarried men and women are excluded from family planning services which are restricted to married couples. This means that many people who need the service are denied it.

Constraints to facilitating informed decision making among clients

The policy of the Church (i.e. disallowing condom distribution and artificial contraception) is the key factor that prevents Kananga providing the full package of national health policy services. Staff acknowledge (and feel that the Church should also acknowledge) that the realities of people lives mean that they do have sex and therefore condoms are needed for discordant couples, and also for sex workers and their clients. Secondly, there is in general a lack of availability of these services among other facilities, and supply lines are frequently disrupted. The result is that these services are not consistently available.

Parts of the population (both Catholic and not Catholic) are against artificial contraception. But while natural methods are accepted, Kananga would like to see much more dissemination of the information because it seems currently under-promoted at the moment for those that would like it. At Mbuji-Mayi family planning services lack integration, capacity and logistical support. The Catholic identity of the organisation was cited as a reason that very little planning happens in this area. Basic information materials are absent, and without examples of the various commodities to show clients, explanation of artificial contraceptive methods is considerably more complicated. The stigma surrounding HIV continues among clients and as a result, VCT is not always embedded in other services. The amount of time that staff would prefer to spend with clients is always more than is available.

Illiteracy creates challenges for staff, as does those local customs and practices which are contrary to conventional medical strategies to prevent disease and ill-health. Mbuji-Mayi staff also find that stigma and discrimination remain high, which deters people from seeking help. Kinshasa staff find the low levels of knowledge among patients is a hindrance to facilitating informed decision making. The staff took a critical view of attitudes promoted outside the clinic which encourage sexual relationships and a general lowering of moral standards. It is seems that it is modern and commercial influences that are most responsible for this. Alongside these views on the levels of promiscuity and "moral depravity" that pervades society, Kinshasa also highlighted the reality of poverty that affects clients, and other social problems such as alcoholism.

Managing expectations of donors

Kananga appreciates the fact that Cordaid, as a major donor, understands the position of the church already and therefore does not create conflicting expectations for the organisation between Cordaid as its donor and the Church hierarchies. However, other development partners such as UNDP would like to see the facility distributing condoms. Various other development partners have also expressed their desire to see BDOM apply the national health policy without restrictions. Sometimes the competing priorities place Kananga in a difficult situation. The Provincial Medical Inspector and the (national) reproductive health program staff want condoms and all methods of family planning to be distributed. The clinic continues to implement its training and services

in line with the principles of the Church, but notes that the Church does not perform aggressive monitoring on its approaches. Therefore, at those times when condoms are made available to the clinic, the staff do distribute them. Staff note that those religious health providers who have been trained "in the field" are more accepting of the distribution of condoms. Kananga felt that conflict does arise for staff who are trying to reconcile their medical training, the needs of the community, the priorities of the church and the country's national health policy. The Church faces a contradictory position: it is in support of VCT, during which staff "cannot fail to refer to condoms".

Kinshasa felt that some donors impose their ideological views by spending huge amounts on condoms, that could be better spent on activities which promote human dignity. The organisation also felt that financing from the Global Fund to Fight AIDS, TB and Malaria has a detrimental impact on the country's bilateral aid flows. Donor governments may direct their aid flows into the Global Fund, which can impact on the funding levels of existing funded through bilateral arrangements. Mbuji-Mayi did not see any conflicting expectations between its donors and partners which it sees as having very different roles. It hopes that Cordaid will continue to support the BDOM institution, that UNICEF will continue its nutritional support for people living with HIV, OSISA (South Africa) will continue its rehabilitation project, and Spanish donors will continue their contributions to the physical infrastructure.

Malawi

One of the partners in Malawi, St Joseph, noted that the fact that the clinic does not provide the full range of services has several consequences. Firstly, it challenges clients to go to the district hospital in terms of the costs (time and transport) of accessing the services elsewhere. Secondly, the staff at the clinic have limited knowledge on family planning:

> "Our knowledge on family planning becomes limited because it is like when we come here I have not seen anyone sent for family planning training. Otherwise we have the knowledge through reading the books or knowledge from our college lessons but every time things are changing"
>
> Interview with key informant at St Joseph

The quote above highlights the fact that ongoing training is essential to ensure that staff have full and up to date knowledge. Another challenge that was acknowledged by all three partners in the national workshop was the fact that the emphasis on *not* providing condoms and *not* providing family planning services had displaced the role of natural family planning methods. The partners realized that they could and should be teaching natural methods, and noted that several years ago organisations like UNFPA had also been promoting these. There were mixed approaches to managing official church messages on condoms and contraceptives among the Malawian partners. At St Joseph staff were adamant that they remain consistent with the moral messages but also recognised that the realities of their clients' lives does not mirror church teachings. As a result, the staff find themselves busy treating preventable diseases (HIV and STIs) instead of focussing on other important diseases like malaria which has extremely high rates in the country.

At St Montfort staff felt that the church messages which discourage use of condoms impacts negatively on clients, especially young people. Sex without condoms results in many young people presenting to the clinic with unwanted pregnancies and/or STIs. Further staff feel that natural family planning methods are not very effective at preventing unwanted pregnancies. This could be because clients do not fully understand the method or because they are combined with other 'traditional' methods which generally turn out to be superstition (such as wearing certain beads around the waist).

Despite the fact some people come to St Montfort's looking for natural family planning services, others still ask for artificial methods. Staff recognise that they are not satisfying all the needs of the community if they do not provide these services. ECC is in a very different position as an ecumenical organisation that works with many partners of differing Christian faiths. During its training with pastors, it emphasises the need for people to look to the guidance provided by the participants' individual churches. At the same time it highly values its own policy of facilitating decision making among community members through empowerment by providing all information in relation to condom use, and stresses the importance of individuals making decisions for themselves.

Religion and faith is an important part of daily life for most people in Malawi. The partner organisations' Catholic identity is prominent in their service delivery as they draw on Catholic values as their motivation to respond and they also provide their services in line with perceived standards of the Catholic Church as defined by the national bishops' conference. This means that the three health clinics provide services to clients of all faith and non-faith backgrounds. At the same time, the health clinics do not provide family planning services but make referrals to

government clinics, and within HIV prevention, they do not provide condoms with the exception of one partner who provides them to discordant married couples.

The clinics do not proselytise as such but do feel compelled to advise clients based on Catholic moral teaching regardless of the religious affiliation of the clients. Such advice is largely in line with mainstream HIV prevention messages such as abstinence before marriage and fidelity within relationships. Guidelines require staff to inform clients of all HIV prevention approaches including condoms. A minority of staff expressed disappointment that they cannot provide condoms, and that their advice on family planning and referrals to government health services are often not followed up by clients who return several months later pregnant. Another minority of staff seem to have missed an important part of their orientation and misunderstood the clinics' approach to full information about HIV prevention: they seemed to be afraid to discuss condoms fearing that it would be against clinic policy.

The approach to providing information and referrals in place of services related to both HIV prevention and family planning is problematic where the Catholic clinic is the only realistically accessible option for people in the area. Condoms are available to purchase at local shops, although clients may be reluctant to buy them because of their cost and because they may feel embarrassed.

In Blantyre, two different perspectives were given on the role of local church leaders. On one hand, the Archdiocese authorities are open to input and they expect to be advised on technical aspects of the response. On the other hand, another interviewee felt that the policy of the Catholic church happens at Vatican level, and therefore at local level leaders are powerless to make changes.

In STI management a client is encouraged to bring their sexual partner so that they can be treated together to avoid re-infection. In practice many clients find it hard to have open dialogue on sexual health matters, while staff sometimes felt that clients were unwilling or unable to understand the implications of not bringing their partners: although it is the clients' choice, treatments for STIs are often rendered effectively useless if only one partner is treated. Similarly, in maternity care, clients are informed of the identified risk factors of parity and Caesarean sections, for example, in relation to having further pregnancies, but do not necessarily adhere to advice. There are cultural practices that vest powers in men in terms of decision making: men often do not accompany their wives to antenatal and yet women cannot make decision unless advised by their husbands. High illiteracy levels and low levels of education that impact on clients' capacity to make informed decisions. For example, many clients fail to understand the link between STIs and HIV infection and decline opportunities for voluntary counselling and testing.

Constraints to facilitating informed decision making among clients

The challenges that the organizations encounter include people's preconceived ideas and their unwillingness to change, cultural practices (gender inequality) and illiteracy. The lack of time available to spend with clients was also cited as a major frustration and constraint.

> "When they come here we receive them and start counselling about HIV and AIDS and also STI but their mind is stuck at the mission of their visit."
>
> St Joseph/Nguludi

St Montfort's noted that many women will not make a decision about their options without their husband's consent. The power imbalance among couples also makes it difficult for women to disclose their status to their husband for fear of rejection – and it is often the woman who finds out her HIV status first because she is tested as part of routine pregnancy procedures. ECC also find that women have a low role in decision making. ECC integrates reproductive health information in broader trainings designed to empower women in decision making (funded by NorwegianAid). The organization also aims to influence the mindset of the church and its leaders in order for them to better understand the position of women in the family as well as in the church.

At St Joseph a constraint to facilitating informed decision making is the lack of written materials available for clients. Despite some people being illiterate, not all are, and reading materials would offer the opportunity for people to take information away with them to read in their own time and to share with others.

The organisation's Catholic identity can also cause challenges according to a staff member of Blantyre Archdiocese because they staff members have mixed views about the appropriateness of providing information about condoms. While some feel it is important to provide all information, others may "take offence" at hearing colleagues discussing condoms because this is seen to go against Catholic teaching. This highlights the need for organisations to have clear policies on what information staff are duty bound to provide, and equally the need for staff to understand the medical reasons for providing the information, and reassurance that providing information does not infringe on Catholic values.

Illiteracy and low levels of education present problems at St Joseph because the general lack of understanding exhibited by clients in the issues. Therefore it can take them a long time to fully appreciate all the information and implications, and make decisions. Myths continue to circulate about HIV and other STIs such as having sex with a virgin or a person with a disability can cure one's disease.

Gender power differences were cited by all three partners as significant barriers to women's decision making ability. Women who find out they have an STI before their husband find it extremely difficult to disclose to their husband for fear of being blamed for contracting the infection. The staff at Chikwawa find this hugely frustrating to know that they are treating a woman who most likely will become re-infected if she will not or cannot persuade her husband to come for testing. St Joseph has introduced blood testing for pregnant women at their first antenatal visit, and encourages male partners to attend antenatal clinics in order for the couple to receive the same information and messages together. To address the fact that St Montfort does not provide family planning services, staff ensure that clients are taught natural family planning methods and given referrals to government services for artificial methods.

Managing expectations of donors

Malawian partners all felt that they managed their donor relationships well because there was a mutual partnership understanding between all stakeholders. At Blantyre, staff said that they must choose their donors in accordance with what is best for the organization, just as the donors choose partners that suit their priorities. Further, the efforts of multiple donors to communicate with each other and share information in order to reduce competing demands on partners was appreciated. ECC made similar comments, and although several donors have high expectations of them, the staff ensure that they submit proposals that adhere closely to ECC's mandate. In response donors have respected the organization's priorities.

South Africa

The HIV/AIDS Nursing Manager at Nazareth House explained how she provides information on menstrual cycles, particularly to help HIV positive women get pregnant by having unprotected sex only once at their time of peak fertility. At St Joseph's family planning services are not provided but staff give advice to people living with HIV who want to have children, on the risks and precautions, and they refer to other clinics that provide family planning services. Tapologo staff described how they integrate information about contraceptives into the broader range of information. Most people did not see the fact that the services are not provided as a problem because referrals are made or condoms provided. However, some staff pointed out the social and cultural factors which create a situation where sex is not openly discussed. Some clients feel trapped by society's inability to discuss sexuality and by expectations placed on them, for example to have children. In response to these challenges staff emphasised the need to encourage dialogue and create a safe non-judgemental environment.

Equally, there is so much information about HIV available to some clients that they get tired of hearing about the same things repeatedly in information giving sessions. Tapologo combats this by inviting clients to talk about the things that are currently important to them. One member of staff discussed the fact that talking about condoms is difficult for her personally, and said explicitly that she is unhappy about it because she is Catholic and believes condoms are not the right approach. Interestingly at Tapologo, staff expressed differing practices around condom provision – some said they are provided to the organisation by the Department of Health and the staff use them explicitly in demonstrations, while others described their unavailability at the centre and that they must refer people to other clinics. At Nazareth House condoms are not provided. On the whole this does not seem to impact a great deal on service provision as staff are always able to tell people where they can access condoms free of charge. One member of staff expressed a desire to be able to give out condoms, while another thought that condoms encourage risk taking behaviour.

The fact that condoms and family planning methods are not promoted publically at St Joseph's (some condoms are provided in private consultations) does not deter staff from giving full information about them and providing referrals, so there seems little impact of official church messages on services. Sometimes clients express their reluctance to go to other clinics when referred. At both facilities, however, despite providing information about condoms and family planning, and the appropriate referrals, several staff noted that frequently clients return several months later pregnant. It is not clear how many clients take up the referrals and access condoms and family planning methods, or the reasons that clients return pregnant – whether by choice or because they could not access the other services for reasons unknown.

> "...we could educate people better if we could give condoms and show people how to use them properly. A lot of people are complaining about STIs, so we are missing a lot of chances."

Nurse, St Joseph's

Information about family planning is provided as are condoms at Tapologo so staff do not feel that official church messages impact on the service but only on the Bishop who fends off criticism at levels above the facility's service provision. A volunteer caregiver described how it was initially personally difficult for her to discuss and provide condoms but now she has no issues with providing the service.

Religion and faith is an important part of daily life for many people in South Africa. The clinics are all motivated by their faith to respond to HIV but Catholic moral teaching takes a less significant role in service delivery than in Malawi. Some clinics do not provide condoms but there was a general consensus among partners that this does not deny clients a holistic service overall because of the high density of government service provision in close proximity. None of the clinics provide family planning services per se and staff expressed a desire to become more versed in reproductive health to support their clients. Currently they feel that clients hide their pregnancies from them as long as they can. The staff try to encourage their clients to be open with them so they can ensure that they receive the right treatment regimens but there seems to be an expectation from patients that pregnancy will be disapproved of.

The service at Nazareth House is influenced in the sense that it is oversubscribed because other clinics continually refer patients who are 'undocumented' i.e. have no ID papers. The funder (PEPFAR) has agreed to a certain amount of resources to treat 1730 patients by mid 2010 and Nazareth House is likely to reach this number well before the funding cycle ends.

One of the patient escorts reported some local church leaders who advocate against taking ART and replacing it, possibly with traditional medicine. This causes adherence problems among some clients. The Mother Superior mentioned that Nazareth House had to put a stop to some religious groups visiting the hospice to dissuade people from taking ART. Local societal attitudes can affect people's likelihood of returning for their test result: an auxiliary social worker referred to the fact that some people are in denial about HIV, despite coming for a test, and often these people do not return.

A staff nurse St Joseph's described the challenges of building relationships with other local clinics. St Joseph's does not treat opportunistic infections and found that some other clinics were not completely happy with the referrals made to them. The staff had to do a great deal of explaining about the services that St Joseph's does provide and why they were making referrals. At the same time government clinics sometimes run low on ARVs and rely on St Joseph's to help out. While the government services have improved recently, there have been plenty of reports from clients about poor service which encourage people to seek out organisations like St Joseph's instead of government services.

Sometimes low knowledge among community members about HIV and about the role of Sizanani can deter people from seeking help. They may assume that people only come to St Joseph's to die, or that all staff are living with HIV. So the general fear and misconceptions make it difficult for some people to come forward. Such misconceptions extend to beliefs in traditional medicines over ART which affects people's adherence. Staff are often unaware of such influences until changes in CD4 counts or viral loads are detected. The challenge lies in extending the understanding of ART to family members who may be the ones to convince a patient to change medication approaches.

Founder and Director Elizabeth Schilling is aware that St Joseph's does not necessarily have the same outlook as the government. Despite some Christian values being opposed to those of secular society, the organisation will not compromise on issues it views as extreme, such as abortion.

The social protection system in South Africa can interfere with treatment provision. Patients who get healthy on treatment may find their entitlements cut off, before they have had a chance to find work. This creates a situation whereby people do not have an incentive to get better knowing that if they do, they will be denied a valuable source of income. The manager of the Tapologo's health department described the situation as: "on or off grants means on or off treatment". He would like to see policies which ensure that the grants system is better synchronised with the aims of the treatment.

Constraints to facilitating informed decision making among clients

All three South African partners expressed the frustrations they feel by being constrained by time – while they are seeing more patients than ever, they would all love to have more time to spend with each one. Additionally, the opening hours of the clinics are usually in line with general work hours. No after hours services means that clients who work struggle to meet their appointments. The next issue that affects all three partners is the high levels of poverty among their patients. The cost of transport to attend the clinics is prohibitive. The clinic staff see the clients are in need of shelter, income, clothes and food but cannot afford to provide these things. At Nazareth House, X-rays for TB are not available so referrals are made. The service is also hindered by a lack of

translators. The number of counselling rooms available is also too little for the amount of patients that the staff would like to see. The partner organisation does not provide condoms but ensures that people know where to access them free of charge. St Joseph's struggles with donor requirements, which do not clients to collect more than one month's supply of treatment at a time. More than one month's supply can be provided during home-based care. However, those clients that are not receiving home-based care and travel for work, may not be able to access treatment while they are away.

Maintaining a full staff of qualified and experienced counsellors is also a challenge: many of the counsellors are living with HIV and often need to attend to their own ill-health needs so staff turnover can be high. The partner does not publicly provide condoms but in private counselling sessions will give them to clients. Staff cannot meet all the needs of patients and cannot, for example, provide literacy classes to help people read their appointment cards. Various 'hidden costs' means that the comprehensive service that the partner wants to provide is very difficult to implement: for example, funds do not cover counsellor stipends, professionals to interpret test results or petrol.

Tapologo staff felt that staffing levels are inadequate which risks impinging on the service provided, as does the lack of resources to purchase essential equipment such as refrigerators. Tapologo does not have enough funding to pay for the expenses of the volunteer counsellors who make home visits; they often pay their transport costs out of their small stipend or their own resources. The outreach clinics take place in each local area only once a week – this means that people have to remember which day the clinic is in their area and if they get it wrong they may have to wait another week to see a counsellor. Tapologo does not have a specific programme to impact on the use of traditional medicines, some of which can interfere with ARV treatment. Despite referrals made between clinics, there is a lack of coordinated and cohesive partnership between the local community organisations and the government service providers.

The social constraints faced by all three South African partners are very similar. Stigma continues to be a major issue. For Nazareth House's already isolated migrant patients, there is too much fear that current friends and roommates may reject them if they know they are living with HIV so disclosure is a big hurdle for the clients. There still seems to be high levels of misunderstanding about how HIV is transmitted which increases stigma and fear. At St Joseph's many clients assume that everyone who works at Sizanani is HIV positive. Finding foster families for children is problematic because of the stigma and staff have seen children as young as 12 attempt suicide because they have been ostracised.

Differing gender expectations between men and women pose various challenges, especially people's ability to disclose their status. Women are often economically dependent on men and afraid to be left alone and have no-one to provide for their children, while men are sometimes too proud to get tested or to talk about their status with their wives. Nazareth House notes, however, that they are seeing an increase in the number of men willing to talk about HIV and bring their wives and children for testing. In the meantime, the fear of disclosure means that people will not do anything which reveals or hints at their status, such as using condoms. St Joseph's also find that disclosure to partners is resisted by clients who are afraid of rejection. The result is a general lack of openness – female clients tell the staff they refrain from sex yet obviously have not been able to tell their partners they are HIV positive because they return several months later pregnant. Often women who present at the clinic before their husband are blamed for bringing HIV into the relationship. In many cases men would like their wife to have a child which puts pressure on women.

Sex and related issues remain taboo among some clients. At St Joseph's the age and gender of staff contributes to some client's ability to discuss intimate aspects of their lives: older men do not like to be asked about their sex life or life style. Older women also sometimes find it difficult to discuss personal issues and it takes them a long time to get comfortable with the staff. Some male patients prefer to receive counselling by another male but there is a shortage of male counsellors.

Poverty continues to be a huge social problem leading to people's increased risk of contracting HIV (e.g. through exchanging sex for food or money), not seeking the appropriate support, not living healthily and not adhering to treatment. Language barriers exist for clients at Nazareth House who do not speak Zulu or English or any of the other languages that the staff can speak. Many of the migrants from Zimbabwe and Mozambique seem to have low literacy and education levels which makes relying on proving them with written information or appointment cards very difficult. Poverty levels affect people's shelter and nutritional intake. For those without ID there is an assumption that they cannot be referred to government services. ART is available to these clients from government clinics but the process (and definition of emergency) seems unknown and unclear to both partners and clients. St Joseph's and Tapologo also find that low literacy levels affect some clients' ability to adhere to their medication. Patients with low education levels often need the same information explained to them many times because they cannot use printed materials to remind themselves or for reference. Tapologo finds that some of the practices around using traditional medicines is ingrained in some people's psyches and it takes quite a paradigm shift for them to understand the role of ART.

Managing expectations of donors

At Nazareth House the maximum number of patients that can be seen is set by the donor (PEPFAR) which is frustrating to staff when their services are in high demand. The donor does not provide food which the clinic sisters need to source from elsewhere. At the same time, high expectations of donors about the quality of service motivates the staff to meet these, even if they don't have a say in the budget allocations. St Joseph's also found donor limits on funding and maximum numbers of patients affects the staff who are forced to make referrals to government clinics. Often patients are unhappy with these referrals as they complain that the service is not as good and they are treated poorly.

Reporting to different donors can cause problems. The financial reporting periods are often different. While staff understand the need for monitoring and data collection they feel overwhelmed with the amounts they are asked to collect. The ARV Programme Coordinator asked why donors cannot come up with a common template seeing as they are usually seeking the same information. For staff closer to the ground, they feel that while funds are often provided for medications, there is less provision for staff salaries. The same can be said for office running costs and other overheads – these and salaries are often unpopular with donors. The expectations of donors need to managed particularly when they emphasise areas of work that are not the core business of the organisation such as advocacy. In some cases the organisation has had to turn down offers of funding because the specific area of work that the donor wants to support is already covered, while other aspects of the service are in need of financing. St Joseph's response is to be assertive and assured about their identity and priorities.

Tapologo also finds that donor priorities do not always fit with the organisation's work plans – some want the service to provide more home visits, while other want more of an emphasis on vulnerable children. The donor reporting requirements also put pressure on staff. In some instances there is a need to educate donors about the qualitative work that takes place, as they cannot always understand the services provided through examining quantitative data only. The imposition of auditors and monitors gives some staff the impression that donors think they are trying to hide something from them, which is not the case. While some donors seem to dictate the terms of the relationship, staff are also aware that they must choose their donors as carefully as the donors choose them. Sometimes donors have unrealistic expectations that their funding of medications will result in decreases in HIV prevalence, for example. Unfortunately there are many societal and contextual issues that interrupt adherence such as high levels of poverty which results in a lack of food and money to get to the clinic. Some donors seem unaware of these additional factors and how their funding is ultimately not as effective as it could be because drugs are only part of the response required. Some staff feel the best approach is to comply with reporting expectations to stay on the right side of donors, and some feel it is equally important to maintain a proactive dialogue with donors to increase mutual understanding.

Sexuality and development

Sexuality and sexual rights are areas which have long been under-represented in the development response. They deserve their own prioritisation rather than only being viewed in the context of family planning and HIV prevention. This primary aim of this research was to understand the practices around facilitating informed decision making, but there were opportunities to ask questions on attitudes about sexuality and sexual rights.

The rights of clients, in relation to their expectation of service providers, was only mentioned by Tapologo in South Africa. Several partners discussed the rights of clients to be informed about all health issues. Although the rights of clients may inform all partners' work to a certain extent there was very little evidence of proactive rights-based approaches. This absence of explicit rights language extends to sexuality and sexual diversity. However, issues around sexual behaviour were frequently discussed with clients and in this context the rights of the clients were upheld through partner staff's largely consistent impartial and non-judgemental attitudes in their interactions. Issues of sexuality impact on some clients' ability to make decisions because of wider societal taboos around discussing sex. During the focus group discussions with clients in Malawi, it was noted that there were some clients who said they fail to express themselves freely because the service provider is of the opposite sex while for others this posed no problems.

> "If the one asking questions is a fellow woman, for us it is easy to discuss that. Similarly if it is a man it is difficult for us to explain to him"
>
> "For me I feel that being free to talk about sexual issues even if it is a man we are able to discuss easily. This is because if he is freely explaining such issues you are also able to freely discuss that. There is no uneasiness."
>
> Women FGD, Malawi

There were indications during the focus group discussions in Malawi that some male service providers hinder women from discussing such issues because they are perceived to be too intrusive of women's privacy. More seriously, some women complained that occasionally male health workers make inappropriate comments or even sexual advances towards them. Women seemed more in favour of being accompanied by their husbands when going to family planning and reproductive health services while men preferred privacy in order to openly discuss intimate issues with health workers.

> "The men [health workers] can help provided they have the advice which should not harbour ulterior motives such as making advances at us, no So if a person is being told something without harbouring different thoughts the client feels free and can explain issues to him."
>
> "They should invite wives and husbands as a family because when people are married they become one rib. So when you want to give counsel the family should be together so that if there is any problem such as when it is the issue of blood testing we are together. Therefore I think the best way for us to freely discuss these matters is that both wives and husbands should be available."
>
> Women FGD, Malawi
>
> "There should be just two of you not in a group like this. A person cannot be free to disclose issues because in a group like this some are shy. When we are in a group where they teach us, although we acquire facts but for you to be free, you should be two people only. Then you become really free to bring out everything that your heart desires."
>
> Men FGD, Malawi

Some issues around sexual behaviour go unaddressed with clients. For example, in South Africa partner staff talked about the fact that the conditions of PEPFAR funding includes the non-promotion of sex work. In practice however, whether clients have or intend to sell sex is not a question that comes up. Partners do not work with clients who self-identify as sex workers, and HIV prevention messages are the same for all clients. There is a chance that some clients will engage in much higher risk behaviours than others, and the partners may not be able to identify these clients.

The issue of homosexuality also seems rarely discussed with clients. There are opportunities for partners to raise issues related to male to male sex, such as information around the risks of anal sex (applicable for women too), but during the observations of client and service provider interactions this issue received no mentions. While

homosexuality may be clandestine and taboo in both South Africa and DRC and not openly discussed, there did not seem to be any strong views expressed about it. However, in Malawi homosexuality is both illegal and highly taboo. When asked in the national workshop what staff's course of action would be if a client declared their homosexuality, the participants did not seem to know what they would do and it seemed that such a situation would be highly unlikely. One participant suggested that the correct course of action would be to call the police. With such ambivalent societal and punitive legal attitudes towards homosexuality, there are very few people who have a 'gay identity'. Although this does not mean that partners do not have a role in responding appropriately to the needs of homosexual people but there are currently limited entry points for raising issues with clients.

Providing sexual health services for young people

CIE in South Africa was the only participating partner that had a specific focus on young people. CIE took part through a one-day consultative meeting with the in-country researcher as its approaches were not conducive to the research tools that were designed for the service delivery partners. CIE is an education organization rather than a service delivery partner like the other three ART partners that took part. The biggest tension is around teaching sexuality in Catholic schools. Depending on how conservative their Church is, teachers and principals will be more or less at ease with the topic. For many teachers in Catholic schools it is not clear what they are and are not allowed to teach in relation to sexuality. Teachers are unsure of the boundaries, despite a two-page guideline which seemed quite clear. However, if teachers lack experience in discussing sexuality then they may lack confidence also.

CIE has begun working with a Jesuit organisation, which has developed *Sexuality Education Guidelines*. CIE's approach is work firstly with parents and teachers in workshop formats using the guidelines to inform them and moved the focus beyond the popular debate around condoms. The discussions try to bring issues into context, based on the question: 'what are pupils supposed to know at a certain age and what is appropriate to teach them?' It tries to make discussions more comfortable in classrooms. Teachers clearly need more support to become fully skilled and comfortable in discussing sexuality. Some CIE fieldworkers found that teachers avoid the Q and A cards that deal with sexual issues directly. And in the resource *Today's Choices* they avoid the chapter on contraceptives. Pressure comes from both teachers and parents: the Department of Education does not like the graphic nature of some of CIE's materials.

One of CIE's resources is called *Auntie Stella*, which is particularly enjoyed by children because it gives them a chance to talk which they appreciate. The purpose of 'life orientation' is for students to think for themselves. Most teachers also seem to enjoy working with the *Auntie Stella* material. Some modules of the programme are more difficult than others and sometimes there may be a 'lull' in the modules schools request. Some schools prefer not to deal with difficult issues that are very relevant to them – perhaps it is easier to address issues that are not so close to home. Even though government rules instruct schools to teach sexuality classes, teachers resist because they are uncomfortable and do not want to come into conflict with parents. Sometimes, very apparent issues are simply not discussed, unless organisations like CIE raise them, such as high levels of teenage pregnancies. Schools, especially high schools, often find it easier to talk about HIV and AIDS than sexuality. But often the teaching is limited to anatomy, and in this the knowledge of both teachers and students is extremely low.

In general gender relations is a very sensitive topic. The teachers are mainly female and therefore many have experienced gender based violence which became apparent during a CIE workshop. The teachers had had little opportunity in the past to share with anyone the impact of the violence and were in need of meeting their own support needs, evidenced by the fact that personal stories kept coming from the participants and people were not ready to leave the workshop. There is a huge need to talk about gender violence, for survivors to come to terms with their experiences, and gain the skills to talk to students about it. In many cases women do not recognize that what they have experienced is domestic violence. The same can be said for recognizing child abuse. People simply do not know what it is and is not abuse, and whether behaviours are illegal and actionable. The result is that there is a great deal of abuse of children by teachers, including in the Catholic schools.

Also in South Africa, St Joseph staff explained how some cultural practices are at odds with the conventional HIV prevention messages, such as views on transitioning from childhood to adulthood. In Chiradzulu customs girls are adults at age 15 and are encouraged to engage in sexual relationships and/or get married. Young people in tribes like the Yaos undergo rites of passage rituals and girls (sometimes as young as nine) are encouraged to have sex to 'cleanse' themselves. This exposes them to the risks of both STI infection and pregnancy. However, not all people in the vicinity hold the view that young people should express their sexuality. In fact, among other communities people often take the opposite view, and are against anything that they feel promotes sexual activity among young people. This includes the provision of HIV prevention and sexual health services to adolescents and unmarried men and women. Essentially the complaints that have been levied at St Joseph were the risk of 'moral hazard' i.e. that believing all STIs can be cured or treated will encourage young people to take risk. While among clients of St Montfort, the objection has been that information related to sex is age-inappropriate for young people. In DRC none of the BDOMs target young people, and family planning information is only available for married couples.

Strategies for developing further good practice

Each country has different context and within these the partners provide different levels of service depending on the needs of the communities they serve, what other services are available to clients, and to what extent they believe their services are autonomous of official church teaching on condoms and family planning.

Promoting adherence to existing organisational policies related to sexual and reproductive health

Recommendations

1. Ensure clarity among partner organisations of Cordaid's existing policy on full and accurate information on HIV prevention and family planning

2. Ensure mechanisms and resources for ongoing training staff so they have the capacity to fulfil the existing policy on full and accurate information

3. Ensure that partner staff have access to appropriate IEC materials and examples of commodities to demonstrate them to clients

Cordaid's existing policy on ensuring that partners provide full and accurate information needs to be discussed with partner organisations to ensure that they have a strategy for communicating the policy among the service providers, and also ensuring that training mechanisms are in place so that staff members are fully equipped to provide information accurately.

The topic of informed consent and decision making in reproductive health seemed unfamiliar to many of the respondents on the Malawi research so they were not necessarily primed to respond in full to the questions. Further, the in-country researcher noted that many people seemed uncomfortable discussing HIV prevention and family planning because they were concerned about expressing themselves fully without raising the sensitivity of church doctrines. Some key informants explicitly said that they felt constrained to talk openly about condoms in an environment that does not provide condoms and that informed consent and decision making among clients would be limited in the context of limited service provision.

The reticence of some staff (among partners in all three countries) to discuss condoms highlights the need to ensure that all staff receive induction on existing organisational policy on providing full and accurate information on HIV prevention.

Defining policy on facilitating informed decision making in sexual and reproductive health services

Recommendations

4. Define Cordaid's policy on facilitating informed decision making

5. Support partner organisations to define their own policies and strategies to facilitate informed decision making

6. Work with partner organisations to examine whether the policy on full and accurate information is adequate to facilitate informed decision making among clients in practice

7. Support partners to define the rights of the client, and promote these among those who visit their facilities

It is important that Cordaid defines informed decision making and works with its partners to help them define for themselves their own understandings of informed decision making.

In addition to defining informed decision making, Cordaid needs to be clear with its partners what its expectations are of them in terms of facilitating informed decision among clients. Both Cordaid and its partner organisations need to consider whether providing solely *information* about HIV prevention and family planning is sufficient to ensure that clients are able to make informed decision making. This important question will require further investigation among clients and other service providers to find out how effective referrals are. If other referrals to other services are found to be ineffective then strategies to improve them are needed. This is challenging for Cordaid and its partners because some of the reasons that clients do not take up referrals may be outside their influence. If other services are poorly funded and the service is of a low quality, or other services are inaccessible because of cost and distance, Cordaid and its partners will need to advocate for changes in other services, and consider whether partner organisations need to or should provide services in addition to those they already provide, including the provision of condoms in HIV prevention and family planning services.

While some evidence from this research suggests that clients are unable or unwilling to take up referrals for family planning services and accessing condoms, there are also many other factors of sexual and reproductive health the partners are already supporting them to making informed decisions. One of the key mechanisms for support clients through a decision making process is their interaction with counsellors. Cordaid needs to ensure that counsellors at their partner organisations are fully equipped and supported to work effectively with clients through difficult issues such as deciding whether to go on ARV treatment, or disclosing their status to their partner. These and other areas are challenging for both the clients and the staff. Regular training for counsellors and regular support for them are required to help them provide the most appropriate and effective service possible.

Kananga wants to be able to reconcile the trends of the Church and of the medical profession. The important aspect to staff is that the decision about options must be made by the client, and the position of the Church should in no way infringe the freedom of the client. The staff also pointed out that the service operates within a multi-faith environment and cannot expect people of other faiths (or of no faith) to comply with Catholic values in the context of health service provision.

A policy on facilitating informed decision making on sexual and reproductive health should consider the following:

- Recognition of the role of counsellors and their need for skills training to include facilitating voluntary and informed decision making, supporting clients to disclose to their partner and encourage their partner to attend clinics for STI management and maternal care, and emphasizing the role of the client in making decisions
- Safety issues – to protect the staff, and also to ensure appropriate behaviour and conduct by staff to protect clients

- Clarity on service accessibility for youth and for people who are unmarried
- Clarity on what sexual and reproductive health information is age appropriate for young people

Addressing external factors to facilitate informed decision making among clients

Recommendations

8. Support partners to address external barriers to facilitating informed decision making by increasing their capacity to dialogue with other stakeholders to contribute to: increasing awareness of patient rights, low literacy rates so that clients can read their appointment cards, low education levels, gender power imbalance in decision making

9. Help partners make links with traditional practitioners to increase their ART literacy and create mutual referrals where appropriate

10. Facilitate or provide HIV and AIDS awareness training for clergy, local community and religious leaders

11. Support partners to develop advocacy strategies to make changes with local government on issues such as health service access for people without ID papers and for immigrants (including illegal immigrants)

Many of the barriers to clients' ability to make informed decision making on sexual and reproductive health are external to the services of the partner organisations, for example, low literacy levels and gender inequality. These are challenging areas to address as it is often important for an organisation to stay focussed on its core work. However, there may be ways of addressing these issues by partnering with other organisations, for example, a literacy organisation to visit the clinic to work with patients so they can read their appointment cards.

Some of the barriers to clients making informed decision making include their interaction with other influential individuals such as traditional healers and local church leaders. These church leaders include Catholic clergy and the layers of Diocesan and national Church management. Dialogue with church leaders is essential in order to offer training and capacity building in sexual and reproductive health, and link health issues with the realities of people's needs. Cordaid may be able to do part of this work itself, and it may be able to support partner organisations in their own initiatives. One of the DRC partners has already taken the approach of raising awareness among bishops and priests about HIV and AIDS, so Cordaid can facilitate the sharing of the partners strategies. Additionally Cordaid can collaborate with other faith-based and ecumenical HIV organisations such as its peer Caritas agencies, the Ecumenical HIV/AIDS Initiative in Africa, and national and international networks of religious leaders living with HIV. Dialogue and advocacy with local government is also needed to ensure that services provided to the communities are holistic and complementary.

Kananga would like to see the heads of local churches promoting informed decision making in line with government policy on reproductive health. The BDOM itself could also clarify its position on informed decision making by making it explicit in its agreement with the government. Kananga would like Cordaid to do more advocacy with churches, support the BDOM to establish comprehensive service packages without any restrictions, and train the service providers, priests and bishops.

Chikwawa Diocese believe that as a donor CORDAID has the power to negotiate directly with Church authorities about the issues of family planning and HIV prevention. Further Cordaid can help sensitize the community to advocate for the change themselves.

Nazareth House would like local Church leaders to respond to the pandemic and transfer accurate and current knowledge about HIV and AIDS, including treatment, to the people in their communities.

St Joseph's would like to see church leaders work with young men to reduce gender inequality and violence against women. It could also be of benefit if Church leaders were trained in counselling as well so they are better informed and able to support people.

Tapologo described some already very effective relationships with some Church leaders who provide support, make food for the organisation and invite staff to speak at the church services. However, there remain Church

leaders that do not have the same messages as Tapologo which the organisation would like to work with more. Staff had a sense that the local churches do not talk to each other and there could be more networking between them. Staff also raised concerns about the very small scale projects that some Churches initiate that are sometimes unsuccessful: failed projects can have damaging effects on the expectations of people living with HIV but also community members can become unwilling to support charity if they see a number of projects fail.

St Montfort would like Cordaid to discuss at Diocesan level the need for staff members to attend family planning training. Cordaid would probably have to effectively sponsor such training.

Further, partners would like support in increasing their interaction with governments and other health service providers. Kananga would like the members of the provincial government to promote informed decision making by enforcing the national guidelines and policy on reproductive health. Tapologo would like the government clinics to consistently supply and promote condoms. Staff feel that currently the government clinics do not provide enough awareness raising. St Montfort would like the local government to work closely with the Catholic Secretariat to either advocate for a fuller range of services or provide complementary services so that communities are not deprived of vital services which the Catholic institutions do not currently provide.

Kananga would like other community organizations to promote informed decision making especially by skilling up outreach and field workers. Nazareth House would like other community and health organisations to provide VCT, blood testing, CD4 counts and provide referrals to Nazareth House. Staff would also like more networking between the organisations so they can learn from each other. St Joseph's would also like better strategies to work with traditional healers so they are better informed about HIV and AIDS and appropriate care for patients.

St Montfort would like more collaboration between itself and local organisations to ensure that the different services are complementary rather than competing. Tapologo would like Cordaid, as a donor, to further understand and help them overcome the barriers to clients accessing the services. In many cases more funding is required because of the low economic status of community members who cannot afford the travel to the clinic and cannot afford to eat properly or adequately.

Addressing internal capacity factors to facilitate informed decision making among clients

Recommendations

12. Support partner organisations to ensure there are enough male and female staff so that clients have a choice of seeing a health care worker of the same gender if they prefer

13. Support partner organisations to ensure translators are employed where necessary

14. Support partner organisations to integrate family planning information and services

15. Support partner organisations to increase ability and confidence of partner staff to discuss condoms and family planning

16. Work with partner organisations to review the accessibility of the clinics including their opening hours, and how to reduce the cost of accessing the clinics' services

In addition to developing the policy on facilitating informed decision making among clients, there are additional organisational factors that will contribute to supporting patients. The gender ratio of the staff, for example, needs consideration to ensure there is at least one male and female staff member available for clients to see someone of the same gender if they prefer. In general all staff need to have the capacity, confidence and skills to discuss HIV prevention and family planning, and support clients to be open about their needs and questions. Some partner staff have clients who have different first languages so translators need to be made available and paid for.

Partner would like more skills to provide information on natural family planning methods. Practical aspects of the clinics opening hours and the distances that clients have to travel need to be addressed. For those partners that already provide family planning information and/or services, they would like to see these more integrated with the rest of their services.

ECC would like Cordaid to help build internal capacity among staff to help them advance their skills in different areas such as counselling or providing training so that they are able to provide effective and quality materials in training and counselling. St Joseph would like help with providing transport so their nurses can do more outreach on family planning in villages to increase awareness. Nazareth House staff would all like Cordaid to provide more funding especially for outreach work and additional support to people in dire poverty. St Joseph's would like their services strengthened to support clients further in the areas of prevention, PMTCT, and TB. Additionally Cordaid could help by increasing stipends for home-based carers and wages for counsellors and introducing more training for them so that they have less financial stress and can do their jobs better. Importantly, the terms and conditions of employment affect staff's ability and incentives to stay with organisations like St Joseph's.

Leading theological discussion and analysis with partner organisations on effective approaches

Recommendations

17. Facilitate a series of reflections and discussions with partner organisations including such issues as: the difference between providing information and promoting options; reconciling religion and science i.e. what role does faith have in motivating action, and in delivering services?; medical ethics and Catholic morality; the role of national guidelines and policies in Catholic service provision; rights-based and needs-based approaches; the effectiveness of referrals.

During the research there were a number of partner organisations that were either keen to discuss the interaction between health provision and Catholic teaching, or indicated that they were open to discussing these issues further. For Cordaid this is a key opportunity to work with their partner organisations in open and candid discussion the moral and ethical dilemmas that the staff are facing. Catholic ethics and medical ethics are two important areas that can be reconciled and Cordaid is in a position to have these discussions with both partner organisations and Church leaders at Diocesan and National levels.

It is important that Cordaid listens to its partner organisations to hear their perspectives and equally important that Cordaid is clear with partners and stakeholders what its position is on informed decision making on sexual and reproductive health, including what its expectations of partners are. It is as important that partner organisations understand Cordaid's position as much as the Cordaid must understand its partners. In a meaningful partnership both parties need to be clear about what their priorities are and what they are willing to compromise on.

Mbuji-Mayi would like to see much greater integration of family planning services. It would also like to increase the number of qualified personnel in order for more time to be spent with each client who seeks HIV prevention and treatment services.

In all cases partners rely on referrals to help clients to access services that they do not provide; the most obvious examples, being condoms and modern contraceptives but also other important related services such as x-rays for TB. From the comments and observations of the staff at all facilities there is definite albeit undetermined rate of failure of clients to take up referrals; particularly the examples clients referred to family planning services, who later return pregnant. If facilitating access to a full range of services is a key part of facilitating informed decision making, partners need to ensure that referrals are an effective mechanism. In the first instance partners need to document the rate of referrals that are not taken up by clients, and understand the reasons for the lack of follow through. Based on the evidence gathered, dialogue with partners can take place about the effectiveness of referral systems, whether they can be improved, and whether alternative strategies are additionally required.

Appendix: Analysis by country

DRC

BDOM Kananga, DRC

BDOM Kananga health clinic is in urban area and has access to public transit. In the reception hall, there is a private room to assure confidentiality of clients as they arrive and speak to a member of staff. The buildings are generally in good repair and the walls display information on family planning and malaria.

BDOM Mbuji-Mayi, DRC

The location of health facilities BDOM of Mbuji-Mayi is a semi rural area and the clinic is a long distance from public transit.

BDOM Kinshasa, DRC

BDOM Kinshasa is in an urban area, yet not close to public transit. Confidentiality is assured for clients as they arrive, but there are often long queues.

Catholic Identity

Kinshasa highlighted the values that the Church teaches, such as dignity, love, and solidarity and psychosocial support for people living with HIV and AIDS as affirmative and enabling influences in their work. The partner also cited the Church's promotion of non-discrimination in the fight against stigma as positive message. The staff mentioned the church's rejection of the beliefs and practices of sorcerers, presumably because of the misinformation that sometimes is perpetuated by uninformed traditional herbalists or spiritual healers.

Mbuji-Mayi cited the fact that the church preaches abstinence, mutual fidelity and natural methods as positive aspects, and the fact that it rejects the use of condoms and artificial family planning methods, but did not elaborate on why. However, staff at Kananga were more explicit. Senior staff at Kananga thought that the overall Church messages around rejecting "sinful" behaviour can protect people from HIV infection (by abstaining and being mutually faithful) and high moral standards can have exponential impacts ultimately with the potential to lead the country towards sustainable development. This is perhaps an overoptimistic extrapolation of the values of individuals into positive national progress.

In relation to family planning, the staff interviewed at Kananga suggested that a reliance on artificial contraception can discourage people from their responsibilities. They drew a distinction between the negative consequences of artificial methods failing, and couple having to deal with an unexpected pregnancy, and the impacts of using natural methods: "If using natural methods, we accept what God gives, which has no adverse consequences." Although this is arguably a simplistic and optimistic view, the partner did explain further that with natural family planning, the couple is obliged to take responsibility and plan sex in order to get or avoid pregnancy.

These views present challenges in the context of informed decision making among clients. The emphasis on the behaviour of individuals, seems to centre around a pre-conceived expectation about what the most appropriate actions are, and excludes the possibility that clients will make alternative decisions about their behaviours. The views expressed assume that clients will have the same attitudes towards sexual and reproductive health also therefore exclude the role of conscious among clients. While staff at Kananga felt that moral values associated with its Catholic identity are positive and enabling factors in their approach to facilitating informed decision making, their views may in fact reduce clients abilities to make decisions.

At Kinshasa staff were adamant that it was not appropriate to talk about limits: rather the values of the church should be upheld, for the long-term well-being of individuals. An emphasis was placed on understanding rather than opposing the church. Mbuji-Mayi staff believed that due to the aspects of HIV and family planning services that they cannot provide directly, there needs to be greater efforts to ensure that all staff have their capacity strengthened in order to fully inform clients. The organisation would like to explore more ways to reconcile science and religion.

Kananga felt that the "extremism" of the church is somewhat limited or diluted by external factors such as globalisation and national policies advocating a comprehensive scientific package. The church risks marginalising itself if it continues to place itself outside the main current and refuses to acknowledge people's expression of sexuality. The pressures and expectations of donors creates a situation whereby the partner organisation risks the withdrawal of financial support if it does not adhere to conventional medical approaches to HIV prevention. at the same time, Kananga believed that the church must remain faithful to its primary mission to "promote human life and remove man from sin".

Challenges in providing family planning and sexual health options

Kinshasa does not see any challenges with providing information only about family planning and HIV prevention options because other providers are able to provide these services. Therefore clients do have all choices available to them. However, the staff noted the lack of participation of men in the services provided by the clinic and expressed the need to further educate and raise awareness among men on sexual health issues.

Kananga would like to see some kind of harmonization between the various political trends in the Church, the desire of communities, and national policies. They felt that the organisation can continue to restrict its range of services but importantly effective referral systems must link clients with other government run facilities. Other parallel and complementary structures (OACS) must be strengthened and supported to provide family planning and HVI prevention commodities as they are managed autonomously. Alternatively, staff noted that HIV prevention and family planning would be successful globally if the values of the church were upheld but this would involve convincing all individuals and all service providers in the country (and the world) to ally with the church's principles – and this is unrealistic in practice.

Mbuji-Mayi finds the referral systems between services need more coordination. It seems that some clients that are referred to another clinic, do not return to Mbuji-Mayi and it is not clear whether these people access the services they were seeking or are deterred from visiting all health centres, or whether they are deterred from visiting the BDOM because they have been asked by the clinic to go elsewhere. The clinic also wonders whether it should provide a comprehensive package in line with the national government policy and guidelines. In the meantime, strong links between BDOM and state services are a must for clients to be able to access all HIV and family planning services. Secondly, staff must be well trained in those areas of services that the clinic does not provide in order to fully inform clients.

Kananga noted that both the Church's principles and the national reproductive health policy are both influential on its services. The major challenges seem to be a lack of understanding and training among health providers of the role of the Catholic Church, and equally a lack of understanding and training among clergy about the medical side of HIV treatment and prevention.

During interviews with key members of staff Kananga explained that the government policy for HIV prevention consists for four key messages: abstaining from sex; being mutually faithful within a relationship; using condoms; and seeking VCT. Staff attempted to remain optimistic by pointing out that the exclusion of condoms means that there are still three possibilities in the fight against HIV, but equally they stated that VCT cannot be effective without referring to condoms.

They emphasised the duty of staff to provide all information about family planning to clients because the clients have the right to choose from all methods available, even if the service itself does not provide their preferred option. The ambiguous question arises, whether staff should provide information on artificial contraception, or can they *advocate* for its use among clients. Ultimately the clinic thinks that the quality its service is affected negatively because it cannot provide a comprehensive package for either HIV prevention or family planning.

Kinshasa noted the broader global external influences of donors and international organisations, which "impose" their views on condoms. Ultimately, the organisation felt that church organisations would be forced to comply with donor preferences if they want to access certain funding. Clearly the official church messages impact on Kinshasa in the sense that condoms and artificial family planning are not provided as part of service delivery. However, staff highlighted the fact that these restrictions means instead that they put an emphasis on other important aspects of HIV prevention and treatment such as educating youth and couples, providing psychosocial support, and giving hope to those who suffer.

Mbuji-Mayi acknowledged that Catholic Church leaders reiterate the Vatican's positions on condom use and artificial planning methods, but did not say how this affected their service delivery. There seems to be some faith leaders that Mbuji-Mayi thinks have a poor grasp of confidentiality around HIV testing, such as demanding to see the results of pre-marital HIV tests. While this may not affect the clients' interaction with the clinic, it may create challenges in the clinics' negotiation and advocacy with these church leaders. Mbuji-Mayi staff are very

clear that the confidentiality of the patient is paramount and the decision to disclose one's HIV status must be with the person living with HIV only.

Mbuji-Mayi took the view that it tries to reconcile science and religion, but ultimately feels that not providing condoms has a negative effect on service delivery. The fact that family planning options are not integrated into the rest of the service makes it impossible to evaluate the relationship between family planning and other services. Minors, adolescents and unmarried men and women are excluded from family planning services which are restricted to married couples. This means that many people who need the service are denied it.

Constraints to facilitating informed decision making among clients

The policy of the Church (i.e. disallowing condom distribution and artificial contraception) is the key factor that prevents Kananga providing the full package of national health policy services. Staff acknowledge (and feel that the Church should also acknowledge) that the realities of people lives mean that they do have sex and therefore condoms are needed for discordant couples, and also for sex workers and their clients. Secondly, there is in general a lack of availability of these services among other facilities, and supply lines are frequently disrupted. The result is that these services are not consistently available.

Parts of the population (both Catholic and not Catholic) are against artificial contraception. But while natural methods are accepted, Kananga would like to see much more dissemination of the information because it seems currently under-promoted at the moment for those that would like it.

At Mbuji-Mayi family planning services lack integration, capacity and logistical support. The Catholic identity of the organisation was cited as a reason that very little planning happens in this area. Basic information materials are absent, and without examples of the various commodities to show clients, explanation of artificial contraceptive methods is considerably more complicated. The stigma surrounding HIV continues among clients and as a result, VCT is not always embedded in other services. The amount of time that staff would prefer to spend with clients is always more than is available.

Illiteracy creates challenges for staff, as does those local customs and practices which are contrary to conventional medical strategies to prevent disease and ill-health. Mbuji-Mayi staff also find that stigma and discrimination remain high, which deters people from seeking help.

Kinshasa staff find the low levels of knowledge among patients is a hindrance to facilitating informed decision making. The staff took a critical view of attitudes promoted outside the clinic which encourage sexual relationships and a general lowering of moral standards. It is seems that it is modern and commercial influences that are most responsible for this. Alongside these views on the levels of promiscuity and "moral depravity" that pervades society, Kinshasa also highlighted the reality of poverty that affects clients, and other social problems such as alcoholism.

Managing expectations of donors

Kananga appreciates the fact that Cordaid, as a major donor, understands the position of the church already and therefore does not create conflicting expectations for the organisation between Cordaid as its donor and the Church hierarchies. However, other development partners such as UNDP would like to see the facility distributing condoms. Various other development partners have also expressed their desire to see BDOM apply the national health policy without restrictions.

Sometimes the competing priorities place Kananga in a difficult situation. The Provincial Medical Inspector and the (national) reproductive health program staff want condoms and all methods of family planning to be distributed. The clinic continues to implement its training and services in line with the principles of the Church, but notes that the Church does not perform aggressive monitoring on its approaches. Therefore, at those times when condoms are made available to the clinic, they staff do distribute them. Staff note that those religious health providers who have been trained "in the field" are more accepting of the distribution of condoms. Kananga felt that conflict does arise for staff who are trying to reconcile their medical training, the needs of the community, the priorities of the church and the country's national health policy. The Church faces a contradictory position: it is in support of VCT, during which staff "cannot fail to refer to condoms".

Kinshasa felt that some donors impose their ideological views by spending huge amounts on condoms, that could be better spent on activities which promote human dignity. The organisation also felt that financing from the Global Fund to Fight AIDS, TB and Malaria has a detrimental impact on the country's bilateral aid flows. Donor governments may direct their aid flows into the Global Fund, which can impact on the funding levels of existing funded through bilateral arrangements.

Mbuji-Mayi did not see any conflicting expectations between its donors and partners which it sees as having very different roles. It hopes that Cordaid will continue to support the BDOM institution, that UNICEF will continue its nutritional support for people living with HIV, OSISA (South Africa) will continue its rehabilitation project, and Spanish donors will continue their contributions to the physical infrastructure.

Malawi

St. Joseph Hospital (Nguludi Hospital), Blantyre, Malawi

St. Joseph Hospital employs a total of 271 staff. It is located in Chiradzulu District, 20 kilometres from the city of Blantyre. With clearly labelled direction signs, the facility is within metres of public transport services. The waiting room is large enough to accommodate 130 clients. It has a television set and staff provide health education to occupy clients while they wait – queues can be lengthy in the mornings but there are five consultation rooms which means staff are able to see several clients at a time between them.

St. Montfort Hospital, Chikwawa District, Malawi

St. Montfort Hospital is located in rural parts of Chikwawa District sixty kilometres from the government hospital. Since it is remotely located, the hospital serves more patients; the ratio of health service provider to clients is at 1 to 148.

Lilongwe Ecumenical Centre

The Lilongwe Counseling and Training Centre (ECC) is located in Lilongwe, the Capital City of Malawi. Its main purpose is to train pastors from all denominations in HIV sensitisation, and ECC also offers counselling and testing services. It has a total of 17 staff members of which three are trained counsellors. The ratio of staff to clients for counselling is one to one and one to twenty five for training.

Catholic Identity

St Joseph found that the respected reputation of the Church was important because community members feel safe visiting the facility. For people who have a strong faith, staff at St Montfort saw itself as the obvious and reassuring choice of health service for those who needed drugs for treatment as well as God to heal them. There was an implication that clients may believe they will get the best treatment because the institution believes in God.

The partners said they strive to provide information without being judgmental regarding the choices the clients made. They provide information on the client's choice of service and listen to the concerns of the clients. The clients are given an opportunity to ask questions and the service providers also ask questions to the clients.

> "They explain everything then they tell you that you should discuss. After discussing for some time they ask that do you have any questions on what I said. So you ask them questions. If you do not have questions you do not ask so they know that everything is understood. Sometimes when you do not ask when they ask you if you have any questions, when you say we do not have then they ask you questions for them to know that you have understood the issue"
>
> Women FGD, Malawi

The lack of comprehensive service provision at St Montfort means that staff need to make referrals and some staff are concerned that the very fact that they do not provide some options can discourage people from seeking them elsewhere.

At St Joseph staff acknowledged that the organization's expression of its Catholic identity may put some people off from attending, such as starting some groups sessions with a prayer. Staff at St Joseph also discussed their need to strengthen their referral systems because they realize that they do not know how many of their clients actually take up the referrals, and neither do they know the reasons that these clients decline the referrals.

During the partner workshops, staff agreed by providing only information about modern contraception, they were limited in practice in their ability to facilitate informed decision making among clients. The services that clients are referred to are sometimes a long distance to travel and clients may simply not be able to access alternative health providers.

In addition, some individuals within organisations feel constrained further and do not even give information on condoms and family planning because they think this goes against the organisation's policies. Either these staff are not fully and properly orientated in policies of the organizations or there is pressure or expectation from the heads of the organizations that disapproves of the official policy which requires full and accurate information be provided to clients.

Ultimately, not providing family planning services means that knowledge and skills among the majority of the service providers is limited as they do not stay abreast of the latest information on modern family planning technologies. This affects informed decision making among clients as the service providers may not have the confidence to provide adequate and updated information.

Clients in the focus group discussions indicated that the Catholic identity of the health services had little impact on them for two reasons. Firstly, they are well aware of the Catholic values of the service so there are no unexpected surprises about the range of services that the institution provides. Secondly, clients noted the service providers assisted the people to talk freely and openly about issues of sexual and reproductive health without being influenced by their own religious and personal values.

> "They are able to discuss with us very private and personal issues pertaining to our individual sexual and reproductive health matters and help us to make decisions and choose services of our liking"
>
> FGD young men, Malawi

Challenges in providing family planning and sexual health options

One of the partners in Malawi, St Joseph, noted that the fact that the clinic does not provide the full range of services has several consequences. Firstly, it challenges clients to go to the district hospital in terms of the costs (time and transport) of accessing the services elsewhere. Secondly, the staff at the clinic have limited knowledge on family planning:

> "Our knowledge on family planning becomes limited because it is like when we come here I have not seen anyone sent for family planning training. Otherwise we have the knowledge through reading the books or knowledge from our college lessons but every time things are changing"
>
> Interview with key informant at St Joseph

The quote above highlights the fact that ongoing training is essential to ensure that staff have full and up to date knowledge.

Another challenge that was acknowledged by all three partners in the national workshop was the fact that the emphasis on *not* providing condoms and *not* providing family planning services had displaced the role of natural family planning methods. The partners realized that they could and should be teaching natural methods, and noted that several years ago organisations like UNFPA had also been promoting these.

There were mixed approaches to managing official church messages on condoms and contraceptives among the Malawian partners. At St Joseph staff were adamant that they remain consistent with the moral messages but also recognised that the realities of their clients' lives does not mirror church teachings. As a result, the staff find themselves busy treating preventable diseases (HIV and STIs) instead of focussing on other important diseases like malaria which has extremely high rates in the country.

At St Montfort staff felt that the church messages which discourage use of condoms impacts negatively on clients, especially young people. Sex without condoms results in many young people presenting to the clinic with unwanted pregnancies and/or STIs. Further staff feel that natural family planning methods are not very effective at preventing unwanted pregnancies. This could be because clients do not fully understand the method or because they are combined with other 'traditional' methods which generally turn out to be superstition (such as wearing certain beads around the waist).

Despite the fact some people come to St Montfort's looking for natural family planning services, others still ask for artificial methods. Staff recognise that they are not satisfying all the needs of the community if they do not provide these services.

ECC is in a very different position as an ecumenical organisation that works with many partners of differing Christian faiths. During its training with pastors, it emphasises the need for people to look to the guidance provided by the participants' individual churches. At the same time it highly values its own policy of facilitating decision making among community members through empowerment by providing all information in relation to condom use, and stresses the importance of individuals making decisions for themselves.

Religion and faith is an important part of daily life for most people in Malawi. The partner organisations' Catholic identity is prominent in their service delivery as they draw on Catholic values as their motivation to respond and they also provide their services in line with perceived standards of the Catholic Church as defined by the national bishops' conference. This means that the three health clinics provide services to clients of all faith and non-faith

backgrounds. At the same time, the health clinics do not provide family planning services but make referrals to government clinics, and within HIV prevention, they do not provide condoms with the exception of one partner who provides them to discordant married couples.

The clinics do not proselytise as such but do feel compelled to advise clients based on Catholic moral teaching regardless of the religious affiliation of the clients. Such advice is largely in line with mainstream HIV prevention messages such as abstinence before marriage and fidelity within relationships. Guidelines require staff to inform clients of all HIV prevention approaches including condoms. A minority of staff expressed disappointment that they cannot provide condoms, and that their advice on family planning and referrals to government health services are often not followed up by clients who return several months later pregnant. Another minority of staff seem to have missed an important part of their orientation and misunderstood the clinics' approach to full information about HIV prevention: they seemed to be afraid to discuss condoms fearing that it would be against clinic policy.

The approach to providing information and referrals in place of services related to both HIV prevention and family planning is problematic where the Catholic clinic is the only realistically accessible option for people in the area. Condoms are available to purchase at local shops, although clients may be reluctant to buy them because of their cost and because they may feel embarrassed.

In Blantyre, two different perspectives were given on the role of local church leaders. On one hand, the Archdiocese authorities are open to input and they expect to be advised on technical aspects of the response. On the other hand, another interviewee felt that the policy of the Catholic church happens at Vatican level, and therefore at local level leaders are powerless to make changes.

In STI management a client is encouraged to bring their sexual partner so that they can be treated together to avoid re-infection. In practice many clients find it hard to have open dialogue on sexual health matters, while staff sometimes felt that clients were unwilling or unable to understand the implications of not bringing their partners: although it is the clients' choice, treatments for STIs are often rendered effectively useless if only one partner is treated. Similarly, in maternity care, clients are informed of the identified risk factors of parity and Caesarean sections, for example, in relation to having further pregnancies, but do not necessarily adhere to advice. There are cultural practices that vest powers in men in terms of decision making: men often do not accompany their wives to antenatal and yet women cannot make decision unless advised by their husbands. High illiteracy levels and low levels of education that militate against clients' capacity to make informed decisions. For example, many STI clients fail to understand the link between STIs and HIV infection hence refusing VCT.

Constraints to facilitating informed decision making among clients

The challenges that the organizations encounter include people's preconceived ideas and their unwillingness to change, cultural practices (gender inequality) and illiteracy. The lack of time available to spend with clients was also cited as a major frustration and constraint.

> "When they come here we receive them and start counselling about HIV and AIDS and also STI but their mind is stuck at the mission of their visit."
>
> St Joseph/Nguludi

St Montfort's noted that many women will not make a decision about their options without their husband's consent. The power imbalance among couples also makes it difficult for women to disclose their status to their husband for fear of rejection – and it is often the woman who finds out her HIV status first because she is tested as part of routine pregnancy procedures.

ECC also find that women have a low role in decision making. ECC integrates reproductive health information in broader trainings designed to empower women in decision making (funded by NorwegianAid). The organization also aims to influence the mindset of the church and its leaders in order for them to better understand the position of women in the family as well as in the church.

At St Joseph a constraint to facilitating informed decision making is the lack of written materials available for clients. Despite some people being illiterate, not all are, and reading materials would offer the opportunity for people to take information away with them to read in their own time and to share with others.

The organisation's Catholic identity can also cause challenges according to a staff member of Blantyre Archdiocese because they staff members have mixed views about the appropriateness of providing information about condoms. While some feel it is important to provide all information, others may "take offence" at hearing colleagues discussing condoms because this is seen to go against Catholic teaching. This highlights the need for organisations to have clear policies on what information staff are duty bound to provide, and equally the need for

staff to understand the medical reasons for providing the information, and reassurance that providing information does not infringe on Catholic values.

Illiteracy and low levels of education present problems at St Joseph because the general lack of understanding exhibited by clients in the issues. Therefore it can take them a long time to fully appreciate all the information and implications, and make decisions.

Gender power differences were cited by all three partners as significant barriers to women's decision making ability. Women who find out they have an STI before their husband find it extremely difficult to disclose to their husband for fear of being blamed for contracting the infection. The staff at Chikwawa find this hugely frustrating to know that they are treating a woman who most likely will become re-infected if she will not or cannot persuade her husband to come for testing.

Myths continue to abound about HIV and other STIs, such as having sex with a virgin or a person with a disability can cure one's disease.

To address the fact that St Montfort does not provide family planning services, staff ensure that clients are taught natural family planning methods and given referrals to government services for artificial methods.

St Joseph has introduced blood testing for pregnant women at their first antenatal visit, and encourages male partners to attend antenatal clinics in order for the couple to receive the same information and messages together.

Managing expectations of donors

Malawian partners all felt that they managed their donor relationships well because there was a mutual partnership understanding between all stakeholders. At Blantyre, staff said that they must choose their donors in accordance with what is best for the organization, just as the donors choose partners that suit their priorities. Further, the efforts of multiple donors to communicate with each other and share information in order to reduce competing demands on partners was appreciated.

ECC made similar comments, and although several donors have high expectations of them, the staff ensure that they submit proposals that adhere closely to ECC's mandate. In response donors have respected the organization's priorities.

South Africa

Nazareth House, South Africa

Nazareth House is located in Yeoville, in the heart of Johannesburg. It is close to regular urban public transport. But the neighbourhood has a reputation for crime.

Nazareth House employs over 100 people and consists of a convent for nuns, an old age home, a children's home, a hospice, an ARV clinic with a home based care service, a support group of clinic patients that does bead work as well, and a charity shop. There are also big kitchens and dining halls for the old age home, some green grounds, a small swimming pool and tennis court, a church, recreation facilities for staff, and a home for the maintenance person.

Some 85% of Nazareth house's patients are immigrants; people who are here often alone, coming from all over Africa. Patients speak many different languages and there are not always translators available. Most people are poor and often have no work, no place to stay, no family or relatives in the country. If they do have work, it may be illegal, which makes them very vulnerable to exploitation and leaves them without any rights.

St Joseph's Care and Support Trust, South Africa

St Joseph's is part of Sizanani Village located just outside of Bronkhorstspruit, along a fairly busy road in a semi-rural area. The village is a complex which hosts a range of facilities: it has a health department with a hospice, an ARV and VCT clinic with a dispensary, data capturers, an outreach programme and home based carers; a social development/work programme with community programmes and programmes targeting youth; training and conference facilities with 41 rondavels for guests and another 20-40 beds in the facility, a children's home for disabled (and sometimes orphaned or abandoned) children, a factory for cuddly toys, vegetable gardens, a crèche, and a church.

Tapologo, South Africa

Tapologo is a facility based on the outskirts of Phokeng village, about a 20 minute drive from Rustenburg towards Sun City. This area is the heart of the mining district; the landscape is dominated by the many platinum mines. This also means that there is much migrant labour: many men from other parts of the country and of Africa have left families behind to work at the mines. They usually live in hostels, where they may share rooms with other mine workers. Many of these workers are known to be infected by HIV. Most workers are on treatment programmes at the mines, but it is also assumed that many do not seek treatment – or at a very late stage.

Tapologo's premises are located just off the main road through Phokeng, on a dirt road. The buildings and grounds look organic in the way they are constructed; round, fluent shapes and buildings made out of wattle and daub (mud houses).

On its grounds Tapologo has a hospice (IPU; in patient unit), offices, training facilities, a vegetable garden, small playground and they are building more parking facilities and new offices. The home of the Bishop, founder and still driving the place, is also near its premises. Most of its work is in the communities. They main element are the outreach ARV clinics, but Tapologo also offers a programme for vulnerable children and an empowerment programme for (mainly male) youth.

CIE, South Africa

CIE is an educational organisation that works with teachers and school children on HIV education.

Catholic Identity

At Nazareth House the staff felt that being Catholic identified the service as available to all people regardless of their religion or legal status to be in the country. The organisation's catholic identity ensures that people know they are here to help, not only with medical problems but social problems too. This sentiment was reiterated by St Joseph's where staff valued the holistic approach that the organisation took to working with patients. The partners provide food, toys, blankets and spiritual support if clients want it. There is a sense that Catholic organisations serve the whole community, and staff members give all they can and wholeheartedly to support people and bring them hope. Clients recognise this and view the service as non-judgmental and trustworthy.

"We don't notice any difference between people of different faiths or beliefs. They all treat us with respect and don't try to push their values."

"It is a Catholic organisation, they give bread and tea, and they take care of people. They do that because they are Catholic. But they never talk about religion or how they personally feel. They are who they are and do what they do. They don't do condoms, but tell you where to get them."

Focus group participants, South Africa

At St Joseph's the Catholic identity was also cited by a VCT counsellor as a reason that the facility is a place of respect and peace. At Tapologo the Catholic identity allows staff to interact with clients because they trust the Church and therefore trust the Church-based organisations which have credibility. The organisation was proud of its Catholic identity, the values of which motivated the staff to serve people. At the same time staff were careful not to aggressively promote the Catholic religion because it is a health facility and for people of all religions.

The heads of the organisations were also very aware that their Catholic identities allow them to access much needed sources of Catholic funding.

Because certain services are omitted or left to government run facilities, ambiguity and confusion can arise among clients who arrive looking for family planning services particularly. At Nazareth House, however, to resolve this usually takes one explanation and referrals to other clinics where condoms and other contraceptives can be accessed. Clients are usually very understanding once they are given the reasons that these are not available at Nazareth House. Some staff felt that not providing condoms is a limitation, while others are content not to provide them because they believe that it encourages "bad behaviour".

At St Joseph's the inability to provide condoms puts them in a "bizarre" position for some staff who see divergence between the policy and people's realities. The Department of Health provides condoms which the staff clandestinely give out in one-to-one counselling sessions which they believe goes against the policy of the organization. On the whole staff do not think the moratorium on providing condoms affects their work a great deal because they are accessible at other places. Working with young adults and promoting abstinence and fidelity messages can be a struggle for some staff as they feel they are swimming against the public and popular tides.

Tapologo acknowledges that some people may be hesitant in coming to the clinic because of its Catholic identity. Some home based caregivers may be selective about the information they provide because of their personal beliefs, while more conservative Catholics might avoid the clinic because Bishop Dowling's stance on making condoms available is well known. For Bishop Dowling, he finds himself isolated, having to justify himself continually and being accused of breaking ranks within the Catholic Church. He firmly believes that "Thou shalt not kill" must supersede "Do not use condoms".

Challenges in providing family planning and sexual health options

The HIV/AIDS Nursing Manager at Nazareth House explained how she provides information on menstrual cycles, particularly to help HIV positive women get pregnant by having unprotected sex only once at their time of peak fertility. At St Joseph's family planning services are not provided but staff give advice to people living with HIV who want to have children, on the risks and precautions, and they refer to other clinics that provide family planning services.

Tapologo staff described how they integrate information about contraceptives into the broader range of information. Most people did not see the fact that the services are not provided as a problem because referrals are made or condoms provided. However, some staff pointed out the social and cultural factors which create a situation where sex is not openly discussed. Some clients feel trapped by society's inability to discuss sexuality and by expectations placed on them, for example to have children. In response to these challenges staff emphasised the need to encourage dialogue and create a safe non-judgemental environment.

Equally, there is so much information about HIV available to some clients that they get tired of hearing about the same things repeatedly in information giving sessions. Tapologo combats this by inviting clients to talk about the things that are currently important to them. One member of staff discussed the fact that talking about condoms is difficult for her personally, and said explicitly that she is unhappy about it because she is Catholic and believes condoms are not the right approach.

Interestingly at Tapologo, staff expressed differing practices around condom provision – some said they are provided to the organisation by the Department of Health and the staff use them explicitly in demonstrations, while others described their unavailability at the centre and that they must refer people to other clinics.

At Nazareth House condoms are not provided. On the whole this does not seem to impact a great deal on service provision as staff are always able to tell people where they can access condoms free of charge. One member of staff expressed a desire to be able to give out condoms, while another thought that condoms encourage risk taking behaviour.

The fact that condoms and family planning methods are not promoted publically at St Joseph's (some condoms are provided in private consultations) does not deter staff from giving full information about them and providing referrals, so there seems little impact of official church messages on services. Sometimes clients express their reluctance to go to other clinics when referred.

At both facilities, however, despite providing information about condoms and family planning, and the appropriate referrals, several staff noted that frequently clients return several months later pregnant. It is not clear how many clients take up the referrals and access condoms and family planning methods, or the reasons that clients return pregnant – whether by choice or because they could not access the other services for reasons unknown.

> "...we could educate people better if we could give condoms and show people how to use them properly. A lot of people are complaining about STIs, so we are missing a lot of chances."
>
> Nurse, St Joseph's

Information about family planning is provided as are condoms at Tapologo so staff do not feel that official church messages impact on the service but only on the Bishop who fends off criticism at levels above the facility's service provision. A volunteer caregiver described how it was initially personally difficult for her to discuss and provide condoms but now she has no issues with providing the service.

Religion and faith is an important part of daily life for many people in South Africa. The clinics are all motivated by their faith to respond to HIV but Catholic moral teaching takes a less significant role in service delivery than in Malawi. Some clinics do not provide condoms but there was a general consensus among partners that this does not deny clients a holistic service overall because of the high density of government service provision in close proximity.

None of the clinics provide family planning services per se and staff expressed a desire to become more versed in reproductive health to support their clients. Currently they feel that clients hide their pregnancies from them as long as they can. The staff try to encourage their clients to be open with them so they can ensure that they receive the right treatment regimens but there seems to be an expectation from patients that pregnancy will be disapproved of.

The service at Nazareth House is influenced in the sense that it is oversubscribed because other clinics continually refer patients who are 'undocumented' i.e. have no ID papers. The funder (PEPFAR) has agreed to a certain amount of resources to treat 1730 patients by mid 2010 and Nazareth House is likely to reach this number well before the funding cycle ends.

One of the patient escorts reported some local church leaders who advocate against taking ART and replacing it, possibly with traditional medicine. This causes adherence problems among some clients. The Mother Superior mentioned that Nazareth House had to put a stop to some religious groups visiting the hospice to "convince" people. It is not clear what the aim of the "convincing" was, and Mother Superior said that now people cannot come on to the premises without the staff agreeing in advance.

Local societal attitudes can affect people's likelihood of returning for their test result: an auxiliary social worker referred to the fact that some people are in denial about HIV, despite coming for a test, and often these people do not return.

A staff nurse St Joseph's described the challenges of building relationships with other local clinics. St Joseph's does not treat OIs and found that some other clinics were not completely happy with the referrals made to them. The staff had to do a great deal of explaining about the services that St Joseph's does provide and why they were making referrals.

At the same time government clinics sometimes run low on ARVs and rely on St Joseph's to help out. While the government services have improved recently, there have been plenty of reports from clients about poor service which encourage people to seek out organisations like St Joseph's instead of government services.

Sometimes low knowledge among community members about HIV and about the role of Sizanani can deter people from seeking help. They may assume that people only come to St Joseph's to die, or that all staff are living with HIV. So the general fear and misconceptions make it difficult for some people to come forward. Such

misconceptions extend to beliefs in traditional medicines over ART which affects people's adherence. Staff are often unaware of such influences until changes in CD4 counts or viral loads are detected. The challenge lies in extending the understanding of ART to family members who may be the ones to convince a patient to change medication approaches.

Founder and Director Elizabeth Schilling is aware that St Joseph's does not necessarily have the same outlook as the government. Despite some Christian values being opposed to those of secular society, the organisation will not compromise on issues it views as extreme, such as abortion.

The social protection system can interfere with treatment provision. As the manager of the Tapologo's health department stated: "on or off grants means on or off treatment". He would like to see policies which ensure that the grants system is more in sync with the aims of the treatment.

The positive roles that Churches and supportive political leaders play was highlighted. Conversely staff were aware that the organisation is essentially protected by Bishop Dowling who deflects criticism which comes from Church hierarchies.

The local societal beliefs that the hospice is somewhere people go to die, and therefore the staff are to a certain extent viewed as causing people to die, can prevent some patients, particularly men, from presenting at the clinic until it is too late. A patron of the clinic, Queen Mother of the Bafikeng, has done a great deal of advocacy in communities to try and change these attitudes.

Constraints to facilitating informed decision making among clients

All three South African partners expressed the frustrations they feel by being constrained by time – while they are seeing more patients than ever, they would all love to have more time to spend with each one. Additionally, the opening hours of the clinics are usually in line with general work hours. No after hours services means that clients who work struggle to meet their appointments. The next issue that affects all three partners is the high levels of poverty among their patients. The cost of transport to attend the clinics is prohibitive. The clinic staff see the clients are in need of shelter, income, clothes and food but cannot afford to provide these things.

At Nazareth House, X-rays for TB are not available so referrals are made. The service is also hindered by a lack of translators. The number of counselling rooms available is also too little for the amount of patients that the staff would like to see. The partner organisation does not provide condoms but ensures that people know where to access them free of charge.

St Joseph's struggles with donor requirements, which do not clients to collect more than one month's supply of treatment at a time. More than one month's supply can be provided during home-based care. However, those clients that are not receiving home-based care and travel for work, may not be able to access treatment while they are away.

Maintaining a full staff of qualified and experienced counsellors is also a challenge: many of the counsellors are living with HIV and often need to attend to their own ill-health needs so staff turnover can be high. The partner does not publicly provide condoms but in private counselling sessions will give them to clients. Staff cannot meet all the needs of patients and cannot, for example, provide literacy classes to help people read their appointment cards. Various 'hidden costs' means that the comprehensive service that the partner wants to provide is very difficult to implement: for example, funds do not cover counsellor stipends, professionals to interpret test results or petrol.

Tapologo also feels that its staffing levels are inadequate which risks impinging on the service provided, as does the lack of resources to purchase essential equipment such as refrigerators. Tapologo does not have enough funding to pay for the expenses of the volunteer counsellors who make home visits; they often pay their transport costs out of their small stipend or their own resources. The outreach clinics take place in each local area only once a week – this means that people have to remember which day the clinic is in their area and if they get it wrong they may have to wait another week to see a counsellor. Tapologo does not have a specific programme to impact on the use of traditional medicines, some of which can interfere with ARV treatment. Despite referrals made between clinics, there is a lack of coordinated and cohesive partnership between the local community organisations and the government service providers.

The social constraints faced by all three South African partners are very similar. Stigma continues to be a major issue. For Nazareth House's already isolated migrant patients, there is too much fear that current friends and roommates may reject them if they know they are living with HIV so disclosure is a big hurdle for the clients. There still seems to be high levels of misunderstanding about how HIV is transmitted which increases stigma and fear. At St Joseph's many clients assume that everyone who works at Sizanani is HIV positive. Finding foster

families for children is problematic because of the stigma and staff have seen children as young as 12 attempt suicide because they have been ostracised.

Differing gender expectations between men and women pose various challenges, especially people's ability to disclose their status. Women are often economically dependent on men and afraid to be left alone and have no-one to provide for their children, while men are sometimes too proud to get tested or to talk about their status with their wives. Nazareth House notes, however, that they are seeing an increase in the number of men willing to talk about HIV and bring their wives and children for testing. In the meantime, the fear of disclosure means that people will not do anything which reveals or hints at their status, such as using condoms. St Joseph's also find that disclosure to partners is resisted by clients who are afraid of rejection. The result is a general lack of openness – female clients tell the staff they refrain from sex yet obviously have not been able to tell their partners they are HIV positive because they return several months later pregnant. Often women who present at the clinic before their husband are blamed for bringing HIV into the relationship. In many cases men would like their wife to have a child which puts pressure on women.

Sex and related issues remain taboo among some clients. At St Joseph's the age and gender of staff contributes to some client's ability to discuss intimate aspects of their lives: older men do not like to be asked about their sex life or life style. Older women also sometimes find it difficult to discuss personal issues and it takes them a long time to get comfortable with the staff. Some male patients prefer to receive counselling by another male but there is a shortage of male counsellors.

Poverty continues to be a huge social problem leading to people's increased risk of contracting HIV (e.g. through exchanging sex for food or money), not seeking the appropriate support, not living healthily and not adhering to treatment.

Language barriers exist for clients at Nazareth House who do not speak Zulu or English or any of the other languages that the staff can speak. Many of the migrants from Zimbabwe and Mozambique seem to have low literacy and education levels which makes relying on proving them with written information or appointment cards very difficult. Poverty levels affect people's shelter and nutritional intake. For those without ID there is an assumption that they cannot be referred to government services. ART is available to these clients from government clinics but the process (and definition of emergency) seems unknown and unclear to both partners and clients. St Joseph's and Tapologo also find that low literacy levels affect some clients' ability to adhere to their medication. Patients with low education levels often need the same information explained to them many times because they cannot use printed materials to remind themselves or for reference.

Tapologo finds that some of the practices around using traditional medicines is ingrained in some people's psyches and it takes quite a paradigm shift for them to understand the role of ART.

Managing expectations of donors

At Nazareth House the maximum number of patients that can be seen is set by the donor (PEPFAR) which is frustrating to staff when their services are in high demand. The donor does not provide food which the clinic sisters need to source from elsewhere. At the same time, high expectations of donors about the quality of service motivates the staff to meet these, even if they don't have a say in the budget allocations.

St Joseph's also found donor limits on funding and maximum numbers of patients affects the staff who are forced to make referrals to government clinics. Often patients are unhappy with these referrals as they complain that the service is not as good and they are treated poorly.

Reporting to different donors can cause problems. The financial reporting periods are often different. While staff understand the need for monitoring and data collection they feel overwhelmed with the amounts they are asked to collect. The ARV Programme Coordinator asked why donors cannot come up with a common template seeing as they are usually seeking the same information. For staff closer to the ground, they feel that while funds are often provided for medications, there is less provision for staff salaries. The same can be said for office running costs and other overheads – these and salaries are often unpopular with donors. The expectations of donors need to managed particularly when they emphasise areas of work that are not the core business of the organisation such as advocacy. In some cases the organisation has had to turn down offers of funding because the specific area of work that the donor wants to support is already covered, while other aspects of the service are in need of financing. St Joseph's response is to be assertive and assured about their identity and priorities.

Tapologo also finds that donor priorities do not always fit with the organisation's work plans – some want the service to provide more home visits, while other want more of an emphasis on vulnerable children. The donor reporting requirements also put pressure on staff. In some instances there is a need to educate donors about the qualitative work that takes place, as they cannot always understand the services provided through examining

quantitative data only. The imposition of auditors and monitors gives some staff the impression that donors think they are trying to hide something from them, which is not the case. While some donors seem to dictate the terms of the relationship, staff are also aware that they must choose their donors as carefully as the donors choose them. Sometimes donors have unrealistic expectations that their funding of medications will result in decreases in HIV prevalence, for example. Unfortunately there are many societal and contextual issues that interrupt adherence such as high levels of poverty which results in a lack of food and money to get to the clinic. Some donors seem unaware of these additional factors and how their funding is ultimately not as effective as it could be because drugs are only part of the response required.

Some staff feel the best approach is to comply with reporting expectations to stay on the right side of donors, and some feel it is equally important to maintain a proactive dialogue with donors to increase mutual understanding.

Appendix: Partner self assessment

This section brings together the results of the self assessment research tool that each of the partners completed during the workshops. The aim of the tool was to present partners with a framework of the factors which enable them to facilitate informed decision making among clients, and allow them to decide where their strengths are currently, and at what level they would like to be in 18 months time.

The left column shows the five key areas that are necessary for facilitating informed decision making (as defined by Engender Health 2003). The top horizontal line shows the five levels of action from awareness of issues to fully integrated ongoing daily practice.

The framework itself was open to interpretation: although different "levels" implied a progressive process, the options did not always appear to be linear for some of the participants.

Further, time constraints meant that not all partner workshops were able to devote the same amount of time or discussion to completing the tool. Other differences in the use of the tool included in Malawi, for example, the workshop participants completed the tool individually so averages were taken of their ratings. In DRC, two partners chose to provide different sets of responses for their HIV work and for their family planning work.

It is important to note that this research process was the first time that the partner staff had seen the tool, and therefore the results should be taken as preliminary. At a later stage, it is recommended that the partners are provided with the tool and given time to discuss it at length, and make adjustments to it in order to ensure that they agree with the language and content of each level.

Despite the challenges with using the tool facilitated by different researchers in each country, the results do provide some indication of where partners feel their strengths lie, and what areas they would like to work on most to improve their service delivery.

Below is the Framework which sets out the assessment context. Following this are the combined results of the partners who completed the tool. A "stairs" diagram is reproduced for each of the five key enabling factors. The partner with the most strengths will find their names further towards the "top" of the stairs, so that those partners which have "something to learn" (i.e. expressed a desire to move up one or more levels) can see which of their colleagues may have "something to share" about their current practices.

For example, in the first stairs diagram below for 'Service options are available' all three DRC partners placed themselves at level 2 (on row number 2). Kinshasa and Kananga are in the column marked "1" because their target is to move up one level within 18 months. Mbuji-Mayi are in the column labelled "2" because their target is to move two places up to level four in the next 18 months. Therefore all the partners above level 2 may have important lessons and experiences to share that could be of value to these partners.

Alongside the stairs diagrams and the partners self assessments, the current practices from the perspective of the partners are discussed with reference to the views of the clients gained through the questionnaires and focus groups discussions.

STRENGTHS SELF-ASSESSMENT	Level 1. Indicators that show us we are aware	Level 2. We act within constraints	Level 3. We aim for a holistic approach	Level 4. Continuous action, systematizing what we do	Level 5. The practice is part of our life-style
A. Service options are available	We have basic knowledge of what services are available to our clients	We provide the services that are not controversial to the local political, social or religious context	We discreetly provide services that may not be in line with the local political, social or religious contexts	We proactively ensure the community is aware of the full range of services we provide	We systematically provide clients with the appropriate services and have efficient referral systems to and from other services
B. The decision making process is voluntary	We are aware of the importance the client's role in making decisions	We facilitate a voluntary process in a limited framework due to local political, social or religious contexts	We ensure the client understands all the options, and the personal implications of their choice through the counselling process	We are objective regarding all clients and methods, and separate conflicting personal, social, and faith beliefs from public health messages	We fully support and respect the client's decision, and are able to help them realize their choice without influence from those who do not support the client's decision
C. Individuals have appropriate information	We provide the basic and essential information to clients about the options available to them	We provide materials, illustrative and written within the constraints of the local social and religious values	We provide information about all sexual and reproductive health options	We assess clients' knowledge, fill gaps in knowledge and correct any misinformation	We ensure clients understand their options, and the way their choice may affect their personal circumstances
D. Good client-provider interaction	We understand the importance of good client-provider interaction	We respond to clients' needs as they present them to us	We are trained in counselling and comfortable in discussing all aspects of sexual and reproductive health	We use counselling as the checkpoint to ensure informed and voluntary decision-making	The community is involved in planning and evaluating our service provision
E. The social, religious and rights context support autonomous decision making	We are aware of the social, religious and rights contexts and how they impact on clients' decision making	We help clients make decisions within the constraints of social and religious expectations	We help clients make decisions that may be contrary to local social and religious expectations	We implement a policy or guidelines which put the client at the centre of our approach	We engage in dialogue with local social, political or religious leaders to promote a rights-based approach alongside our faith-based identity

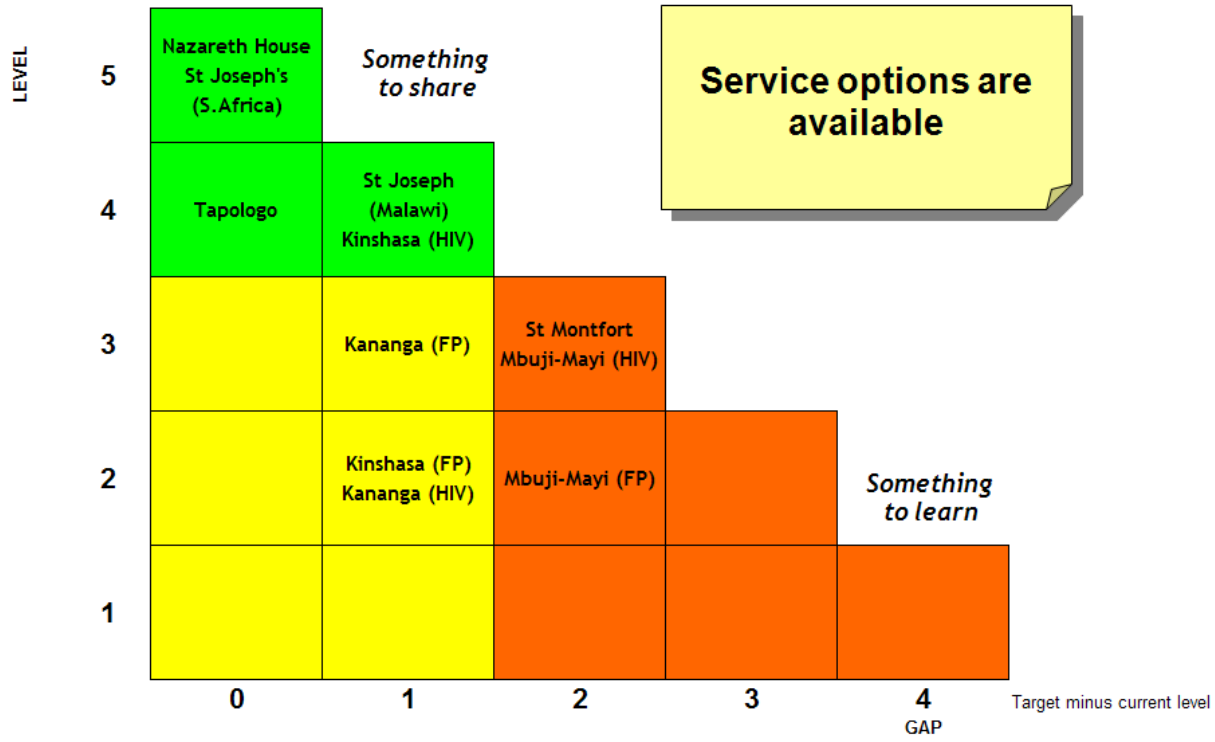
Service options are available

Ideal conditions

- Family planning services are available where and when individuals need them
- A choice of methods is offered
- Options are affordable
- Referral mechanisms are in place for other methods
- Linkages exist with other health services

St Joseph (Malawi) placed itself at Level 4: "We proactively ensure the community is aware of the full range of services we provide" possibly because it is very clear with the local community about its limited range of services, rather than it actually provides comprehensive services.

The data collected from the clients of the Malawian partners through the questionnaires show that although there was spontaneous mention of different contraceptives available as a family planning method, only 10% of the clients reported health service providers mentioning this area. The implication is that clients are not being made aware of the full range of contraceptives that can be used a family planning methods. But the data must be taken with caution because clients may not have been seeking family planning advice at this particular visit.



In relation to HIV prevention, 30% of clients said they were provided with a range of options. Again this must be taken with caution because not all clients will have been seeking HIV prevention information or services. In fact, only 10% of clients were seeking HIV prevention services, 10% were seeking VCT, and the remaining 80% had attended the clinics to accessing medical help in relation to malaria, headaches, abdominal pains and general fever.

During the focus groups, clients were able to identify a wide range of services that the partners provide related to HIV prevention and family planning. These included antenatal care, maternity (labour and delivery services), postnatal care, clinic based VCT services, outreach antenatal and family planning information, education and communications services. Other than VCT, the institutions also provided other HIV and AIDS related services including, prevention of mother to child transmission (PMTCT) of HIV, ART and food supplements (Likuni flour, Sibusiso) for those who are HIV positive.

The focus group participants indicated that the partner organisations provide information on STI and HIV prevention including condom use abstinence and being faithful to one's partner. There was some concern among the clients that information rather than services were provided in the case of condom provision and family planning options.

> "As a Catholic institution the hospital does not provide family planning services. This is their policy and they also do not provide condoms for HIV/AIDS prevention"
>
> Men FGD, Malawi

> "It would have been better if this clinic was giving out condoms just they do in other clinics. This is because when people want condoms they go and buy from shops which is something embarrassing but also it erodes one's respect. People see you they would conclude that you are an adulterous person. That is not good."
>
> Young men FGD, Malawi

The participants discussed the referrals to government, nongovernmental organizations and the private sector for family planning and STI and HIV prevention services (particularly condom provision). The institutions also refer the chronically ill HIV patients to Home Based Care (HBC) services that are provide by nongovernmental organizational and community based organizations operating in the villages.

The referral system poses challenges for clients who expressed their desire for the partner organisations to provide family planning options such as oral contraceptives, injectables and also condoms for prevention of pregnancy, STIs and HIV.

> **"**We travel long distances to access them from other service providers. It also requires money and courage to buy condoms from commercial outlets. Those of us who are HIV positive need them all the time to avoid HIV transmission and re infection**"**
>
> Young men FGD, Malawi

> "For us if the injection method was available here we would be very happy because we will not go far away we will get assistance right here because this is our nearest hospital"
>
> Women FGD, Malawi

The three South African partners are perhaps unsurprisingly the partners with the most experience of comprehensive service provision. Only Tapologo is publically known for providing condoms in HIV prevention services, and St Joseph's gives out condoms in a more confidential manner, but all three partners are in areas where there is a fairly high density of government and private (NGO) services where all options of HIV prevention and family planning are easily available.

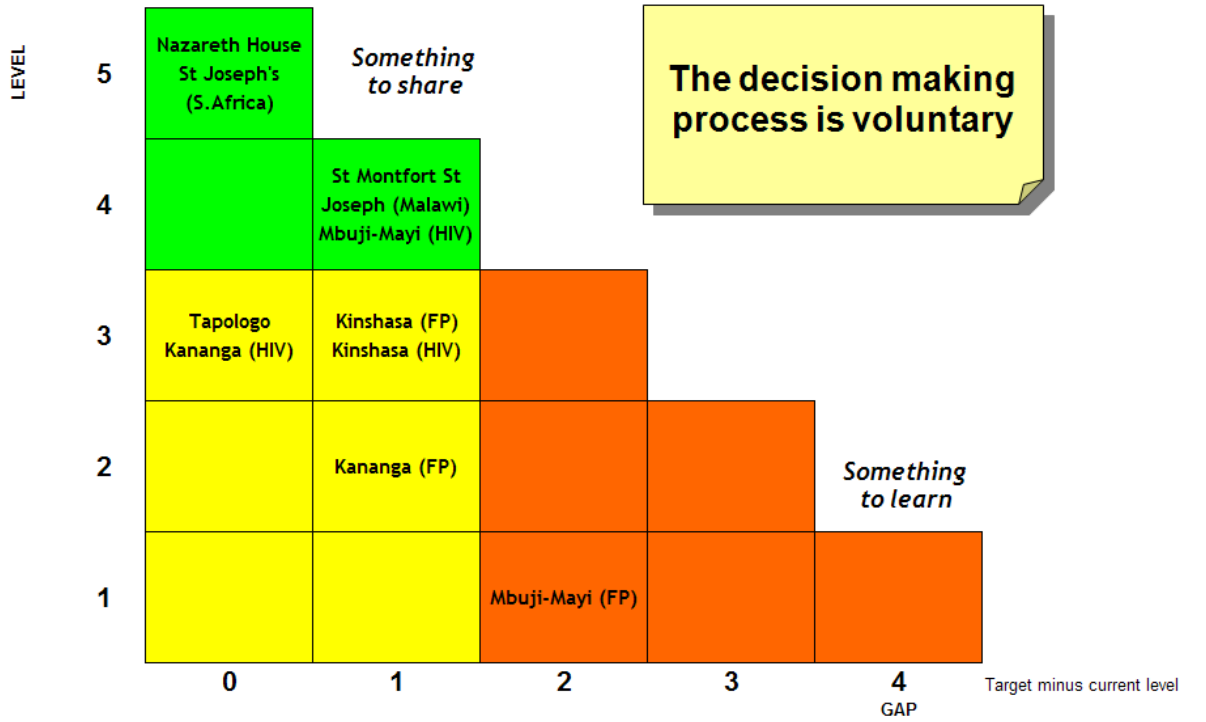
All three South African partners focus in ART delivery. In relation to a comprehensive service, not all are equipped to provide TB x-rays and treatment such as Nazareth House, but clients in the focus group discussion were very satisfied with the staff's referrals because they are taken to and from the TB clinic.

The decision making process is voluntary

Ideal conditions

- Individuals are free to decide whether or not to use services, without coercion or constraint
- Clients are free to choose among available methods, without coercion or constraint
- A range of service options is accessible to all categories of clients, including adolescents and unmarried individuals
- Service providers are objective regarding all clients and methods
- The individual's right to choose is respected and supported

Two of the South African partners rated themselves at level 5, and Tapologo rated itself at level 3. Interestingly both Tapologo and DRC partner Kananga (HIV) placed themselves at level 3 and did not see themselves making any significant moves up the levels within 18 months. This may be because the changes that need to happen in order to ensure that decision making is a voluntary process are somewhat beyond the capacity of the organisation to influence because they are external factors. Staff mentioned the influence that family members have in people's decision making, and the extreme difficulties some clients have in disclosing their status to their partners. Additionally many women will not make a decision without their husband's consent.



Clients were asked whether they received help from the staff in making a decision related to either HIV prevention or family planning options. In Malawi, 50% of clients said that the staff helped them make a decision during this visit on either, HIV prevention, family planning or VCT options.

During the focus groups, there were mixed views from clients on how voluntary the decision making processes are depending on the situation. Some clients found that staff are very supportive, for example during counselling sessions, and provided information in such a way that the final decision to take a course of action remained with the clients.

> "Hospital personnel give us different options and disadvantage and advantages of each option so that when it comes to making final decision we should not have a problem and that all the information is made available to us. They make sure that the final decision should not come from them but giving proper guidance for us to make proper choices"

Men FGD, Malawi

However, there does seem to be cases where clients are not given the opportunity to make their own decisions. Pregnant women in particular find that service provider initiated testing for HIV has more or less become compulsory:

> "At first they were saying a person was free to go for HIV testing or not. But nowadays you have no choice. When leaving your home you automatically know that I will be tested, there is no way you can go back home without testing"
>
> Women FGD, Malawi
>
> "Sometimes it happens that you are suffering from a different disease and staff decides that since the illness is not improving it is better to conduct an HIV blood test. Once again you do not have any options; they just carry out the test"
>
> Young men FGD, Malawi

During the observation of the client and service provider interactions, in most cases, the staff member emphasised to the clients the right to make the final decision, given the information available rested in the hands of the client. Similarly, high scores were observed in circumstances in which the health providers gave assistance the clients to fully weigh the alternatives.

The decision making processes for the clients of the South African partners centre around ART. It can be a difficult decision to start treatment because of the psychological aspect that "medicine for the rest of one's life" can have on some people. Clients agreed that staff at Nazareth House consistently reassure them that the decision is theirs to make. However, the "encouragement" that the staff exhibit by asking patients each time they see them whether they have made a decision makes a minority of clients feel bothered. However, most agreed that the staff are only there to help and have the patients' best interests at heart. One women took an alternative view: that the decision to go onto ART is not hers because she is not given the option unless her CD4 count falls below 200.

At St Joseph's in South Africa clients reiterated the staff's emphasis on their role in the decision making process. They trust the staff to give them advice that will improve their health

> "They never force us; they always support us."
>
> Focus group discussion, St Joseph's, South Africa

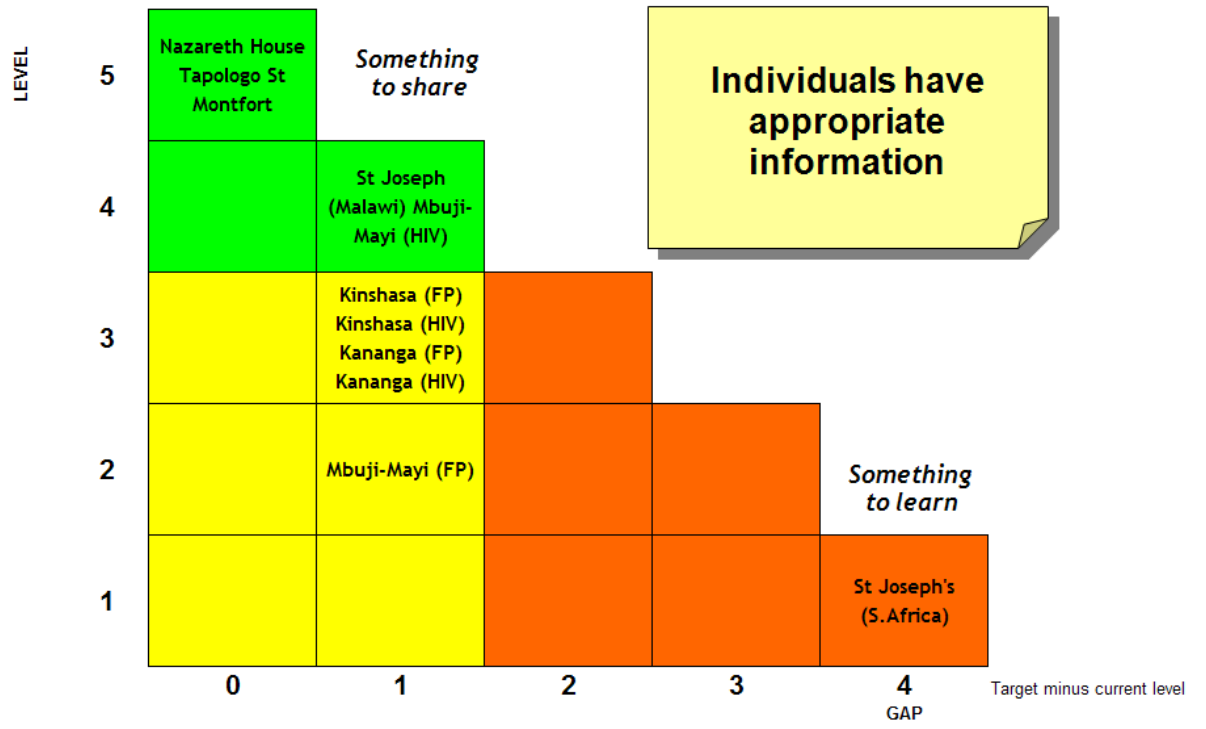
Similar sentiments were conveyed by clients who attend Tapologo clinic.

Individuals have appropriate information

Ideal conditions

- individuals have access to appropriate accurate information about services and options
- individuals understand their risk for STI/HIV/AIDS and the protection that family planning method options provide
- service providers assess client knowledge, fill any gaps, and correct any misinformation
- comprehensible posters or flipchart are clearly in clients view
- samples of family planning methods are available for clients to see and touch
- clients understand their options, the essential information about their chosen method or treatment (including benefits and risks, conditions that would render it inadvisable for use, and common side-effects), and the way their choice may affect their personal circumstances

The clients of the Malawian partners felt that they are given the right information that they need to help them make decisions, particularly on issues related to family planning, antenatal care , delivery, prevention of mother to child transmission (PMTCT) , HTC and ART.



The observations of the client and service provider interactions showed low levels in terms of options discussed in relation to HIV prevention and family planning. The use of condoms (15%), abortion (31%) and use of barrier contraceptives (8%) were least mentioned during the interaction. It may be argued that the health providers did not attempt to mention these because they do not offer the services. But it was also observed that the staff made no reference to church ideologies during the consultations either so it may be more likely that many clients had come for other health related issues so these topics may not have been applicable to the context of their visit.

However, during the course of the consultations health service providers were able to highlight the most important topics regarding the spread and prevention of HIV such as HIV and AIDS related symptoms, modes of transmission, availability of ARV treatment (either at the facility or at another facility) as well as treatment for opportunistic infections.

Health providers were observed to discuss a number of effective ways for clients to adopt safer sexual practices that included reducing the number of partners (46%), abstaining from sex (46%), exclusive monogamy (39%), correct and consistent use of latex condoms (46%) and whether their current partner knows the HIV status of their regular partner (23%).

However, there was consistently much lower mentions around related issues such as sexual violence and forced sex, avoiding alcohol and drug use, sexual identity/orientation and the risks of HIV transmission through anal sex.

In South Africa, clients of St Joseph's indicated during the focus group discussions that they found the information provided very helpful, particularly around stress free living, on accepting themselves, and on maintaining a healthy life style. The ART related information also appears to be very comprehensive on the regimes, side effects, HIV re-infection and drug resistant strains.

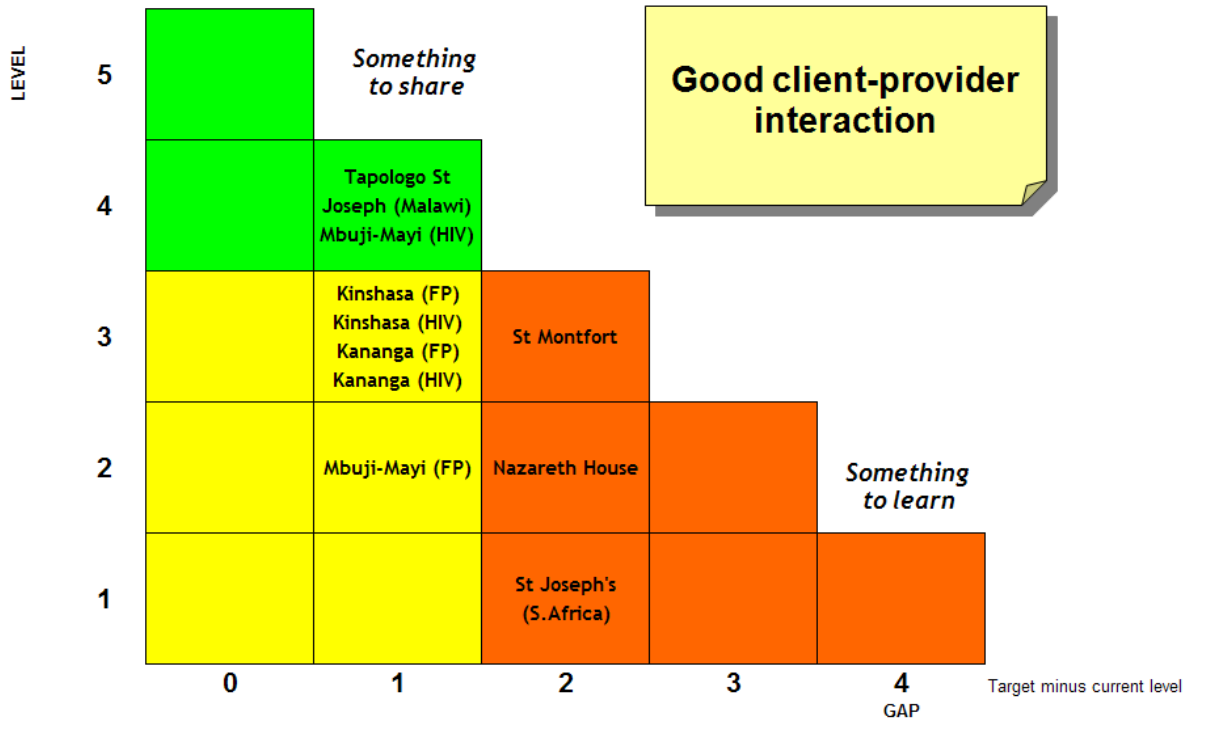
Interestingly St Joseph's scored themselves very low on their current level in this aspect of service provision. This may be because staff were focussing on the fact that they do not have an overt strategy around providing family planning information which is something that some members of staff expressed a desire to skill up on at the national workshop.

Good client-provider interaction

Ideal conditions

- Clients and service providers have dynamic, two-way interaction
- Clients actively participate in discussions under encouraged to ask questions
- Staff have good communication skills (talking, listening, eliciting, probing, assessing)
- Counseling staff provide individualized care, tailoring the client provider interaction and information to what clients want and need, and addressing individual circumstances and concerns
- All staff use language in terms that clients can understand
- Counseling staff have complete and correct information about sexual and reproductive health and available services
- All staff are sympathetic, respectful, non-judgmental, and sensitive to power imbalances and gender differences between clients and providers
- All staff maintain client privacy and confidentiality
- Counseling serves as the checkpoint to ensure informed and voluntary decision-making
- Memory aids are used by staff and provided to clients
- The server provider is organized, clean, and cheerful to put clients at ease
- Adequate seating is available during counselling for counsellors, clients, and anyone else that clients choose

All partner staff seemed to have good interaction with their clients on the whole. The main constraint that nearly all partners expressed was their feeling of lack of time to spend with each client. An impact of this, is that in the effort to transfer information to the patient, some staff felt that there was not enough time to remember to listen the client.



In Malawi the in-country researchers observed a number of interactions between clients and the staff during consultations. In Malawi at both St Joseph and St Montfort, in all interactions staff observed routine interpersonal procedures such as inviting the client to the private room for consultation, greeting, assuring them of confidentiality, encouraging the client to speak etc. However, there were instances where staff expressed some kind of disapproval either the clients' self reported behaviours or their choice of service option. It is impossible to understand from the quantitative information collected what level of "disapproval" took place – it could be anywhere on a scale of a concerned frown to a verbal reprimand. Given the fact that in all cases the observer

noted that the clients were treated with respect, and the positive comments from clients about their experiences at the clinic, it seems unlikely that staff were judgemental in their interactions.

Clients at Nazareth House felt that staff listen carefully to their concerns and problems, and that they take their time with each patient.

> "I can feel that they feel for me and that they understand my worries."
>
> Client, Nazareth House, South Africa

One of the challenges that the South African partners mentioned in the national workshop was the fact that as they get to know the clients, the relationship becomes important. This means that when the clinic cannot provide a certain service or there is a shortage of supplies for some reason, the clients feel let down by the staff. This places staff in a very difficult position as they try to maintain good relations with the client whilst managing their expectations.

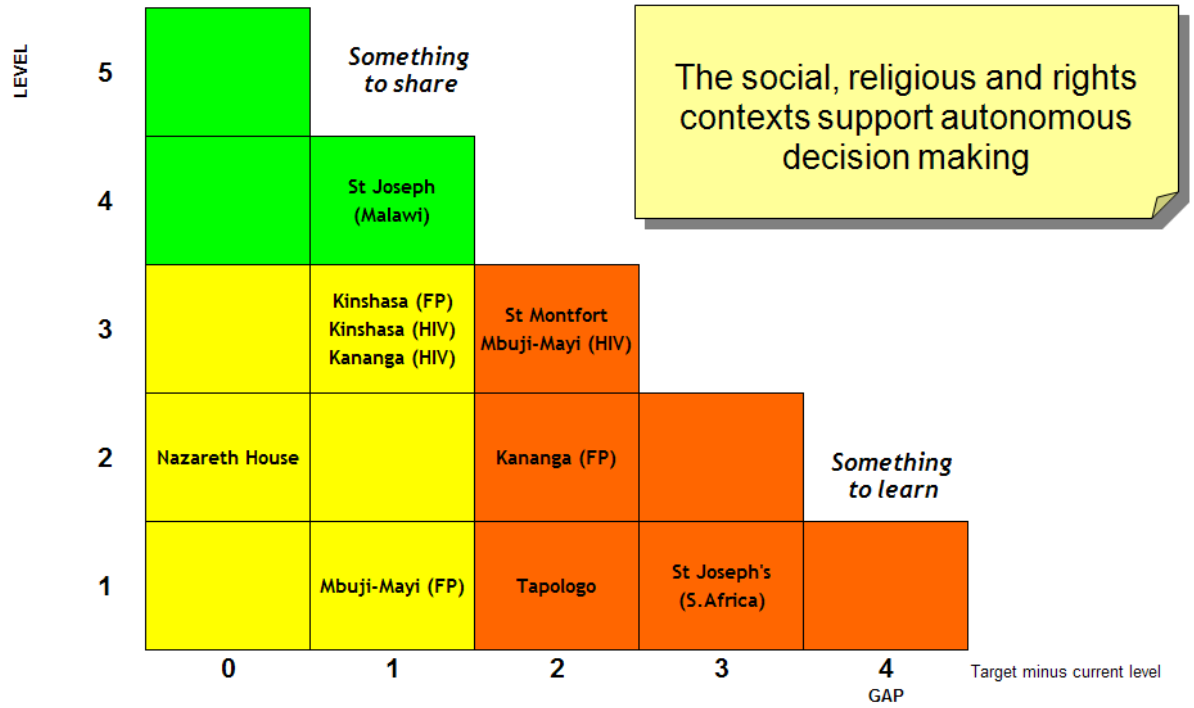
The social, religious and rights contexts support autonomous decision making

Ideal conditions

Laws, policies, and social norms support the following:

- gender equity
- individuals rights to decide whether and when to have children, and how many
- clients rights to access sexual and reproductive health information and services regardless of age, sex, marital status, or sexual orientation
- clients right to make decisions and exercise control over their sexuality and reproduction free of discrimination, coercion, and violence
- clients right to protect their health and prevent disease
- clients right to privacy, confidentiality, dignity and safety

In South Africa, St Joseph's (South Africa) scored itself low in this aspect (Level 1) and the reasons for this may be seen in the comments from the clients in the focus group discussion around the continuing stigma surrounding HIV making disclosure very difficult. In particular, some people who have not been to Sizanani Village still hold the view that it is a place where people go to die, and clients reiterated a view that staff expressed: some people believe that the staff at Sizanani are actually responsible for killing patients who go there.



Nazareth House also scored itself low (Level 2). Clients discussed the fact that there are both men and women who do not want to use condoms for several reasons, including the fact that requesting their use with their regular partner means they must also disclose their HIV status. One young woman was afraid to tell her boyfriend her test results because she feared rejection – that he would blame her and either leave her or harm her in anger. Clients felt also that some men do not want to be told what to do by their girlfriends, so women have a difficult time convincing them to seek testing.

St Joseph (Malawi) rated itself highly (Level 4) in this area of informed decision making: "We implement a policy or guidelines which put the client at the centre of our approach". St Joseph was the only partner organisation in Malawi to declare that it provides condoms to discordant couples. While some staff from other Malawian partners seemed very surprised about this, it does provide an important opportunity to build on the reasoning of St Joseph staff with them as well as the other partners.