The potential and perils of partnership: Christian religious entities and collaborative stakeholders responding to HIV and AIDS in Kenya, Malawi and the DRC

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REPORT

Reporting on a participatory collaborative process

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Beverley Haddad, Jill Olivier and Steve de Gruchy

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Executive summary

The report, *The promise and perils of partnership*, concerns the possibilities and challenges of collaborative relationships in the struggle against HIV and AIDS in Africa, specifically between Christian religious entities on the one hand, and national governments and donors on the other. These collaborative partnerships are considered within the framework of the *Three Ones* policy promoted by UNAIDS, the principles of which include one agreed action framework, one national coordinating authority, and one monitoring and evaluation system.

The findings in the report emerge from a participatory research process with a range of stakeholders in three African countries, namely, Kenya, Malawi and the DRC. They point to both the real challenges facing collaboration in the Three Ones approach, but also to the potential that these partnerships have for responding to the HIV and AIDS epidemic.

These findings are presented as the first phase of an ongoing process. The second phase includes gathering a wide range of responses to the findings, and then engaging the same stakeholders in a way that enables them to develop a series of recommendations and strategies to guide their own work.

1. Background

In June 2007, the Christian relief and development charity *Tearfund* (UK office) in partnership with *UNAIDS* approached the *African Religious Health Assets Programme* (ARHAP) with a view to undertaking research into the relationships between donors and governments, and religious organisations. The primary purpose of this research was to build mutual trust and create effective and more long-term sustainable partnerships in the response to HIV and AIDS.

By common agreement between UNAIDS, Tearfund and the ARHAP research team it was decided that the research would take place in Kenya, Malawi and the DRC, and would focus primarily on Christian organizations as these represented the most prevalent form of religious organizations in the three countries. As the research involved partnership with government and donors, it was further decided to focus first on those organizations with a national presence. The term 'Christian religious entities' was used rather than the more common 'faith based organization' (FBO), as it better captures the reality of religious formations in Africa.

The Three Ones approach was not originally part of the research framework, but emerged as a significant structure for thinking about partnership through the research process itself.

The contract was awarded to ARHAP, through the University of KwaZulu-Natal in South Africa, in December 2007, for an initial study to be conducted from January 2007 to July 2008, with an interim report available for comment in August 2008. It was understood that the collaborative process would continue beyond the interim report. The lessons learned would be taken back to the three countries, and the process continued and widened to include a broader collaborative group.

2. Research overview

The research involved a qualitative research design using three methods, namely, desk review, participatory inquiry, and self-administered questionnaires. The desk review made use of previous ARHAP research reports, and a variety of further materials including academic databases, web-based information, and information gathered directly from religious entities and participants. In all cases, materials were individually assessed in terms of relevance, interest, the scarcity of other documentation of its type, and quality. The report of the literature review is itself a significant contribution to the goals of the research.

For the participatory workshops, a stratified purposive method was used to identify the study population in the three countries, aided by fifteen key informants who were recognised to have significant knowledge of the research terrain. In each country the study population was divided into two groups, namely, Christian religious entities and collaborative stakeholders, (meaning government, donors and other religious groups), each with their own workshop, which meant that six workshops were held (2 in each country). 56 Christian religious entities in total were identified as meeting the research criteria in the 3 countries, and of these 38 participated in the workshops (67%). 58 collaborative stakeholders in total were identified as meeting the research criteria in the 3 countries, and of these 32 participated in the workshops (55%). These figures suggest that those who participated in the research are a significant cross section of the key organisations involved in responding to HIV and AIDS in the three countries, and that the findings are representative of the situation as it exists.

The self-administered questionnaires were used to confirm the findings of the participatory workshops, and to provide more specific detail where necessary. 22 of 45 questionnaires were returned by the Christian religious entities (48%), and 16 of 48 questionnaires were returned by the collaborative stakeholders (33%).

Because of the differences across the three countries, the findings for each country are represented in their own dedicated chapter. These findings fall into four key areas, namely, the context in which Christian religious entities are working, the work of Christian religious entities in the promotion of Universal Access, the strengths and weaknesses of collaborative partnerships between Christian religious entities and other role players; and the challenges and potential of collaborative partnerships between Christian religious entities and other role players. These chapters each conclude with country-specific recommendations for taking forward the process. These are understood to be preliminary suggestions to stimulate the second phase of the research.

3. Findings about collaboration

The final chapter in this report seeks to synthesise the findings in these three countries in terms of what this might mean for collaborative partnerships in Africa. Here the importance of the Three Ones approach has emerged as crucial. The principles of the Three Ones include: one agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners; one National AIDS Coordinating Authority, with a broad based multi-sector mandate; and one agreed country level Monitoring and Evaluation System

The report identifies seven key findings that are important in terms of strengthening the collaborative involvement of Christian religious entities in the Three Ones approach. These are:

1. Different contexts in Africa are at different stages of multi-sectoral collaboration as expressed in their commitment to the Three Ones principles. The implementation of the Three Ones principles is a development strategy, and not simply a response to a medical problem.
2. One national action framework, one coordinating body, and one monitoring and evaluation system, in and of itself, does not promote better collaboration between government, donors, and Christian religious entities. Trust is an important element in making the Three Ones work.
3. The Three Ones principles can only be effective if there is recognised and effective representation on the co-ordinating structures through which government operates, and a common commitment to monitoring and evaluation.

4. For multisectoral collaboration to be an effective response to the AIDS crisis, each group of collaborative stakeholders need to be in existing collaborative relationships within their sectoral grouping.
5. The nature of donor involvement is crucial to national governments and Christian religious entities 'owning' the agendas of strategic plans to mitigate the epidemic
6. Christian religious entities need to be recognised by national governments as having vital assets necessary to mitigating the HIV and AIDS epidemic, including reach, legitimacy, resources and structures. The leverage of these assets in this task necessitates ongoing collaboration
7. Christian religious entities need to acknowledge their conservative belief systems as being a hindrance to an effective collaborative and be willing to build a contextual theological response that recognises poverty as a key driver of the HIV and AIDS epidemic.

4. Recommendations

It was envisaged that Phase I would culminate in an Interim report. This report and these findings provide the foundation for Phase II, which involves the following two further steps:

- To make the findings of the research and the proposed policy implications available to key actors in the field of AIDS work, and to gain their perspectives. It was agreed that this would take place at the International AIDS conference in Mexico in August 2008.
- Thereafter to work with a representative gathering of key leaders from both the Christian religious entities and the collaborative stakeholders to establish ways of strengthening their partnerships, and their alignment around the National Aids Strategy.

It is recommended that this Interim Report be the basis for this second phase, and that all stakeholders be invited to participate in this on-going process.

5. Report Structure

This report presents the data and findings from the study in seven chapters:

Chapter 1, 'Introduction' covers preliminary introduction, the general research approach and the basic theoretical framework and assumptions on which this work rests.

Chapter 2, 'Methodology' works through the design and process of the research method.

Chapter 3, 'The context of partnership' draws on secondary literature to outline key thematic concerns emerging from current work on collaboration in the context of HIV and AIDS in Africa. This provides the backdrop for the country-specific analysis that follows.

Chapters 4 (Kenya), 5 (Malawi) and 6 (DRC) draw from the research process in each country to articulate what was learned about collaboration with Christian religious entities in each context.

Chapter 7, 'Recommendations' summarises the findings of the study and its general recommendations for sustaining and enhancing collaboration.

The full report is available on the ARHAP website: www.arhap.uct.ac.za

Chapter 1

Introduction to the study

Figure 1.1 Malawi workshop participants - 2008

Chapter overview

This chapter introduces the study, sketching how it came about, and describing the purpose of the study and the objectives it was designed to achieve.

1.1 Introduction

> *The AIDS pandemic demands a more effective response. The church in Africa offers much but needs help. International development agencies and the church need to work together. However, they must address their differences and suspicions if they are to achieve more in the response to AIDS.*[1]

The drive towards multisectoral collaboration in the struggle against the HIV and AIDS epidemic has been evident for several years now. More recently there has been a growing interest in the contribution that religious entities or organizations can make to such partnerships.

Despite the vocal calls for increased collaboration, there are lingering questions surrounding such collaboration and partnerships between religious entities, donors and governments. Who or what are these religious entities? How do they function in their particular HIV and AIDS contexts? What particular strengths or weaknesses might they have? How do religious entities understand and work with government and funding partners? All such concerns are based on a desire to improve the response to HIV and AIDS - to better understand obstacles to collaboration and to be able to better plan a way towards a response that utilizes all possible assets in a responsible manner together.

[1] Taylor 2006

1.1.1 Purpose

This study seeks to investigate collaboration between religious entities and their collaborative stakeholders (donors, governments and interfaith) in three African countries, Kenya, Malawi and the Democratic Republic of the Congo (DRC).

Its primary *goals* are to strengthen collaboration, increase mutual respect and understanding between religious entities, government and donors in three countries, and to ensure significant long term contributions will be made to National AIDS Plans through effective collaboration between government, donors and religious entities.

By common agreement between *UNAIDS*, *Tearfund* and the *African Religious Health Assets Programme* (ARHAP) research team it was decided that the research project would focus primarily on Christian religious entities, as the most pervasive religious entities in the three countries.

1.1.2 How the study came about

In June 2007, the Christian relief and development charity *Tearfund* (UK office) in partnership with *UNAIDS* approached ARHAP[2] with a proposed scope of work, saying:

> There is a prevailing lack of understanding from donors and governments about religious organizations; who they are, how they operate at country level and what their comparative advantages are in the response to HIV and AIDS. Tearfund and UNAIDS are currently investigating the possibility of co-facilitating a good practice document on the role of the church as an effective partner to UNAIDS, governments and donors.
>
> This would be followed by a series of dialogues between religious leaders, donors and governments to … increase understanding and disseminate knowledge … (and) build mutual trust and create effective and more long-term sustainable partnerships. The country case studies will critically look at donors, government and churches working together and try and identify what are the keys that open the door.[3]

This scope of work was further negotiated between Tearfund and ARHAP, and a preliminary research design and methodology were developed. The three countries to be studied, Kenya, Malawi and the DRC, were chosen in consultation between Tearfund, UNAIDS in-country offices and researchers from ARHAP.[4] A contract was awarded to ARHAP (through the University of KwaZulu-Natal) in December 2007, for an initial study to be conducted from January 2007 to July 2008, with an interim report available for comment in August 2008.

It was understood that the collaborative process would continue beyond the interim report, where the lessons learned would be taken back to the three countries, and the collaborative process continued and widened to include a broader collaborative group.

[2] ARHAP is a network of scholars and practitioners working towards a better understanding of the contribution of religion and religious health assets to public health. See www.arhap.uct.ac.za for information on this network and Appendix 3 for further discussion of central concepts and work

[3] Agenberg 2007

[4] See section 1.3 below

1.1.3 Objectives of the study

There were three main objectives:

1. To identify the kinds of AIDS work being undertaken by religious entities (in the initial stage specifically *Christian religious entities* with a *national* presence) - in *Malawi*, *Kenya* and the *DRC*.
2. To examine the interaction of this work with national AIDS strategies in those countries, with a view to examining the nature of the relationship between the government, donors, and these religious entities.
3. To propose strategies for strengthening the collaboration for health between the religious entities, government and donors.

1.2. Research approach

In order to meet these objectives, the following research approach was adopted, in two phases:

Phase I: (January 2008 - August 2008)

- To rapidly survey the religious sector in Kenya, Malawi and the DRC via a key informant, snowball sampling method to identify the key national Christian religious entities responding to the HIV and AIDS epidemic.
- To engage with the representatives of these Christian religious entities to establish a picture of what is being contributed to the promotion of Universal Access (see below) using three research methods: (1) desktop review, (2) participatory workshops and (3) a self-administered questionnaire.
- To engage with these Christian religious entities using the same methods to identify the relationship between their work and the national AIDS strategy, and the strengths and weaknesses of the relationships with other collaborative stakeholders.
- To engage with representative collaborative stakeholders to identify the strengths and weaknesses of their relationships with Christian religious entities who are responding to the HIV and AIDS epidemic.
- Synthesise the above research through interdisciplinary analysis to produce an interim report on the above.

Phase II: (October 2008 - 2009)

After the interim report, the approach proposed two further steps:

- To make the findings of the research and the proposed policy implications available to key actors in the field of AIDS work, and to gain their perspectives. It was agreed that this would take place at the International AIDS conference in Mexico in August 2008.
- Thereafter to work with a representative gathering of key leaders from both the Christian religious entities and the collaborative stakeholders in each of the three countries to establish ways of strengthening their partnerships, and their alignment around the National AIDS Strategy.

1.2.1 Theoretical framework

The research that lies behind this report is shaped by three sets of principles: a) basic research principles, b) principles of religious-health asset research, c) principles of AIDS research. These principles are discussed here; for other relevant terms see the glossary of terms in Appendix 2.

A. Basic Research principles

Grounded theory: The fundamental theoretical approach that characterizes ARHAP research as a whole is *'grounded theory'.* Given that we are exploring areas with, as yet, little established theory, we intentionally shape our research as a spiral that takes data from the field as centrally important in pointing to appropriate and relevant theory, which means allowing our initial theoretical assumptions to come into question, be adjusted, and conceptually reframed through further analytic reflection upon the data, at which point the spiral begins again. This gives an inductive emphasis to our work.[5] It furthermore sustains our conception of the research study as a collaborative *process* that is guided and adapted by what is learned as we progress.

Appreciative inquiry: Our research attitude is one of respect for the insights and perspectives of ordinary people, community and religious leaders, and health workers, and in doing this we draw from the approach of *Appreciative Inquiry*, which is a form of organizational study that selectively seeks to highlight the 'life-giving forces' of the organization's existence, including the unique structure and processes of an organization that makes its very existence possible, and the ideas, beliefs, or values around which the organizing activity takes place.[6]

Participatory inquiry: The workshop tool utilized for this research is a variation of the PIRHANA tool[7] developed for previous religious health asset mapping research, designed to encourage the participatory probing of community or group perceptions and judgments rather than merely collecting information from individuals.

B. Principles of religious health assets research[8]

Religion is defined as the wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organizations that range from fluid to codified, popular to formal, centralised to decentralised, and communal to institutional. In Africa, this includes particularly African traditional religions, Islam, Christianity and a wide variety of other identifiable but smaller religious formations.

Asset: This term refers to a range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a context, by which people endogenously engage in activities that respond to their experienced situation. Assets carry value and may be leveraged to create greater value. Beginning with assets is to set aside the dominant approaches that begin with needs or deficits, so as to make local agency more clearly visible. *Needs*, by contrast, imply that we are seeking to identify and overcome what is found to be lacking. Another common concept, *resources,* as distinct from assets, is more passive; they are there to be *used* rather than leveraged and grown.

[5] ARHAP 2006
[6] See Appreciative Inquiry 2008
[7] See ARHAP 2006
[8] The following section draws on the ARHAP 2006 report, and builds on the ARHAP body of work see www.arhap.uct.ac.za

An asset-based approach takes as its starting point the concern that people and their communities should be viewed as having assets, which can be effectively mobilised or leveraged in order to empower communities, rather than viewing them in terms of deficits, which hamper their development.[9]

A **religious health asset (RHA)** is an asset located in or held by a religious entity that can be leveraged for the purposes of development or the health of the public. The notion of an RHA captures the basic idea that assets carry value and may be leveraged for greater value. If they are not used then they remain at rest, but they are always available for use through some agentive act. The term is used broadly to encompass any religion or faith.

The term **religious entity (RE)** seeks to capture the broad range of tangible RHAs, incorporating religious facilities, organizations and practitioners, both bio-medical and traditional. This encompassing term is necessary in order to be able to speak to the more formalised religious entities such as faith based organizations, as well as those less institutionalised entities such as individual traditional healers.

> **Christian religious entity (CRE):** This research concerns the work of Christian religious entities in three African countries, namely, Kenya, Malawi and the DRC. 'Christian religious entities' is a new term in the literature, requiring definition. ARHAP's work over the past five years has required and led to greater precision about the names that we use for organizations, agencies, formations, networks and individuals who are engaged in public health activity. The traditional generic term, Faith Based Organization (FBO), has been found wanting because of two reasons. First in a multi-religious environment which includes African Traditional Religious and a variety of diverse African religious responses to formal religious initiatives, the term 'organization' is a misnomer because many of the most significant impulses do not have fixed organizational status in a way that outsiders might expect. Second, while the term 'FBO' can be legitimately applied to a range of formal civil society organizations that relate strongly to religious faith or religious formations, it certainly is not broad and comprehensive enough to capture the full range of religious initiatives, such as worshiping congregations or national Church denominations, (see the section 3.3.1 below for further discussion on the nomenclature of religious entities.)

Collaborative stakeholders: The research objectives focused on the relationship between these Christian religious entities on the one hand, and government agencies and donor partners on the other. This latter group has been defined as 'collaborative stakeholders'. As the research finding makes clear some of these stakeholders are already engaged in collaborative partnerships with Christian religious entities (to differing degrees), and some express their interest in such future partnerships. This term was also adopted due to differing use of the term 'collaborative partner' in each of the three countries - a term that is beginning to replace the term 'donor' in some places. 'Collaborative stakeholders' encompass any partners from government, donor agencies, or 'secular' civil society.

C. Principles of AIDS research and practice

Universal Access: In July 2005, leaders of the G8 countries proposed an expanded initiative for Universal Access to HIV and AIDS treatment, care, and prevention by 2010, building on treatment

[9] For further description of the foundations of an 'assets based approach', see ARHAP 2006

gains achieved through 2005 and the furtherance of the health-related Millennium Development Goals. Since then, the initiative has been further endorsed by Heads of State and widely taken up including by the World Health Organization (WHO).

It is recognised that Universal Access will require a comprehensive health- and community-sector response, with increased advocacy, action, and alignment of resources. Five key strategic directions, with focused top-priority interventions, will guide global health efforts.[10]

Box 1.1: Universal Access: Five strategic directions

1. **Knowing HIV status through confidential HIV testing and counselling**, and leveraging these services as important entry points for treatment and prevention activities
2. **Maximizing six prevention strategies**:
   - promoting safer sex, especially for young people at high risk
   - reducing mother-to-child transmission
   - reducing transmission through injecting drug use
   - reducing transmission within the health-care setting
   - improving services to people living with HIV and AIDS
   - developing new health technologies

   Prevention efforts will also address gender inequalities and will target most vulnerable populations.
3. **Continuing scale-up of HIV/AIDS treatment and care**, expanding partnerships and multisectoral collaboration
4. **Improving strategic information**, and providing cross-country access and sharing
5. **Building health systems capacity**, in-country and across regions

Source: WHO 2006a

The 'Three Ones': The Three Ones principle originated from the International Conference on AIDS and STIs in Africa (ICASA - Nairobi, September 2003) and was endorsed in April 2004 by countries affected by AIDS and their development partners as the basis for concerted country-level action to scale up national AIDS responses. The Three Ones are:[11]

- One agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners;
- One national AIDS coordinating authority with a broad-based multisectoral mandate; and
- One agreed country-level monitoring and evaluation system.

The Three Ones is the basis for multisectoral collaboration in response to HIV and AIDS. It is understood that the concepts of national ownership, multisectorality, mainstreaming, harmonisation and coherence have been combined in these principles, "which aim to increase the pace of the AIDS response and promote more effective use of resources by clarifying relevant roles and relationships."[12] (See section 3.6 for more on multisectoral collaboration, and chapter 7 for more on the Three Ones).

[10] WHO 2006a
[11] See UNAIDS 2006b
[12] NACC 2005

1.2.2 Ethics clearance

The study design and tools were passed through the Ethics Committee, Faculty of Development, Human and Social Sciences, University of KwaZulu-Natal. Unconditional approval was given for the study. Participants in all workshops were fully informed of the purpose and character of the research at the time of invitation and again at the start of the workshops. An Information Sheet which provided further details of the study and contact details should they have required further information was provided. This sheet reaffirmed that they were not obligated to participate and could have withdrawn at any stages. A full consent form was read, translated and discussed in detail where necessary, and participants were required to sign this, giving permission for their collective insights and images to be used in research reports. The facilitators ensured that all consent forms were filled in and signed before any workshops began. [13] Permission was also requested to make use of a digital voice recorder. The consent forms and transcripts as well as other data sources (e.g. researcher workshop notes and early workshop reports) have been safely stored in the Department of Religious Studies at the University of Cape Town.

1.2.3 Research team

The research team consisted of three primary researchers who shared research duties. Together, the team includes expertise in religious studies, critical theological reflection on development, AIDS and society, participatory methodology and the interface of faith and health. All team members had previously undertaken research on Religion and HIV and AIDS in sub-Saharan Africa.

Co-principle Investigators:

ARHAP Collaborative Centre, University of KwaZulu-Natal, Pietermaritzburg, South Africa

- Professor Steve de Gruchy, Head, School of Religion and Theology
- Dr Beverley Haddad, School of Religion and Theology, Director, Theology and Development Program

Research Manager:

ARHAP Collaborative Centre, University of Cape Town, Cape Town, South Africa

- Ms. Jill Olivier, ARHAP Research Associate, PhD Candidate

This work was also made possible through the work and expertise of in-country assistants, advisors and reviewers (see chapter 2).

1.3 Country selection

The three countries (Kenya, Malawi and the DRC), were selected by the research team in consultation with Tearfund and UNAIDS in-country representatives. The criteria for their selection were based on a combination of factors: the interest of the UNAIDS in-country representatives for this research to occur, ARHAP's familiarity and network in those countries, and country-specific factors that would assist in future learning. In the initial planning for this research, several advisors warned against selecting the DRC as one of the three research sites - with the warning that

[13] See Appendix 4.3

conducting research in the DRC was very difficult: hampered by poor quality secondary literature, poor primary information, and a prohibitively expensive research environment. However, on the urgings of the DRC UNAIDS office, DRC was chosen as one of the three countries - with the caveat that the researchers would treat this as a 'fragile environment', and be prepared for a more challenging research process.

1.4 Focus on Christian religious entities

In the process of defining the research questions and method, and given the short time-scale in which the first stage needed to be completed, the focus of the research was narrowed. This was done by beginning the collaborative process with the research focus on *Christian* entities, rather than on the religious sector as a whole. This was not done to undermine the work of REs of other faiths working in HIV and AIDS, but rather to begin this process in a manageable fashion. Researchers maintained a commitment to engaging with the viewpoints of other faith groups (hence representatives of other faith groups were added as collaborative stakeholder participants in each country), and to broadening the research focus beyond Christian REs in the later stage of the research.

Chapter 2

Research method and process

Figure 2.1 Participatory workshop materials - Malawi 2008

Chapter overview

This chapter describes the method and research process of the three-country study. It provides details of the development and logic of the method, and the participants' response to this approach. The chapter ends by laying out some of the limitations of the study.

2.1 Desk review: method and process

A desk review of the current literature was undertaken during December 2007 - June 2008, by the Research Manager. The limits set for the review were: English and French[14] literature and materials produced in the last 10 years, focusing on religious entities engaged in HIV and AIDS work in Kenya, Malawi and the DRC. The review built on previous extensive literature surveys conducted by ARHAP in 2006 and 2007 that focused on the intersection between religion and public health, in particular:

- Olivier J, Cochrane JR and Schmid B. 2006. *ARHAP literature review: Working in a bounded field of unknowing.* Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town.
- ARHAP. 2006. *Appreciating assets: The contribution of religion to universal access in Africa.* Cape Town: Report for the World Health Organization, African Religious Health Assets Programme.
- Schmid B, Thomas E, Olivier J and Cochrane JR. 2008. *The contribution of religious entities to health in sub-Saharan Africa.* Study commissioned by B & M Gates Foundation. African Religious Health Assets Programme.

[14] The French literature review was limited to a smaller study done within for Schmid et al 2008.

For this study, a variety of further materials were gathered to narrow the field and access more recent material. This included the searching of academic databases and review of academic literature; gathering and review of web-based information (grey literature); and the gathering and review of information directly from religious entities and participants. In all cases, materials were individually assessed in terms of relevance, interest, the scarcity of other documentation of its type, and quality (author, publication, etc). This desk review also contributed to identification of the study population and participants.[15]

2.2 Participatory workshops: method

The participatory workshops built on the PIRHANA workshops designed by ARHAP for research into religious health assets. PIRHANA is an acronym for *Participatory Inquiry into Religious Health Assets, Networks and Agency*. These workshops are a form of participatory action research, mixed with an appreciative inquiry approach, in which research takes place in a communal participatory and transparent way. They are specifically designed to focus on religion, health and assets, and to create wisdom and understanding in a disciplined manner. Two such workshop models have been designed, one for Health Seekers and one for Health Providers.[16]

For this research, PIRHANA for Health Providers was adapted to deal with the specific research questions on collaboration for two study populations:

1. Representatives from key Christian religious entities
2. Representatives from key collaborative stakeholders

2.2.1 A selection of study population and workshop preparation

The research design called for purposive sampling. Therefore, the desk review process not only provided the appropriate context and background to the research, but was also the method through which the study population and participants were identified. Drawing on this extensive review of literature, two lists were established for each country during December 2007 and January 2008: 1) a list of Christian religious entities working in HIV and AIDS with a national presence, and 2) a list of key collaborative stakeholders (government, donor or interfaith).[17]

During February and March 2008, the Research Manager sought the advice of six in-country advisors for suggestions on key participants after explaining the research objectives and design. In each country, between four and six key in-country advisors were requested to review their country's lists of potential participants. These advisors were drawn from funding partners (Tearfund and UNAIDS), the World Council of Churches Ecumenical HIV and AIDS Initiative in Africa (WCC EHAIA) regional representative for each country, as well as other partners from the ARHAP network (see below).

Advisors were requested to narrow down these lists based on their experience in order to identify the key organizations and individuals for this research process. Advisors were therefore able to remove names from the lists, add new organizations, and assist in providing further personal information and contact details. Extensive email communication was undertaken in a snow-balling

[15] See section 2.4 below, and Appendix 5 and 6.

16 See the Glossary in Appendix 2 for further explanation, see also www.arhap.uct.ac.za for further discussion on the PIRHANA tool.

17 See Appendix 6 for a listing of religious entities who are said to be working in health and AIDS in each country.

process until each participant list (two lists per country) had been narrowed down to between 15-25 participants.

The Research Manager then did internet-based research and emails to organizations to follow up on these suggestions, and to acquire further current contact details and in some cases the correct individual's name and details (e.g. the appropriate HIV and AIDS Program Manager).

Invitations and information leaflets were then sent out by email at least a month before the workshop date, and followed up with a second round of emails if there was no response. On positive response, participants were thanked, and were sent the accompanying questionnaire by email.

In-country assistants were utilized in each country for specific tasks, such as in-country logistics, setting up workshop facilities, contacting specific participants by telephone or in person where necessary, and translation.

A week before each of the workshops, participants were contacted by the in-country assistant - either as a reminder or to enquire if they had received the invitation. A day before the workshop, some participants were contacted telephonically again. The DRC communication and documentation was translated and carried out in French.

2.2.2 Participatory workshops: Workshop method

A package of background materials and a formal letter of invitation were delivered in advance, as described above. A Participant Information Sheet and Consent Form, consistent with these original materials, was provided to each participant upon arrival and explained verbally in English, and in French in the DRC. The workshops did not proceed until all consent forms had been signed.

The workshops were designed by the one Co-principal Investigator, Steve de Gruchy, facilitated by the other Co-principal Investigator Beverley Haddad, and coordinated and recorded by the Research Manager, Jill Olivier.

All workshops utilized digital photography, digital voice recordings and handwritten notes taken by the Research Manager and in-country assistant (all after consent had been given).

Participants were provided with lunch and refreshments. It was decided not to pay a 'per diem' to participants (despite this being increasingly common practice in these countries), since the collaborative and participatory nature of the work was designed to have its own value.[18] In Malawi a few participants who travelled from outside Lilongwe were compensated for their travel and accommodation.

2.2.3 Participatory workshops: The logic of the process

A. Workshop for representatives from key Christian religious entities

Seven participatory exercises were designed for this research workshop, which took a full day. They included times for individual reflection, identification of priorities and concerns through indicator cards, group participation, and discussion. The exercises were designed to gain a sense of history and context (exercise 1); to understand the work being undertaken by Christian religious entities (2

18 Per diems for attendance at workshops carry their own particular problems as well, distorting the nature of the process in respect of participation and, hence, bringing into question the meaning of the research results.

& 3); to probe the collaborative context (4); and to reflect on the strengths, weaknesses and way forward around three key collaborative issues (5,6 & 7).

1. Awareness and appreciation of historical trends and social context: A participatory timeline was produced which allowed for (i) deeper appreciation of the historical trends that have shaped the current health situation; (ii) a deeper appreciation of the social constraints in which the struggle for health and wellbeing takes place, and (iii) an introduction to the 'story' of the entities in the workshop, and thus a better appreciation of one another.

2. Oversight of the Contribution of Christian religious entities to Universal Access: This exercise is designed to gain an overview of the way in which Christian religious entities are contributing to universal access, and what some of the gaps might be. It asks participants to identify the work they are doing in five areas: prevention, treatment, care, support and 'other'.

3. The Intended Beneficiaries of Christian religious entities engaged in Universal Access: The third exercise builds on the previous one, by asking participants to identify the intended beneficiaries of the contribution of Christian religious entities to Universal Access. Participants were asked to rank their focus in four areas: age, location (rural/urban), gender (male/female) and inter-religious (Christian/non-Christian). This exercise cannot determine who the beneficiaries actually are, thus we use the term 'intended'.

4. The current state of collaboration: Having identified the work that is currently being undertaken by Christian religious entities, the exercises now move to focus on collaboration and partnerships. A 'spidergram' exercise which enables participants to identify issues to do with social capital and networking was used to gain a picture of the current collaborative partnerships with wider institutions and facilities and to gain a perspective on important relationships that contribute to the success of Christian religious entities.

5. Interaction with government policy: The fifth exercise focused on government *policy*. It was designed to gain an understanding of the key issues to do with the relationship between Christian religious entities and government policy in three areas: agreements, disagreements, and a possible way forward for the future.

6. Interaction with government practice: Having focused on government policy, the next exercise dealt with government *practice*. This was likewise designed to gain an understanding of the key issues to do with the relationship between Christian religious entities and government practice in three areas: agreements, disagreements, and a possible way forward for the future.

7. Interaction with international donors: The final exercise focused on donors and donor partners. In a similar way it was designed to gain an understanding of the key issues to do with the relationship between Christian religious entities and international donors in three areas: strengths, weaknesses and a possible way forward for the future.

B. Workshop for representatives from collaborative stakeholders

Four participatory exercises were designed for this research workshop, and which took half a day (morning). These included times for individual reflection, identification of priorities and concerns through indicator cards, group participation, and discussion. The exercises were designed to gain a sense of the collaborative context (1), and then to identify the strengths and weaknesses of working with Christian religious entities (2 & 3), and hope for the future (4).

1. Collaboration in the country context: This first exercise was designed to assist participants to foreground the national context for the exercises that followed. It focused on the state of multisectoral collaboration in responding to the HIV and AIDS epidemic, the strengths and weaknesses of this type of collaboration, and the possible ways it could be strengthened in the future.

2. Working with Christian religious entities: strengths: In the second exercise participants were asked to reflect upon their collaborative partnerships with Christian religious entities and to identify the perceived strengths of Christian religious entities engaged in HIV and AIDS work in the pursuit of Universal Access.

3. Working with Christian religious entities: weaknesses: The third exercise then moved on to identify the perceived weaknesses of Christian religious entities engaged in HIV and AIDS work in the pursuit of Universal Access.

4. Working with Christian religious entities: ways forward for the future: In the final exercise, participants were asked to identify new opportunities of aligning the health assets of Christian religious entities engaged in HIV and AIDS work with the work of government and international donors.

2.3 Self-administered questionnaires

In order to augment the data gained through the other two research methods, two self-administered questionnaires were designed, one for each set of participants (Christian religious entities, and collaborative stakeholders). These questionnaires were sent electronically to all those organizations that indicated their interest in the research process. The questionnaires were translated into French for the DRC participants.

- **Questionnaire for Christian religious entities:** The questionnaire for Christian religious entities comprised 11 open ended questions dealing with such matters as organizational profile, mission statement, geographic profile, partnerships and collaboration, size of the programme, focus of the programme, and funding (see Appendix 4.1).
- **Questionnaire for collaborative stakeholders:** The questionnaire for stakeholders comprised 10 open ended questions dealing with such matters as organizational profile, mission statement, geographic profile, partnerships and collaboration, and funding (see Appendix 4.2).

Questionnaires were sent electronically at least one month before the workshop. Participants were requested to bring them to the workshop or email them to the Research Manager on completion. After the workshop the Research Manager sent out a further request by email. A week later, the generic questionnaire was sent again to those outstanding as a reminder, followed by a personal email a week later. The in-country assistants in Kenya and the DRC were requested to then follow up outstanding questionnaires telephonically. The submission process was ended on 12/05/2008.[19]

[19] See 2.3 below and Appendix 5 for return rates and details regarding questionnaires

2.4 Participatory workshops and questionnaire: process[20]

2.4.1 Kenya research process

A. Preparation

- Extensive desk review of the current literature on religion and health was done during December 2007-March 2008.
- These **in-country advisors** helped to finalise the invitation list: Jacinta Maingi - WCC, Peter Okaalet - MAP, Jacqueline Makokha - UNAIDS Kenya, Gladys Wathanga - Tearfund, Kenya desk, Mike Mugweru - Africa Christian Health Associations Platform Officer
- **In-country assistants:** Preceding the workshops, Johnson Gatuma (MTh Graduate, UKZN and Anglican priest) and during workshops, Leah Gatuma (MTh candidate, UKZN)
- **Background:** Due to the political and social unrest it was uncertain as to whether or not the research could go ahead. However, advice was sought from Kenyan-based advisors during March 2008, and the general response was that "life and work continues in Nairobi" and that we should go ahead. As it turns out, the workshops were held during a period of relatively peaceful negotiation, and participants and researchers were able to move around the city without any concerns. However, riots broke out in Nairobi again a few days after the workshops making it difficult to retrieve further materials from some participants. In-country team members reported difficulties in accessing internet facilities while completing the research as it was unsafe to leave their homes.

B. Kenya workshop with Christian religious entities

Date and place:	Wednesday 02 April, 08H30-16H30, Grand Regency Hotel, Nairobi
Participants:	In total, of the 20 participants identified and invited, 13 responded positively to the invitation, and 11 participants arrived on the day. All signed consent forms.
Questionnaires:	Of the 13 questionnaires sent out, 6 were returned.
Workshop process notes:	The KIRAC representative attended this workshop rather than the one for collaborative stakeholders. This however, did not change the workshop dynamic. There was a high level of engagement noted in this workshop.

C. Kenya workshop with collaborative stakeholders

Date and place:	Wednesday 03 April, 09H00-13H30, Grand Regency Hotel, Nairobi
Participants:	In total, of the 19 participants identified and invited, 14 responded positively to the invitation, and 13 participants arrived on the day. All signed consent forms.
Questionnaires:	Of the 14 questionnaires sent out, 6 were returned.
Workshop process notes:	There was a high level of engagement noted in this workshop.

20 See Appendix 5 for participant names and organizational affiliation.

2.4.2 Malawi research process

A. Preparation

- Extensive desk review of the current literature on religion and health was done during December 2007 -March 2008.
- These **in-country advisors** helped to finalise the invitation list: Sue Parry (WCC EHAIA), Frank Dimmock (consultant), Emebet Admassu (UNAIDS Malawi, team including Robert Ngaiyaye of MIAA), Francis Gondwe (CHAM).
- **In-country assistant:** Stella Kasirye (PhD candidate, UKZN)
- **Background:** As per the research design, two workshops were held. However, owing to a clash of dates, the order was inverted.
- **A different invitation strategy for Malawi:** On the advice of the in-country assistant, who said that emails were not reliable in Malawi, a third round of invitations were sent to participants during the three weeks preceding the workshops - delivered by hand and courier, including the invitation, information sheet and the questionnaire (hard copy). A week before the workshops, participants were contacted telephonically by the in-country assistant - either as a reminder or to enquire if they had received the invitation. A day before the workshop, some participants were contacted telephonically again.

B. Malawi workshop with Christian religious entities

Date and place:	Wednesday 23 April, 08H30-16H30, Cresta Crossroads Hotel, Lilongwe, Malawi
Participants:	In total, of the 19 participants identified and invited, 17 responded positively to the invitation, and 15 participants arrived on the day. All signed consent forms.
Questionnaires:	Of the 17 questionnaires sent out, 11 were returned.
Workshop process notes:	There was one double (i.e. two participants from one organization). They were asked to respond together in exercises which required rankings.

C. Malawi workshop with collaborative stakeholders

Date and place:	Tuesday 22 April, 09H00-13H30, Cresta Crossroads Hotel, Nairobi
Participants:	In total, of the 17 participants identified and invited, 16 responded positively to the invitation, and 9 participants arrived on the day. (This was due to an unfortunate clash of dates at the last moment.) All signed consent forms.
Questionnaires:	Of the 16 questionnaires sent out, 5 were returned.
Workshop process notes:	There were two doubles (i.e. two participants from one organization). They were asked to respond together in exercises which required rankings. This workshop was lacking in participation of funding organizations, as several did not arrive. There was an unexpected clashing government review meeting on the same day, making several invited Malawian government officials unexpectedly busy. Philippa Newis of Tearfund was an observer for the Malawi workshops

2.4.3 DRC research process

A. Preparation

- Extensive desk review of the current literature on religion and health was done during December 2007 -March 2008.
- These **in-country advisors** helped to finalise the invitation list: Hendrew Lusey (WCC EHAIA), Frank Baer (individual consultant), Sadiki Byombuka (Tearfund Regional), Mendo Chirume (UNAIDS DRC), Pierre Somse (UNAIDS DRC), Badibanga Makambo (EEC-DOM)
- **In-country assistant:** Rev Joseph Mavinga (PhD Candidate, UKZN).
- **French translator and co-facilitator:** Hendrew Lusey
- **Francophone adjustments:** In the DRC, all materials and electronic communication with participants was translated into French. The workshops themselves were co-facilitated by Beverley Haddad and Hendrew Lusey - all questions and responses were translated into English or French during the workshop – i.e. repeated in the other language. This slowed the process down, and reduced the amount of data that emerged in the comparison with the other two Anglophone countries. However, researchers felt that the slower speed provided an added measure of caution, making for more considered and thoughtful responses. Workshop notes were taken in French and in English, and then taken to a French-English translator (at UCT), and were checked and extended by a process of listening to the voice files and working off the English notes.
- **Background:** The DRC context made research more difficult and more expensive than the other two countries.

B. DRC workshop with Christian religious entities

Date and place:	Monday 07 April, 08H30-16H30, Hotel Memling - Kinshasa
Participants:	In total, of the 17 participants identified and invited, 15 responded positively to the invitation, and 12 participants arrived on the day. All signed consent forms.
Questionnaires:	Of the 15 questionnaires sent out, 5 were returned.
Workshop process notes:	There was one double (i.e. two participants from one organization). They were asked to respond together in exercises which required rankings.

C. DRC workshop with collaborative stakeholders

Date and place:	Tuesday 08 April, 09H00-13H30, Hotel Memling- Kinshasa
Participants:	In total, of the 22 participants identified and invited, 18 responded positively to the invitation, and 10 participants arrived on the day. All signed consent forms.
Questionnaires:	Of the 18 questionnaires sent out, 5 were returned.
Workshop process notes:	Several participants arrived late.

2.5 Reporting writing and review

For all three countries, the data that emerged was a combination of secondary literature, audio recordings, digital pictures and workshop notes. The Research Manager compiled a workshop report for each of the six workshops, which included transcription of the audio files, the workshop notes and commentary from team observations and debrief.

This report was compiled through analysis of these data, integrated with the desk review material.

The nature of data that emerges is a case-study of the *perspectives* of key stakeholders in each of the three countries. Each of the country chapters can be seen as stand-alone pieces. The researchers have then pulled key themes together in the final chapter, reporting overarching findings and recommendations.

Due to the low response rate of the questionnaires, the use of this material was changed, now primarily utilized to confirm and check the workshop results. Some questionnaire information is displayed in boxes in chapters 4, 5 and 6. These boxes were not selected on any criteria of best practice, but rather as a demonstration of the main text, and of the important work of some participants.

Much more data was gathered through this research process than can be displayed in this interim report. This report was sent, in draft form, back to all participants for comment. Due to time constraints, participants were only given a week to respond. A few helpful responses were received, and these have been integrated into this final version. It remains the research team's intention to return to these countries at a later stage to check this interim report's veracity more thoroughly with all stakeholders.

A small advisory group of reviewers were drawn from the ARHAP network and were asked to provide comment on the draft report. These reviewers were Prof Jim Cochrane (Religious Studies, University of Cape Town, ARHAP), Ms Barbara Schmid (University of Cape Town, ARHAP), Prof Deborah McFarland (Rollins School of Public Health, Emory University, USA), and Ms Mary Baich (Vesper Society). All these reviewers were chosen for their extensive experience in research at the intersection of religion and public health.

2.6 Limitations

Finally, we will briefly consider a few of the limitations of this research method and process.

Study design

- *Limited to these three countries, not generalizable to all of Sub-Saharan Africa (SSA):* while all attempts were made to get some variation, nevertheless, these three countries cannot be considered representative of the African or SSA context generally. For example, all three countries are predominantly Christian.
- *Questionnaire responses were limited to research time-frame,* therefore skewing the box profiles to those who were able to respond timeously. Several organizations indicated a desire to be included in this research, but were unable to provide information within the prescribed time frame.

- *Limitations in the secondary data:* Tracking information in the SSA context is difficult for a variety of reasons - in many cases research and reports are not available in electronic formats, are not housed in any central repositories, or are not where they are supposed to be stored. Furthermore, many religious entities in SSA do not keep detailed records of their work. In addition, desk reviews such as this, have a tendency to overemphasise English literature and information emerging from religious entities with an internet presence.[21] Previous research has shown that there are many more working 'under the radar'. These tend to be religious entities working at a grassroots level or outside formal denominational structures.

Participation

- *Christian religious entity focus:* The focus of this research is on Christian religious entities with a national footprint thus limiting the review and understanding of organizations from other faith groups, other Christian organizations, and in particular community-based religious entities and/or congregational-level initiatives.
- *Representation:* Given the focus of the research (see previous bullet), not all Christian religious entities working in the field of HIV and AIDS are represented. Given the scope of this desk review, it was not possible to describe the work of all the thousands of Christian religious entities working valiantly in health, often without any recognition.
- *NGOs neglected:* There is a lack of engagement with the issue of collaboration between Christian religious entities and their 'NGO' partners, which was beyond the scope of this study. It is recommended that closer studies are initiated to map these collaborative networks.
- *Gender:* The research design meant that organizations and individuals were recommended - this did not allow for a balanced participant selection by age or gender.
- *Power dynamics:* Attempts were made in the workshops to give all participants a space to talk, however, power dynamics are always a concern in participatory methods especially when dealing with such sensitive topics.
- *Involvement of PLWHA:* Due to the research design, there was limited involvement of PLWHA - that is, PLWHA organizations were not necessarily Christian religious entities, donors, governments or interfaith organizations. However, a representative from the *African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (Anerela+)* was invited in each country, which hopefully provided some perspective from PLWHA networks.

We now move to a brief discussion on the context of participation and collaboration as relating to this study.

21 See Schmid et al 2008 for a more detail analysis of some of the limitations on secondary literature on the religious-health landscape

Chapter 3

Context to partnership and collaboration

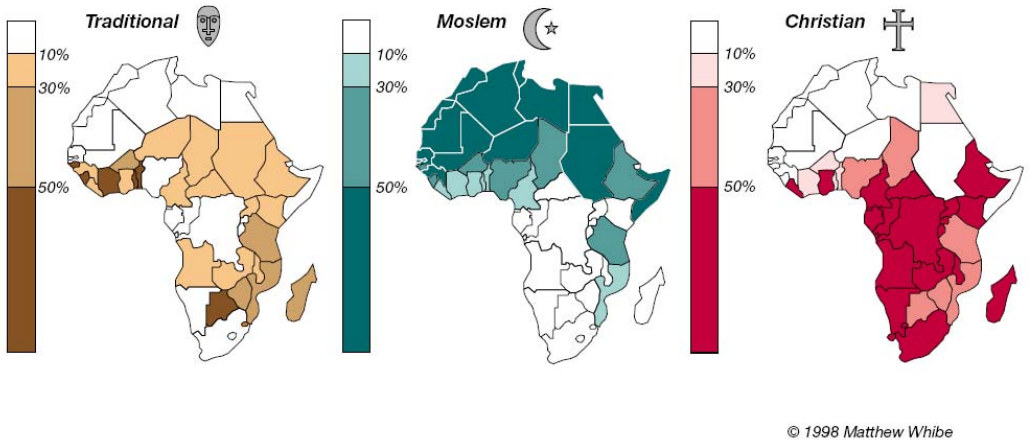


Figure 3.1: Major religions in Africa[22]

Chapter overview

This chapter rapidly appraises the state of current literature which speaks of the religious-health landscape in SSA, and specifically of REs' engagement in HIV and AIDS. Many of the concepts raised here will be addressed again in the country case-studies that follow.

3.1 Surveying secondary literature at the intersection of religion, health and HIV and AIDS

Reviews of secondary literature at the intersection of religion and health in Africa, including the sub-category of HIV and AIDS, have most commonly found a glaring lack of information in this area. The staple of academic literature searches - i.e. peer-reviewed studies and articles - are virtually non-existent. The majority of documentation that does exist emerges from what is commonly termed 'grey literature' - organizational reports, news articles and internet-housed reports.[23] While there are a few key studies and reports emerging, this secondary literature usually has a narrow focus, is often of unknown quality, is more frequently qualitative than quantitative, and is rarely based on data which makes it comparable across countries or the African continent. As a result, a recent landscaping study of religious-health literature in SSA strongly calls for more research in nearly every area of investigation.[24]

It is in this research context, and based on such literature, that this study provides here a brief overview of some of the key themes and concepts relevant to the presence and collaboration of CREs in Kenya, Malawi and the DRC. The aim here is not to present a survey of the entire literature, but rather to briefly acknowledge the body of knowledge - 'grey' or otherwise - upon which this research builds its argument, and upon which the further country case-studies can be tested.

[22] Parry 2005
[23] See Olivier et al 2006, Schmid et al 2008
[24] See Schmid et al 2008

3.2 HIV and AIDS in sub-Saharan Africa

> *In 2007 … Sub-Saharan Africa continues to be the region most affected by the AIDS pandemic ... More than two thirds (68%) of all people HIV-positive live in this region where more than three quarters (76%) of all AIDS deaths in 2007 occurred. It is estimated that 1.7 million [1.4 million-2.4 million] people were newly infected with HIV in 2007, bringing to 22.5 million [20.9 million-24.3 million] the total number of people living with the virus. Unlike other regions, the majority of people living with HIV in sub-Saharan Africa (61%) are women.*[25]

We will not provide here a full description of the HIV and AIDS epidemic in SSA. Briefly, however, we note that despite some successes and declining infection rates (such as can be seen in Kenya and Malawi), the AIDS epidemic continues to hit SSA the hardest.[26] Furthermore, in SSA, the AIDS epidemic is based in a context of broader complexities - of competing issues such as development, poverty and co-existing diseases such as TB and malaria.[27] This results in a population facing inter-related risk factors. What this highlights is that CREs, their partners and the communities they serve are dealing with an epidemic in a broader and more complex context with competing priorities.

3.3 The religious-health landscape in SSA

There has been a recent boom of interest in the potential of religious entities in establishing effective HIV and AIDS interventions. This interest usually reflects a strongly positive attitude towards working with religious entities - and simultaneously some cautionary note, based on perceptions of the potential negative effects of religious messages.[28]

> Despite some negative perceptions of their role and impact, faith-based organizations are among the most viable institutions at both local and national levels and have developed experience in addressing the multidimensional impact of AIDS …[29]
>
> International agencies have only recently acknowledged the important role of faith communities as a legitimate partner in responding to HIV …[30]

This interest emerges from organizations including international agencies such as the WHO, UNAIDS, PEPFAR and The Gates Foundation - and is balanced by a realisation that little is known about these religious entities, who they are, what they can do, what assets they hold that can be leveraged for good health, and how they function.[31] Much of this interest has been centered around the idea of aligning or integrating religious entities in the broader national efforts or health systems.[32]

[25] UNAIDS 2007
[26] UNAIDS 2007
[27] See Schmid et al 2008. For example, it was recently reported that efforts to combat the spread of TB in the DRC have slowed down because of patients co-infected with HIV. See Plusnews 2008a
[28] See Birdsall and Kelly 2007, PEPFAR 2008, Taylor 2005a, Taylor 2007, UNFPA 2004
[29] Foster 2003
[30] Christian Aid 2004
[31] See ARHAP 2006
[32] See ARHAP 2006

3.3.1 Religious entities working in health in SSA

A. The problem of classifying religious entities

There have been substantial difficulties in finding appropriate nomenclature that properly depicts the huge variety of entities that have a faith-aspect to their work or character and are commonly grouped as 'the religious/faith sector'. For example, consider the following list of a few of the types of AIDS-engaged religious entities in Zambia: mission hospitals running complex ART programs, grass roots community organizations spontaneously getting together to run home-based care and OVC efforts, congregations running youth training programs, national religious coordinating bodies and health desks, groups of religious leaders with HIV and AIDS, a Muslim community financially supporting an HIV program in a government hospital, a traditional healer (who is also a Christian pastor) running HIV treatments and referrals to government hospitals.[33] To call all of the above 'FBOs' - as is commonly found in secondary literature - vastly undermines the variety within the faith-response to the AIDS epidemic. Some of the current trends in 'FBO-nomenclature' include the following:

- *Religious entity*: seeking to capture the broad range of tangible RHAs, incorporating religious facilities, organizations as well as practitioners, both bio-medical and traditional.[34] In a previous mapping study of Zambia and Lesotho, ARHAP undertook to develop a more concise typology that would contribute to a better understanding of the role and contribution of religious entities to health. The ARHAP WHO report (2006) provided a detailed multi-level categorisation, differentiating between the *type* of RE (congregation, clinic, support group), its primary *activity*, its geographic *reach* (local up to international) and the *time* it has been active.[35]
- *Faith based organization*: variously used to describe all religious entities, but more commonly used to describe organizations of the 'NGO-variety'. The WCC further differentiates between faith-related organizations, faith-background organizations, faith-centered organizations and faith-saturated organizations.[36]
- *'FBOs as CBOs'*: Increasingly common is the use of 'FBO' to specifically denote community-based organizations with a faith element. For example, PEPFAR material says: "the Emergency Plan prioritises the development of partnerships with FBOs and CBOs as a key strategy for increasing access to services and building sustainability …"[37]
- *Facility-based FBOs and non-facility based FBOs*: Used to create a distinction between religious entities which provide health services from a facility (such as hospitals, clinics, surgeries, dispensaries), and those that are taking place in communities and homes and are usually informal and less dependant on external expertise and funding (such as support groups, home-based care, health education). [38]
- Also common is the differentiation between types of 'FBOs' by using other *commonly used sub-categories*. For example, this can be seen in a WCRP-UNCEF report, namely: congregation (local

[33] All religious entities found in the ARHAP 2006 study
[34] See the glossary in Appendix 2.
[35] ARHAP 2006
[36] See Doupe 2005
[37] PEPFAR 2008
[38] Schmid et al 2008

gatherings of believers that meet on a regular basis, e.g. churches, mosques); religious Coordinating Bodies (RCBs, responsible for coordinating or supporting congregations or other RCBs); non-governmental organizations (NGOs, faith-based organizations that employ staff and are accountable to a group other than a congregation or RCB); community-Based Organizations (CBOs, faith-based groups that rely on volunteers and are accountable to a group other than a congregation or RCB.)[39]

All such typologies are limited, and there is an urgent need for continued investigation and consultation in this area. This is not just a matter of nomenclature, but evidence of the struggle to better understand the nature of religious entities, and the work they do.[40]

B. Problems of generalisation across SSA

In the same way, it has been highlighted in several recent studies that context is critically important when seeking to better understand the religious-health landscape in Africa. There is enormous diversity in social, economic, cultural and religious profiles. However, there are several attempts to describe and plan for the African situation generally, or for 'the AIDS epidemic in Africa'.[41]

> Making summary statements or generalisations about the religious-health landscape (is) not usually meaningful … great care should be taken when applying or interpreting generalisations about the religious-health context, which may not accurately reflect many situations in SSA.[42]

Of course, this does not mean that plans and recommendations cannot be made on a broader scale, but is simply a warning that regional differences in Africa (even within national borders) can be extreme.[43] The variety and inconsistency of the secondary literature and data relevant to the religious-health landscape, and more specifically religious entities' involvement in the HIV and AIDS epidemic, adds to awareness that, based on the current body of knowledge, it is difficult to make generalisations within countries, and across SSA.[44]

C. Religion in SSA

When considering the religious-health landscape in Africa, what is often forgotten is that religion is ubiquitous to the African context - but often hidden from the modernist view.[45] This demands that a better understanding of religious entities and practices be sought.

When seeking to understand the place of 'religion' in SSA health systems, it is critical to understand the complexities within the African religious context. For example, while the 'religious statistics' that are shown in the following three country case-study chapters all indicate that Christianity dominates

[39] Foster 2003
[40] As described in chapter 1 and 2, this research has chosen to use the broader term 'religious entity' - and in this case 'Christian religious entity' to capture the range of organizations, networks and 'religious coordinating bodies' that participated in this study
[41] See Olivier et al 2006
[42] Schmid et al 2008
[43] Indeed, the literature review that follows in this chapter attempts to speak of 'generalizations' across the broad category of 'religious entities'
[44] This study seeks to address this lack of knowledge by running the research in three SSA different countries, and thereby getting some basis for cross-country understanding
[45] See ARHAP 2006

in these countries, it is necessary to reflect that plural religious affiliation is to be expected.[46] In the religious-health landscape and the context of HIV and AIDS, plural religious affiliation can be most effectively seen in the case of plural health seeking behavior. Here, people turn - very commonly and often in unacknowledged ways - to different sources or systems of health, sometimes sequentially, sometimes simultaneously, all of which significantly impacts on the implementation and sustainability of health interventions.[47]

- This highlights that in the African context there are several 'health systems' in place - just as there are several types of healing.
- *African traditional healing* addresses the physical, spiritual and psychological body. A range of specialists including medicine doctors, royalty, herbalists, rainmakers, priests, birth attendants can be involved. *Spiritual healing* is often characteristic of many African Independent Churches, especially those known in southern Africa as 'Zionist', but also newer forms of local Pentecostal churches. *Islamic healing* is an ancient form of healing, incorporating Galen's 2nd Century CE understanding of the body. *Western biomedicine* expanded in Africa initially in response to the health care needs of colonial missionaries and administrators. In time, mission health services became a key form of outreach, especially in rural areas.[48]
- This study has focussed on CREs, and therefore participants express a range of understandings of what is 'healing'.[49]

D. The contribution of religious entities to health in SSA

> *It is generally accepted that religious entities have long engaged in health-related activities such as providing educational interventions and caring for individuals affected by disease. In many locations around the world, such REs have been in the forefront or alone in the struggles to ameliorate suffering and provide support, and have often been doing so with little attention or documentation from public health authorities.*[50]

As stated above, there are severe gaps in our knowledge about the resources and nature of religious entities working in health.[51] A common, but not particularly helpful statement is that religious entities are said to provide 25-70% of health care in SSA.[52]

[46] See ARHAP 2006, Thomas et al 2006.
[47] See Thomas et al 2006
[48] Schmid et al 2008
[49] See Chapter 5, Malawi, for a particularly strong participant response on the various understandings of 'healing' in the context of HIV and AIDS
[50] Olivier et al 2006
[51] See ARHAP 2006 which mapped REs working in HIV/AIDS in locations in Zambia and Lesotho. Several other mapping studies are also currently underway, see Schmid et al 2008
[52] Schmid et al 2008. See Asante 1998, Baer 2007, Benn 2003, DFID 2006, IDT 1998, Nussbaum (ed) 2005, PACANet 2002, Robinson & White 1998

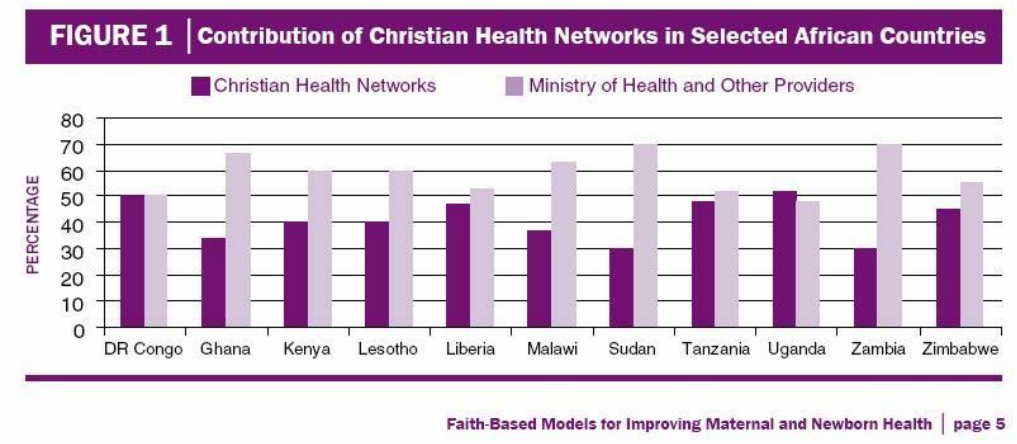


Figure 3.2: Contribution of Christian health networks - Chand & Patterson 2007

What data there is, such as depicted in the table above, is mainly focused on facility-based religious entities providing health services. What is more difficult to measure and understand are the multitude of religious entities who run programmes and initiatives which work to improve health - many of whom are not 'registered NGOs' or facility-based programmes.[53] Indeed, ARHAP mapping undertaken in Lesotho and Zambia in 2006 revealed that while the larger, facility-based entities such as hospitals are (sometimes) visible on public health maps, the mass of smaller non-facility based programmes and initiatives are rarely visible to the public view.[54] Nevertheless, based on secondary literature, what can be said with certainty is that religious entities are widely present in SSA, and have been for a long time, and they are present differently in different parts of SSA, (see box 3.1 below with findings from the Schmid et al 2008 landscaping study.)[55]

Box 3.1: The contribution of religious entities to health in SSA

- Religious entities (REs) make a significant and unique contribution to health services
- Faith-based health services in SSA show great variety in type and extent
- National faith based health networks (NFBHNs) play a crucial role in enabling facility-based services, which yet have a contested place within national health systems
- There have been significant shifts in ownership/funding/responsibility regarding faith-based health facilities over recent years from the historic mission model to local and agency funding, leaving huge discrepancies
- Faith-based health services work under severe constraints, especially regarding their workforce
- A wide range of non-facility-based services in response to immediate local needs are provided by REs, playing a very important role under serious constraints
- Mixing of multiple healing modalities (African traditional, bio-medical, faith healing, alternative therapies) is a common reality across SSA with mostly very little mutual acknowledgement and collaboration
- While the important potential of religious leaders for health promotion has been channelled into some creative initiatives, it is generally underutilised

Source: Schmid et al 2008

[53] ARHAP 2006
[54] ARHAP 2006
[55] Schmid et al 2008

E. Areas of critical concern for religious entities working in health and AIDS

It is perhaps necessary to briefly mention that while generalisations are difficult, there are a few key challenges that REs face that are highlighted in the recent secondary literature.

The African health systems in which religious entities are working are mainly weak and dysfunctional, and most SSA health care systems are coming under increasing pressure from HIV and AIDS in particular, and a wider complex of health crises in general.[56] Many REs are struggling in these increasingly trying circumstances, as many have to work under the constant strain of having to do more with less. An example is the dilemma faced by many facilitiy-based REs, where their 'mission' to serve the poor and marginalised comes into direct conflict with financial survival in these strained contexts.[57]

> This is a critical time in the history of some of these facility-based health providing FBOs[58] - as they are being pushed to weigh their organizational culture and reason for being, against the realities of financial support and survival.[59]

Of particular concern is the workforce crisis which threatens all aspects of health provision - including HIV and AIDS work. [60] Another challenge (particularly since the DRC and Kenya are two of case-study countries), is that REs in SSA are frequently working in conflict situations, and frequently in the regions in which conflict is most heavily felt. Such conflict situations have a heavy impact on health delivery, infrastructure and outreach.[61]

3.3.2 The strengths and weaknesses of religious entities

Little in-depth case study research has been done on religious entities involved in health, and virtually nothing which compares religious entities with secular organizations involved in the same work.[62] This remains one of the key areas needing further investigation. However, there is a great deal of anecdotal material which speaks of the perceived strengths and weaknesses of religious entities involved in health and in HIV and AIDS.

A. The strengths of religious entities

The secondary literature that posits religious entities as viable partners for HIV and AIDS work, frequently state a series of perceived strengths. The most commonly stated are:[63]

- Religious entities have unique and extensive reach and access: are found in all communities, and frequently in inaccessible and rural areas.
- Religious entities have access to dedicated volunteers and educated leadership.

[56] See Schmid et al 2008.
[57] Benn 2002
[58] Please note that in-quote 'FBO' terminology will be left as per the original quotation so as not to lose any significant nuance.
[59] Schmid et al 2008.
[60] See Schmid et al 2008.
[61] See ARHAP 2006, Dimmock 2008, Olivier et al 2006, Lusey-Gekawaku 2003, Parry 2008, Schmid et al 2008.
[62] There are a few interesting exceptions to this broad trend. See for example, CHAK 2007 which is a comparison of faith-based health services vis-a-vis the Kenyan government health services, Thomas et al 2005, Reinikka & Svensson 2003
[63] This summary is from Schmid et al 2008. For more detailed material and referencing see Birdsall & Kelly 2007, DIFAEM 2005, Olivier *et al*. 2006, Parry 2003, Reinikka & Svensson 2003, Taylor 2005, Taylor 2006, Taylor 2007, Thomas et al 2006, UNFPA 2005, World Bank 2004

- Religious entities have unique credibility and acceptance in communities, and therefore a particular potential to change behaviour.[64]
- Religious entities have well-developed networks extending from international to grassroots communities.
- Religious entities also provide an element of 'added value' to their work: intangible factors such as motivated and committed volunteers and workers, spirituality, trust, hope, resilience or durability.

B. The weaknesses of religious entities

Of course, these stated strengths are balanced by the knowledge that REs have not always responded helpfully to the HIV and AIDS epidemic, and in fact have sometimes been harmful.

- **Unhelpful religious attitudes:** Of great concern is the way certain religious beliefs or attitudes have had a negative impact on the fight against HIV and AIDS. Areas include issues of sexuality, cultural practices, the prohibition of condom use, discouraging education of adolescents on reproductive health; limitation of open discussion on sexuality, gender relations, and intergenerational relations; an increased sense of fatalism and increased stigmatisation of people living with HIV and AIDS.[65]

> While religious organizations have sometimes reinforced stigma by too readily associating AIDS with religious teachings about 'sin', there are notable examples where they have worked to foster tolerance and social solidarity using approaches that are non-judgmental and not based on fear. UNAIDS 2002

> In stark contrast to the position that argues that religions enhance stigma, is the opposite position that argues that religion, and therefore REs, are ideally situated to intervene against stigma. Olivier et al 2006

- **Religious attitudes in conflict with biomedicine and public health:** It must be cautiously said that several studies have noted the problematic that occurs when a particular religious attitude comes into conflict with a biomedical perspective - a most obvious example concerns church leaders claiming to cure HIV with prayer.[66] "A pastor in southern Malawi recently hit the headlines when he told five HIV-positive people in his church to stop taking antiretroviral (ARV) medication because they had been treated by prayer … the government has drawn up legislation, currently before parliament, to muzzle anyone claiming they can cure AIDS."[67] Such attitudes can place some religious entities in conflict with 'mainstream' responses to HIV and AIDS, and endanger collaboration.
- **Religiosity both as an aid and an obstacle to behaviour change:** Secondary literature contains several dialectics - such as this one that religiosity both prevents and engenders risky behaviour; REs' focus on abstinence is a strength, and a weakness; that religious leaders should talk about sex, and that they cannot; that preaching is a moralising process that leads to stigma and a method with potential to provoke healthy behaviour change.[68]

[64] A controversial point in public health circles, see below regarding the weaknesses religious entities.
[65] Schmid et al 2008. See Green 2003, Liebowitz 2002, Olivier et al 2006, Tiendrebeogo & Buykx. 2004, UNFPA 2005.
[66] We say 'caution' since it is not the place of this study to make claims either way.
[67] See Plusnews 2008b
[68] See Olivier et al 2006, Schmid et al 2008

- **Condom promotion and distribution:** The above challenges have resulted in REs being seen to be particularly weak in the area of condom promotion and distribution - around which controversy and conversation continues.[69]
- **Women disadvantaged by gender - and religion:** While many REs run programs that seek to intervene in gender issues, the effect of religion on gender has been highlighted as an area of concern - e.g. when patriarchal systems bestow privilege on men while encouraging submissiveness in women, and therefore make women more vulnerable to HIV and sexually transmitted infections (STIs).[70]
- **Religious entities have a particular lack of capacity in the area of documentation:** Secondary literature has noted that REs tend to have a *particular* lack of capacity in the areas of technical and financial support, administration and documentation.[71] As Chand and Patterson say, "even though FBOs have been providing health care for over a century, little has been written about them. FBOs should become proactive in writing, publishing and sharing, through various channels, their knowledge, successes and challenges."[72] Again, this is an area requiring further investigation (see box 3.2 below) - especially as this lack of capacity around documentation seems to result in a related lack of capacity in monitoring and evaluation (M&E) - as one study says, "community based organizations are weak at evaluation, but FBOs within this category are even worse."[73]

Box 3.2: Religious entities' lack of capacity in the area of documentation

Literature on REs' lack of capacity around documentation tends to focus on five main points:

- REs perceive themselves to be implementers: they are the 'doers' with an attitude of 'getting on with the work' - that is, they perceive themselves as to be 'too busy saving lives' in critical conditions to spend time on documentation.
- REs efforts have grown spontaneously and organically from community needs, and frequently either do not have formal NGO status, or have grown into organizations without information planning.
- The documentation that *is* happening is often 'vertical' reporting on specific activities to donors that does not get used in other ways within the programme.
- REs lack knowledge of specific donor requirements, and the capacity to handle a variety of such requirements from multiple donors (for example, project proposals, monitoring, evaluation and reports).
- Staff working in REs, which are often based on a large volunteer base, often do not have the technical skills required to meet the documentation requirements of overseeing agencies or funders.

Therefore, a recommendation that emerges from the secondary literature is that REs, especially the smaller community-based organizations would benefit from support through technical assistance or 'incubation' of their organizational capacity in the area of documentation and technical skills.

Source: Schmid et al 2008

[69] See Byamugisha 1998, Olivier et al 2006
[70] See Soloman 1996
[71] See Birdsall & Kelly 2005, Chand & Patterson 2007, Lusey-Gekawaku 2003, Munene 2003, Parry 2002, Taylor 2005b & 2006, Woldehanna et al 2005
[72] Chand & Patterson 2007
[73] Birdsall & Kelly 2005

3.4 The nature of religious responses to HIV and AIDS in Africa

Churches were largely silent in the first years of the AIDS epidemic …[74]

While there is variation in the speed and intensity with which REs responded to the HIV and AIDS epidemic in SSA, there has been a notable boom in REs responding to the epidemic since around 2000. This can be seen both in the birth of new organizations and programs and in programmatic shift of older established religious entities.[75]

> Especially over the last five years, there has been a largely spontaneous and often locally funded explosion of congregation and community level activity to respond to the HIV/AIDS crisis in many countries.[76]

It is still largely unknown whether this response is a result of community-level need, an increased availability of funding, or a combination of such elements.

Secondary literature says that REs are (differently) involved in *all* aspects of the response to the HIV and AIDS epidemic.[77] However, the AIDS-related work of REs is often embedded within broader service portfolios and studies, making it difficult to disentangle purely 'AIDS-related services' from the total range of services provided.[78]

Box 3.3: Religious entities' responses to HIV and AIDS

The ARHAP literature review noted several generalisations made in secondary literature - in relation to REs responses to HIV and AIDS in SSA - some of which are:

- REs' responses are more prevalent than is currently recognised, and are making a difference in the communities in which they are based.
- REs' responses range across the continuum of prevention, care and support, treatment and rights, and are often 'holistic' in nature.
- REs' responses do not always fit into the norm or schema of health responses, often employing a variety of strategies at the same time.
- There is still a startling lack of information on REs' activities in the HIV and AIDS sector, particularly in relation to small-scale or community initiatives which remain undocumented.
- Much remains to be understood about the nature, scale and scope of these contributions and the way in which they supplement and interface with more centralised responses to the HIV and AIDS crisis.
- There appears to be a crucial lack of alignment between health systems and religious resources.
- OVC are a primary focus of REs, and they are well suited to this work.
- REs are also particularly focused on care, often at a home-based or community level.
- In some cases an element of 'special care' has been attributed to religious interventions.

Source: ARHAP 2006

[74] See Doupe 2005
[75] See ARHAP 2006, Birdsall 2005
[76] Birdsall 2005
[77] See Schmid et al 2008.
[78] Birdsall 2005. See Schmid et al 2008

3.5 Multisectoral collaboration in the context of HIV and AIDS

> *Collaboration, dialogue and partnership should be on an ongoing basis, rather than for a single programme or event. Mature relationships and partnerships would then mature, and create possibilities for other joint activities*.[79]

A multisectoral response to HIV and AIDS has been recommended since the very early stages of the epidemic. Since then, and as the epidemic has been revealed to be a multiplex crisis - touching on multiple elements of health and society - this call for multisectoral collaboration has been strengthened to a point where it is one of the key strategies worldwide, and "nearly all national plans are now multisectoral in design".[80] This strategy calls for a coordinated response from all the elements of government, civil society and business sectors in that country, as well as an internationally coordinated strategy. We will now briefly consider some of the collaborative relationships in which secondary literature shows REs to be involved.[81]

3.5.1 Collaboration with governments

Little comparative research has been done on RE's collaboration with governments in SSA in the context of HIV and AIDS (hence the case-studies that follow). What little secondary literature there is points to two main vehicles or structures through which this collaboration happens. The first, is governments' collaboration with religious health (service) sectors such as national faithbased health networks (NFBHNs), or the Christian health associations (CHAs) - most commonly managed through Ministries of Health. The second is governments' collaboration with REs that are perceived to be part of 'civil society' - this relationship managed (on the governments' side) through national AIDS Commissions or Councils and multisectoral committees.[82] The level of success of these collaborative strategies (with REs in particular) is largely unknown. An interesting recent development has been at the *United Nations High-Level meeting on HIV and AIDS*

> … (which) ended on 12 June with civil society groups complaining over the lack of true partnership with governments in the fight against the pandemic. 'Greater involvement of civil society has been identified by the UN as a critical strategy to combat AIDS ... The involvement of civil society in official national delegations must be effective, not just tokenistic,' stated a Civil Society Declaration signed by some 100 groups. 'Real partnership between donors, governments, civil society, UN agencies and affected populations requires a balance of power in making decisions. Only through genuine partnership can we overcome the challenges and achieve universal access to prevention, treatment, care and support for all people by 2010' …[83]

Several pieces of secondary literature call for REs to be increasingly accountable to governments,[84] for example, to become part of national M&E systems and strategies as part of the Three Ones strategy. However, a review of progress on the Three Ones found that civil society is not an equal partner - particularly when it comes to reviewing and updating national plans - "and that people

[79] UNFPA 2004
[80] CADRE 2007
[81] This brief review does not cover all elements of multisectoral collaboration - for example, collaboration with the business sector, women's groups, networks of medical professionals, or community partnership are not mentioned here.
[82] See Schmid et al 2008 - country profiles
[83] PlusNews 2008c
[84] See Doupe 2005, NACC 2005

with HIV, women's groups and FBOs are particularly under-involved."[85] Just as AIDS is rooted in a wider socio-political context, so the question of collaboration between REs and governments is rooted in a wider context - where issues such as the historical role of civil society in that country, the strength of the state, and the underlying power dynamics upon which the collaborative relationships are built become key. There is a great deal yet unknown about what 'genuine' partnership means in these power-driven collaborative situations, and in particular where REs stand in this collaboration.

3.5.2 Interfaith collaboration

> *There are signs that, more and more, different faiths are working together. Slowly, religious leaders, spurred by the tragedy they see all around them, are feeling compelled to respond to the crisis and even to take a lead in their countries. Although it is too early to see concrete results, there is some evidence of a growing and constructive strategy across the divides of faith.*[86]

The above quote from the WCC reflects what a large body of anecdotal evidence states - namely that the HIV and AIDS epidemic has in fact been a 'driver' for increased interfaith collaboration.[87] However, inter-religious tensions are still dominant factors in international politics and in communities in Africa today.

> It can be said in the same breath that FBOs have a strong historical tradition of ecumenical co-operation (e.g. between Protestant and Catholic health facilities), and that collaboration between religious groups historically has been marred by suspicion and disassociation (e.g. between Christian and Islamic groups, or between 'mainline' churches and the charismatic movements).[88]

The ARHAP study of 2006 found little inter-religious collaboration or cooperation around AIDS at a community level in Zambia.[89] Therefore, while the literature may reflect increased inter-faith collaboration in the context of HIV and AIDS, perhaps a more realistic statement might be this one from UNAIDS, that "collaboration is often possible on AIDS even in situations of significant inter religious tension and conflict."[90]

3.5.3 'Ecumenical' collaboration[91]

Of great concern is how little is known of the nature of collaboration between CREs in the context of HIV and AIDS - for example if particular collaboration is easier or more difficult between particular types of CREs. This may be as a result of the tendency to group all REs together in studies on multisectoral collaboration, rather than seeking the variety within this 'religious sector'. The WCC notes that almost all REs (or 'churches') have experience in building partnerships - many having decade long partnerships with sister churches. Furthermore, that many of these partnerships, particularly the 'North-South' ones, have "often been unbalanced with power over finances and

[85] CADRE 2007
[86] Doupe 2005
[87] See Olivier et al 2006
[88] Schmid et al 2008
[89] ARHAP 2006
[90] UNAIDS 2008
[91] Here meaning collaboration between CREs

direction residing in northern churches ... Partnerships between churches on HIV/AIDS offer an opportunity to redress this imbalance, to create an equitable relationship."[92]

Liebowitz argues that within most of the REs involved in his study on REs involvement in HIV and AIDS in South African and Uganda, "a strong associational infrastructure (exists) at the national and local levels."[93] The Catholic Church is an obvious example, with links between denominational bodies, episcopal councils, international agencies (such as Caritas, CAFOD or Catholic relief) and local structures. Liebowitz gives the example of the Anglican Church of Uganda, which forms an associational infrastructure that includes the Mothers' Union, Fathers' Union, youth groups and other church-related associations, and argues that this provides an advantage to organizations within this umbrella, particularly in rural areas where religious groups are often based.[94] It would seem that such ecumenical collaboration provides support and access to broader networks and resources for local organizations, while the national level structures gain (further) access to local communities.

A. National Faith-based Health Networks (NFBHNs)

Special mention must be made of a particular type of RE, namely the National Faith-Based Health Network (NFBHN): country-level providers of health services, or networks of health service providers such as the Christian Health Associations (CHAs).[95] Based on the available secondary literature, it can be said that these NFBHNs have played a critical role in drawing together the efforts of REs for health in Africa.

> (They are) national or regional networks of church health facilities and programmes which have come together to create a stronger voice in advocacy and facilitate technical support, networking, communication and capacity building … Although the CHAs and their members face various critical challenges such as financing and workforce concerns … it would appear that these associations are exemplars of the positive impact of collaboration, networking and resource sharing. Indeed, it would seem that in countries that do have such national faith-based health networks, there is stronger collaboration between FBOs, as well as between FBOs and secular groups - in particular a stronger advocacy role with government. The NFBHN appears to be a valuable type of FBO that draws together different faith-health activities, and provides support in a variety of ways, from technical to emotional.[96]

Such umbrella networks clearly play a critical role in the development and maintenance of collaborative frameworks. They forge and maintain partnerships between their own members, between other NFBHNs (in their own countries and beyond), with the broader spectrum of secular and non-profit actors, and between their members and the government.[97]

However, there are still challenges - even to this collaboration between NFBHNs and governments. For example, reporting on a CHA meeting, Mandi lays out the main challenges as being: lack of co-ordination among REs when lobbying since they usually approach governments independently and not as a united front; REs do not have adequate lobbying or negotiating powers; there is a lack of

[92] Doupe 2005
[93] Liebowitz 2002
[94] Liebowitz 2002
[95] See USAID 2007b
[96] Schmid et al 2008. See CHAK 2006, CSSC 2007a, Dimmock 2007, Dimmock 2005
[97] See Schmid et al 2008

trust between governments and REs; REs fear that if they partner with governments, they will be absorbed and lose their identities; governments view REs as direct competitors rather than partners.[98] Nevertheless, it would appear that in countries in which NFBHNs are functioning properly, there is an improved degree of collaboration between health providing (facility based) REs and governments (specifically government health ministries).[99]

Figure 3.3: National Faith-based Health Networks in the countries of this study[100]

	Organization	% of NHS	Organizational description
DRC	**ECC-DOM:** Eglise du Christ au Congo - Direction des Oeuvres Médicales	~40%	Established in 1971, created to co-ordinate the health work of the ECC members and to serve as liaison with the Ministry of Health. In 1999, became a major partner in health care in the DRC, currently co-managing 65 of the 515 health zones in the DRC. It has 64 members, 50 hospitals and several hundred dispensaries.
Kenya	**KEC:** Kenya Episcopal Conference, Catholic Health Commission (CHC)	~20%	Catholic health care provision in Kenya dates back to the early 1900s. The Catholic Health Commission provides oversight and co-ordination of Catholic health facilities: 430 health units: 45 hospitals, 92 health centres, 282 dispensaries and 46 community-based programmes. CHC provides oversight, advocacy, lobbying and representation, capacity building, networking, and management to its members.
Kenya	**CHAK:** Christian Health Association of Kenya	~20%	Established in 1930, is an umbrella organization of over 296 member health units consisting of 24 hospitals, 43 health centres and 298 dispensaries, and 51 church health programmes owned by Christian denominations or missionary groups providing health services in various parts of Kenya.
Malawi	**CHAM:** Christian Health Association of Malawi	~37 %	Founded in 1966, members are ecumenical and interdenominational churches that operate health facilities. 30 hospitals and 125 health centres.

3.5.4 Collaboration with donors or 'partners'

Donors or funders are also seen as drivers of multisectoral collaboration. In fact, there is an increasing trend to call them 'partners' rather than 'donors' or 'funders'.[101] In terms of collaboration with REs, secondary literature suggests that international donors themselves can act as 'subregional networks'. For example, the Lutheran World Federation provides both support and a collaborative structure for its members, who are mainly Lutheran religious entities. The Catholic Church also appears to be particularly effective in working as a sub-regional network, and facilitating collaboration between its various bodies and organizations.[102] The specific challenges of collaboration between REs and donors in the context of HIV and AIDS is not well documented, and what there is, is frequently an unbalanced report from one perspective or the other. Some challenges mentioned, for example are: that donor funding has a limited period, and binding conditions can be problematic, donor support (mainly through projects) can be highly unpredictable, volatile and unsustainable,[103] and that there is concern over the growing dependence of REs on, not-always-reliable foreign assistance.[104]

[98] Mandi 2006
[99] See Schmid et al 2008
[100] Schmid et al 2008
[101] As found in this research in Malawi and the DRC
[102] Schmid et al 2008. See Olivier et al 2006
[103] UCMB-UPMB-UMMB 2007
[104] Dimmock 2008. See Schmid et al 2008

3.5.5 Collaboration with secular civil society

Secondary literature suggests that there has been an increase in collaboration between REs and secular groups, particularly as a result of the push towards multisectoral HIV and AIDS action.[105] This conclusion is usually based on the fact that more faith-based-AIDS-networks have been formed, and these are seen to act as avenues for secular organizations to increasingly collaborate with REs.[106] However, it does seem that the HIV and AIDS epidemic has pushed REs into new collaborative associations with secular organizations. For example, in the ARHAP research it was found that the majority of REs working in health in Zambia who were invited as participants had met previously on local 'task forces' and 'AIDS working groups' (although a minority, mainly the Traditional Healers Association and Islamic leaders, were not involved in these multisectoral collaborative structures.)[107] Taylor speaks of some of the challenges of collaboration between congregational-type REs and secular organizations, saying:

> Many church leaders have failed to engage with secular organizations because they consider their differing values as a threat to the church. They may also have little experience in dealing with the sophisticated bureaucracies of international development agencies, which work within short-term, fixed project cycles, while the church feels unappreciated for its long-term commitment. Secular organizations may in turn doubt the effectiveness of the church, and be uncomfortable about the spiritual emphasis. This lack of trust and understanding can have serious implications in terms of co-ordination and planning around national and local strategies for responses to AIDS.[108]

Much is said in the secondary literature about the importance of REs to work with PLWHA, but little is known of the overall state of this collaboration[109] - for example, of specific partnerships between REs and networks of PLWHA. There are two fast developing areas that should be closely observed. The first is the rapid growth of Anerela+ (the African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS),[110] and the second is the emerging concept of 'decent care' which shifts the focus towards the experience and perceptions of PLWHA, and has an underlying recognition of religion. 'Decent care' is a concept adapted from the world of work, and builds on philosophical and spiritual traditions of dignity, respect, agency and integrity - in this context calling for philosophical and ethical perspectives for decent care which treats people living with HIV and AIDS (PLWHA) as collaborators.[111]

This chapter has presented the current literature which speaks of the religious-health landscape, and specifically of REs' engagement in HIV and AIDS. Many of these concepts will be addressed again in the country case-studies that follow.

[105] See ARHAP 2006, Schmid et al 2008
[106] Although it is not known whether this is true - that is, the formation of a collaborative organization does not necessarily result in increased collaboration. See Molonzya 2003, Schmid et al 2008
[107] ARHAP 2006
[108] Taylor 2006
[109] See Olivier et al 2006
[110] See ANERELA+ 2008
[111] Karpf et al 2008

Chapter 4
Kenya case study

Chapter overview

This chapter provides a case study of the collaborative situation in Kenya. First it provides a brief overview of the religious-health landscape in that country, in the context of the HIV and AIDS epidemic. Then it presents the country-specific findings, followed by recommendations arising from the research.

4.1 Kenya country context

Country Information[112]

Geography: Eastern Africa, bordering the Indian Ocean, between Somalia and Tanzania, 582,650 km^2
Capital: Nairobi
Language: English (official), Kiswahili (official), numerous indigenous languages - Kenya's social diversity is reflected in various ethnic groups. They are divided on a linguistic basis into Bantu, Nilotic and Cushitic groups.
Politics: Kenya has been politically stable since independence in 1963. After nearly 30 years of single party rule, the country introduced multi-party democracy in 1991. An election-related conflict situation developed in 2008.
Administration: 7 provinces and 1 area.
Urban Rural Split: 80% of the country's population lives in remote rural areas.

Religion in Kenya[113]

Protestant 45%, Roman Catholic 33%, Muslim 10%, indigenous beliefs 10%, other 2%. A majority of Kenyans are Christian, but estimates for the percentage of the population that adheres to Islam or indigenous beliefs vary widely.

[112] CIA 2007, Molonzya 2003
[113] CIA 2007

WHO Mortality Summary[114]	Year	Males	Females	Both Sexes
Population (millions)	2005	17.2	17.1	34.3
Life expectancy (years)	2004	51	50	51
Under-5 mortality (per 1000 live births)	2004	129	110	120
Adult mortality (per 1000)	2004	477	502	
Maternal mortality (per 100000 live births)	2000		1000	

Other Health Information[116]	Year	%
Total expenditure on health as % of GDP	2005	4.5
Per capita expenditure on health at ave exchange rate $US	2003	20

Top ten causes of death all ages - Kenya 2002[115]	Deaths (000)	Years Life Lost %
All causes	376	100
HIV/AIDS	144	40
Lower respiratory infections	37	11
Diarrhoeal diseases	24	8
Tuberculosis	19	5
Malaria	18	6
Cerebrovascular disease	14	1
Ischaemic heart disease	13	1
Perinatal conditions	13	5
Road traffic accidents	7	2
Chronic obstructive pulmonary disease	6	1

4.1.1 Religious-health landscape in Kenya[117]

Kenya is home to a significant number of religious entities, and is often seen as the hub of regional development and health efforts. Speaking of the AIDS response in East Africa, Parry notes:

> Kenya hosts numerous faith based Associations, Councils, Organizations, Secretariats, Consortiums and Networks that are not only national but also regional and international. Because they are umbrella organizations, or have chapters in many countries, they represent a huge constituency of some millions of believers and as such have the potential for enormous influence.[118]

A. The history of religious involvement in health

In Kenya, the mainline religions have historically set up health centres and hospitals as missionaries arrived in Kenya. For example, Catholic health care in Kenya has a long history, dating back to pre-independent Kenya in the early 1900s and continuing to present day.

Less is known about the historical involvement of non-mainline religions in health, such as the historical role of traditional religions and healers, other minority religions, as well as the more recent growth of Christian charismatic religious entities. What we know of mainline facility-based REs is that they have traditionally provided health services to communities in remote areas where other health providing agencies do not have infrastructure.[119] There are also records of Islamic hospitals and health centres being established in Kenya during the colonial period.

B. Religious entities in the Kenyan health sector (or system)

Although less is known about community-based projects run by religious entities, especially congregational activities, the facility-based health-providing religious sector has a strong and organized presence in the Kenyan health sector. Secondary literature states that faith-based

[114] UNAIDS 2006a, WHO-Afro 2006
[115] WHO-Afro 2006
[116] WHO-Afro 2006
[117] Unless otherwise indicated, this summary is from the Schmid et al 2008 landscaping study
[118] Parry 2002
[119] Schmid et al 2008

organizations and networks currently provide more than 40% of health services in Kenya. This is depicted by the following statements:

- "The present Minister of Health, Hon. Mrs. Charity Ngilu, recently recognized the work of FBOs and singled out the Catholic Church as contributing up to 40% of the national struggle against HIV/AIDS."[120]
- In Kenya there are 974 faith-based facilities, 964 belonging to the Kenya Episcopal Conference (KEC) and the Christian Health Association of Kenya (CHAK), together providing 40% of national health services.[121] "KEC and CHAK together have an allocation volume of 10 million - of whom about 1.5 million are inpatients and about 700,000 actual admissions per year."[122]

Figure 4.1: Kenyan Health facilities by ownership - source KEC participant 2008

Facility type	Government	Private	CHAK/KEC	KEC	CHAK
Hospital	147	42	68	44	24
Health centers	460	15	139	92	47
Dispensaries	1630	391	592	281	311
Medical centers	-	592	-	-	-
CBHC programs	-	-	98	46	52
TOTAL	**2237 (51%)**	**1220 (28%)**	**896 (21%)**	**463 (11%)**	**433 (10%)**

As can be seen from this table, just CHAK and KEC hold and manage a significant percentage of the total facility-based health assets and efforts. Adding to this are the number of undocumented religious entities, including those more spontaneous or community-based efforts. The religious-health 'sector' can thus be considered as significant.

4.1.2 The HIV and AIDS epidemic in Kenya[123]

HIV and AIDS Estimates[124]	Estimate
Number of people living with HIV	1 300 000
National HIV prevalence among adults (ages 15-49)[125]	(1997/8) 10% (2006) 5.1%
Adults aged 15 and up living with HIV	1 200 000
Women aged 15 and up living with HIV	740 000
Deaths due to AIDS	140 000
Children aged 0 to 14 living with HIV	150 000
Orphans aged 0 to 17 due to AIDS	1 100 000

[120] CHAK 2008
[121] Mwenda 2007
[122] Mandi 2006
[123] This report emerged as international epidemiological fact sheets were being updated. New figures are expected by August 2008
[124] Unless otherwise stated, these come from UNAIDS 2006a
[125] These are 2007 readjusted surveillance stats from NACC 2008 (the UNGASS update report)

A. State of the epidemic[126]

Kenya has a mature HIV epidemic[127] that demonstrates one of the region's most notable trends in decreasing HIV prevalence. National adult HIV prevalence is estimated to have halved in a decade (10% in the late 1990s to about 5.1% in 2006)[128] - "a dramatic and sustained decline that has rarely been seen in Africa."[129] This decline is seen as notable even with these newly adjusted estimates of 2007 and 2008.[130] This decline has been attributed in part to critical HIV services being scaled up, resulting in increased awareness and behavioural change, as well as a lower incidence of new infections and higher death rates as Kenya's epidemic moves into its 'death phase' (mortality rates are now double the rate of 1998).[131]

- **Location:** Current estimates place infection levels among urban residents twice as high as those among rural residents (8.3% to 4.0%). In Kenya, rural prevalence rates are historically lower than urban prevalence rates, but rural populations continue to trail behind urban ones in the pace at which infection rates drop.[132]
- **A gendered epidemic**: In Kenya, women face considerably higher risk of HIV infection than men, and also experience a shorter life expectancy due to HIV and AIDS. One of the major challenges identified in the recent UNGASS 2008 update was the extensive differences in the risk of infection faced by different population groups. "Young girls are 5.5 times as likely as young men their age to become infected."[133] In the past, weak linkages in the planning and implementation of programmes addressing women's issues have been noted, with data often not disaggregated by gender.[134] However, recently HIV prevalence among young pregnant women declined significantly by more than 25% in both urban and rural areas.[135]
- **High risk groups:** It has been suggested that because Kenya was previously categorized as a country with a generalized epidemic, this resulted in little attention being given to collecting data on HIV prevalence and behavioural indicators among the most-at-risk groups such as intravenous drug users (IDUs), Men who have sex with men (MSM), truck drivers, commercial sex workers (CSWs) and youth. It is of concern that high-risk social groups have been neglected in programming, treatment and care. "Limited data indicates that the high prevalence in some of these groups confirms that the epidemic pattern in Kenya indeed is concentrated in them. Kenya is preparing to model modes of transmission that it will use in the mid-term review of the HIV and AIDS strategic plan."[136]
- **OVC:** Currently, it is estimated that there are 2.4 million orphans in Kenya. Half are orphans caused by the AIDS pandemic.[137] This remains an area of critical concern in Kenya. "The OVC situation is a deepening crisis as funding and programming fail to keep pace with the 2.4 million orphans who need care and support from their extended families

[126] This section acts as an introduction to the case-study to follow, and therefore not all HIV and AIDS statistics and issues are presented. See NACC 2008 for a more complete update of the Kenyan epidemic and national response
[127] Also sometimes termed 'severe and generalized'. See PEPFAR 2008, UNAIDS 2007
[128] UNAIDS 2007, with updated estimates says the adult prevalence has decreased from a high of around 14% in the mid-1990s to 5% in 2006.
[129] NACC 2008
[130] See NACC 2008, UNAIDS 2007
[131] See UNAIDS 2006a and NACC 2008
[132] NACC 2008
[133] NACC 2008
[134] UNAIDS 2006a
[135] UNAIDS 2007
[136] NACC 2008
[137] NACC 2008

and communities … There is a marked bias favouring the urban in delivery of services, which means that the percentage of support for rural children is significantly lower."[138]

B. Timeline of significant events in Kenya's AIDS epidemic

This timeline does not depict every AIDS-significant event in Kenya, but rather is an amalgam of events important to the participants, in government documentation, and participant documentation. It therefore contains events important to religious entities too.[139]

1984	First public case of AIDS-death in Kenya
1991	Re-introduction of multiparty democracy
1998	The Great Lakes Initiative on AIDS (GLIA) signed by countries of the great lakes region of Africa (Burundi, Democratic Republic of Congo, Kenya, Rwanda, Tanzania, and Uganda). The mission of the GLIA is to contribute to the reduction of HIV infections and to mitigate the socio-economic impact of the epidemic in the great lakes region by developing regional collaboration and implementing interventions that can add value to the efforts of each individual country.
1999	The Government of Kenya (GoK) declared *HIV/AIDS a national disaster* - following the publication of sessional paper number four of 1997 on AIDS in Kenya.
1999	Kenya formally adopted a multisectoral approach to combating HIV and AIDS. The multisectoral approach formed the foundation for the Kenya National HIV/AIDS Strategic Plan (KNASP) 2000-2005 and KNASP 2005/06-2009/10, which seeks to engage and mobilise all key social and economic sectors in the national response.
2000	The *National AIDS Control Council (NACC)* was established.
2000	The development of the *Kenya National HIV/AIDS Strategic Plan (KNASP) 2000-2005*, which set out a multisectoral response to the epidemic, jointly agreed by stakeholders within Government, civil society, the private sector and development partners.
2000	Introduction of ARVs in Kenya
2001	The Ecumenical Response to HIV/AIDS in Africa (EHAIA). *Plan of Action, Global Consultation on Ecumenical Responses to the Challenges of HIV/AIDS in Africa*. Nairobi, Kenya, 25-28 November 2001
2002	Pan-African Lutheran Church Leadership, *Breaking the Silence, Commitments of the Pan-African Lutheran Church Leadership Consultation in response to the HIV/AIDS pandemic*. Nairobi, Kenya, 2-6 May 2002
2002	Council of Anglican Provinces in Africa (CAPA). *Statement from CAPA AIDS Board Meeting.* Nairobi, Kenya, 19-22 August 2002.
2002	NASCOP established a National Antiretroviral Therapy Task Force to guide the way forward to scaling up the provision of antiretroviral therapy across the country. The policy involves both the private and public sector.
2003	East-Central Africa Division of Seventh-day Adventist Church. *East - Central Africa Division (ECD) of Seventh-day Adventist (SDA) Church Regional Workshop on HIV/AIDS. The Nairobi Declaration.* Nairobi Kenya, 10-13 November 2003.
2003	Just before the 2003 ICASA conference the Government of Kenya announced that it would start providing ARVs through public health facilities. Thereafter, multilateral donors led by the Global Fund and PEPFAR assisted Kenya in the provision of ARVs.
2003	International ICASA Conference on AIDS and Sexually Transmitted Infections in Africa ▪ Among other African nations Kenya adopts the Three Ones principle

[138] NACC 2008
[139] Sources: NACC 2008, NACC 2005, UNAIDS 2006a, Webster 2005, WHO 2005, participant workshops and questionnaires

2003 In March 2003, President Mwai Kibaki declared 'total war' against HIV/AIDS (TOWA)

2003 The NACC devolved to the grassroots with the introduction of Constituency AIDS Control Committees (CACCs). By 2007 there was a CACC in each of Kenya's 210 constituencies.[140]

2004 Formation of Kenya Inter-religious AIDS Council (KIRAC) by the government of Kenya.

2005 The development of the *Kenya National HIV/AIDS Strategic Plan (KNASP) 2005-2010*, which set out a multisectoral response to the epidemic, jointly agreed by stakeholders within Government, civil society, the private sector and development partners.

2005 Free ARV delivery

2005 The National Health Sector Strategic Plan 2005-2010 guides the health sector response. The health sector response to HIV/AIDS is addressed primarily through the National AIDS and STDs Control Programme (NASCOP) located within the Ministry of Health.

2006 Mainstreaming HIV into development instruments and key sectors prioritized.

- Progress made with regard to the Emergency Recovery Strategy, Medium-Term Expenditure Framework, Education sector and Home Affairs sector (Children's Department and Prisons).

2007 International Women's summit on Women leadership in HIV, sponsored by the YWCA,4 July 2007.

2007 1st national Catholic AIDS Conference in Kenya 2007

2007 Joint Annual Review Programme (JAPR)

2008 It has been reported that the post-election crisis in early 2008 could have had an affect on the epidemic as thousands of Kenyans dropped out of their HIV treatment programmes in January. According to NACC, at least 15,000 out of the original 600,000 people initially displaced by the violence were HIV-positive. By late February 2008, fewer than half of them had access to treatment, but analysts now say most patients are back on treatment.[141]

C. Kenya's HIV and AIDS national policy: KNASP 2005[142]

NACC (National AIDS Control Council). 2005. *Kenya National HIV/AIDS Strategic Plan (KNASP) 2005/06-2009/10, (A Call to Action).* Nairobi: NACC.

> *Advances in understanding, better national coordination and growing international support and resources have created an unprecedented opportunity to prevent new infection and reduce the impact of HIV and AIDS in Kenya. To grasp this opportunity and build an effective, enhanced national response, all stakeholders need to work together within a common action framework. The KNASP 2005/06-2009/10 provides that framework. The KNASP articulates a set of common targets and results agreed upon by all stakeholders. As such, the KNASP enables all partners, both national and international, to make best use of their individual and collective resources in support of an effective and efficient national response.*[143]

Commitment to the Three Ones: KNASP commits Kenya's strategy to the principle of the Three Ones. The KNASP document constitutes the one agreed HIV and AIDS action framework specified; the National HIV and AIDS Control Council (NACC) provides the one national coordinating authority, and one national monitoring and evaluation system is set in place.

[140] NACC JAPR 2007 in NACC 2008
[141] PlusNews 2008b
[142] Unless stated otherwise, all quotations in Section C come from the NACC 2005 *KNASP* policy document under discussion.
[143] NACC 2005

Commitment to a multisectoral approach: KNASP is described as a 'Plan of Action' for a deliberately multisectoral response to HIV and AIDS. In fact, the first Core Principle that underpins the strategy is, "A multisectoral approach, which enhances advocacy, builds strategic partnerships and mainstreams HIV/AIDS within key sectors". KNASP states that earlier responses to HIV and AIDS were largely centralised and health sector led.

> With increased recognition of HIV/AIDS as a development problem affecting every aspect of life, there occurred a shift to a multisectoral response guided by one coordinating authority, M&E framework and strategy. Implementation of HIV/AIDS interventions devolved to individual sectors and decentralised levels in order to reach affected communities, families and individuals effectively.[144]

The KNASP 2005/06-2009/10 employs three strategies to enhance the multisectoral approach: "strengthening existing and developing new strategic partnerships; mainstreaming HIV and AIDS in all sectors; and strengthening NACC's capacity to coordinate across sectors."

Commitment to a participatory process: It is stated in the KNASP policy that it was developed out of a participatory process in which many stakeholders took part. The stakeholders were drawn from a cross-section of public, private, civil society, faith-based organizations and international institutions.

> The KNASP 2005/06-2009/10 evolved through a highly consultative, broad-based process launched in July 2004.
>
> The KNASP ensures the effective engagement and participation of all stakeholders in the design, implementation and monitoring of strategic interventions. It is particularly important that vulnerable and/or underrepresented groups, such as PLWHA, women and young people, people living with disabilities (PWD), and nomadic and pastoralist groups, are empowered to make an effective and constructive contribution.

Commitment to one national M&E system: KNASP highlights the importance of monitoring and evaluation as "critical for the success of the KNASP." In line with the Three Ones principles, the establishment of a common national M&E framework to track the overall performance and impact of the national response is ensured.

> All partners involved in the implementation of KNASP shall report progress in their specific areas and receive feedback on the overall progress of the national response within the framework set out by the national M&E system.

The NACC UNGASS 2008 report notes that this national M&E system faces some challenges. For example, "some partners still rely on their parallel M&E systems … [although] most stakeholders are willing to buy into the national M&E framework. M&E training should be conducted at local levels … information is useful if used at the source, but there is weak competence in data use at all levels."[145]

Commitment to the Joint Annual Review Programme (JAPR): The NACC UNGASS 2008 report sees JAPR as the tool to reinforce the Three Ones principle.

> Civil society activities are the backbone of the national response to HIV and AIDS while development partners underwrite a major portion of these programmes. It is difficult to monitor and coordinate the diverse spectrum of budgetary and programmatic planning.

[144] NACC 2005
[145] NACC 2008

> This is why JAPR was created in 2002… The JAPR embodies the Three Ones principle and gives it a solid foundation … JAPR has enjoyed seminal achievements.[146]

What is also of interest is that as of 2008, DfID and the World Bank will only commit funding to programmes that come through the national JAPR system.[147] The broadening of the national multisectoral collaboration is currently based on a process of decentralization of NACC's structures and the annual JAPR to district and community levels.[148]

The coordinating structures named in KNASP: The National AIDS Control Council (NACC) was established by the Kenyan government in 2000 to coordinate the multisectoral response. The structures named in the report are:

- NACC: which operates under the Office of the President with the Cabinet Sub-committee on AIDS being the oversight body. The NACC board consists of permanent secretaries drawn from a range of ministries as well as representatives from civil society organizations, people living with HIV and AIDS (PLWHA) groups and the private sector.[149] NACC coordinates all Kenyan programmes, policy and interventions in the AIDS sector. A UNAIDS country profile states that NACC "has been able to establish itself as the one national coordinating authority on HIV, with a substantially enhanced public image and credibility."[150]
- Other structures named in KNASP are: DTC District Technical Committees, CACCS Constituency AIDS Control Committees, ICC Inter Agency Coordinating Committee in NACC, and MCG Monitoring and Coordination Group for each priority area.
- NASCOP (The National AIDS and Sexually Transmitted Diseases Control Programme) of the Ministry of Health is stated as the lead agency in most of the Results Framework in the KNASP document.
- Key faith-based partners identified in the implementation of the KNASP policy are identified as 'KIRAC/FBOs'

4.1.3 A brief survey of the state of collaboration in Kenya

> Kenya is implementing a successful multi-sectoral response to HIV/AIDS … There is an increasing understanding and willingness to cooperate among stakeholders across Government, civil society, the private sector and development partners … But progress cannot be taken for granted; enormous challenges remain.[151]

We will briefly consider some of the key issues emerging from secondary literature on the state of multisectoral collaboration in Kenya - relevant to this research.

A. Collaboration with government

[146] NACC 2008
[147] NACC 2008
[148] NACC 2008
[149] NACC 2008
[150] UNAIDS 2006a
[151] NACC 2005

There is little secondary literature that provides a balanced picture of what the state of collaboration is between Christian religious entities (CREs) and the Kenyan government, hence this research. What literature there is points to two avenues for CREs' collaboration with government, the first is through health-services collaboration (for example between CHAK, KEC and the Ministry of Health), and the second, as part of 'civil society' through NACC.

From CHAK and KEC organizational documentation, there appears to be a strong collaborative relationship with government - not surprising considering their ownership of about 40% of the national health infrastructure[152] - built around health more generally (rather than specific to HIV and AIDS). This literature does speak of some tension in the past, but more strongly of developing collaborative structures and channels between CHAK, KEC and the Kenyan government - mainly around working groups, such as the *Technical Working Group, Ministry of Health-Faith Based Health Services (MOH-FBHS-TWG).* For example, during a recent HR crisis when nurses from the CREs were being recruited into the government health facilities, swift advocacy on the part of CHAK and KEC appeared to generate dialogue and have satisfactory results.[153]

Beyond these health-providing facilities, CREs in Kenya are assumed to be part of 'civil society' involved in multi-sectoral collaboration around HIV and AIDS. Government documentation states that "the inclusion of (civil society organizations) CSOs in AIDS policy, planning and programming has improved."[154] UNAIDS agrees that NACC has been proactive in ensuring that civil society engages in key national planning processes and mechanisms.[155] More research is needed to know exactly how inclusive such collaboration with government is, and in particular, *which* representatives of civil society (and CREs) are included, and which are not.

B. Interfaith and ecumenical collaboration

Again, there is not much clarity on the ways CREs collaborate together around HIV and AIDS - and what we do know is from the documentation of the mainline Christian health providers who appear to have strong collaboration in their health-provision services. For example, CHAK and KEC jointly own the *Mission for Essential Drugs and Supply* (MEDS), which provides essential drugs and medical supplies, as well as training of church and other not-for-profit health facilities in the management and appropriate use of drugs.[156] Of ecumenical or interfaith collaboration around HIV and AIDS little has been reported, apart from the formation of the *Kenya Inter Religious AIDS Consortium* (KIRAC).[157] A World Council of Churches (WCC) study says of Kenya:

> It is our considered opinion that genuine networking among churches and ecumenical organizations needs to be nurtured for them to benefit from the networks. The study has demonstrated that the Inter Religious AIDS Consortium of Kenya (IRCK) has been formed at the initiative of the National AIDS Control Council and not that of the member

[152] See 4.1.2 above
[153] CHAK 2008, CHAK 2007, CHAK 2006
[154] NACC 2008
[155] UNAIDS 2006a
[156] GHC 2007, CHAK 2006
[157] Molonzya 2003

> religious organizations therefore raising questions of genuine ownership of the consortium by the religious organizations.[158]

This same study notes that the avenues for networking for churches and ecumenical organizations in Kenya are: the Kenya AIDS NGOs Consortium (KANCO), the Kenya Inter Religious AIDS Consortium (KIRAC), the Christian Health Association of Kenya (CHAK) and the Ecumenical Pharmaceutical Network (EPN).[159]

It was briefly mentioned above that Kenya is a 'hub' of regional and international REs. Although this has not been investigated, it seems logical that this might have an effect on the degree of collaboration between REs - given an increased access and presence of a variety of national, international and regional representatives. For example, CHAK was recently appointed to host the first secretariat for African Countries CHAs, a platform intended to support and coordinate networking, communication, sharing of information, experiences and planning for the African CHAs.[160] Working out of the CHAK office, it is possible that such a platform function increases CHAK's own collaborative network and functioning.

C. Collaboration between funders

Literature suggests that collaboration between donors remains a challenge in Kenya - even in the multisectoral context of HIV and AIDS response. UNAIDS notes that "harmonizing and aligning donor activities in support of a nationally owned agenda with defined priorities remains a challenge."[161]

However, NACC and the WHO point out that coordination among partners has recently improved with the establishment of coordinating committees.

> Government, international partners and agencies, civil society and the private sector influence strategy and policy through the *Interagency Coordinating Committee for HIV and AIDS* (ICC-AIDS), the *Joint Interagency Coordinating Committee* (JICC) and *the Country Coordinating Mechanism* (CCM). ICC-AIDS is the primary forum for convening stakeholders to deliberate on the national response to AIDS. It presents decisions on Global Fund issues at the CCM.[162]

This suggests that the structures are in place for funding organizations to meet and collaborate.

4.1.4 A brief survey of the state of funding in Kenya

This research did not set out to provide a full funding breakdown for Kenya or for CREs in Kenya. Nevertheless, there are a few themes that emerge:

- CREs experienced a period of funding crisis in the 1990s in Kenya "much of the support FBOs were getting from the big congregations, churches and donors, as well as the assistance received from the government from as far back as the fifties and sixties, came to an end."[163]

[158] Molonzya 2003
[159] Molonzya 2003
[160] CHAK 2008
[161] UNAIDS 2006a
[162] NACC 2008
[163] Mandi 2006

- Major funds are channelled through NACC, such as the Global Fund, the United States Government, the World Bank, and the United Kingdom's Department for International Development.
- Kenya is one of PEPFAR's 15 focus countries. Under the Emergency Plan, Kenya received nearly $92.5 million in Fiscal Year (FY) 2004, more than $142.9 million in FY 2005, approximately $208.3 million in FY 2006, $368.1 million in FY 2007, and is expected to exceed $500 million in 2008.[164]
- CREs (e.g. CHAK) are part of the Global Fund country coordinating mechanism for Kenya, and are PEPFAR recipients.
- International funding for HIV and AIDS initiatives has increased in Kenya, with 98% of currently available funding coming from international donors.[165]
- This heavy reliance on donor funding makes long-term sustainability a challenge.[166]
- While support seems to be aimed across the spectrum of prevention, treatment, care and support - NACC notes that development partners have favored supporting ART rollout over less costly prevention measures.[167]
- In Kenya, the demand for ARV is on the increase and delivery is almost entirely supported by development partners. "The recent emphasis on treatment has overshadowed programmatic activity in prevention and is becoming costly … This raises concerns about the long-term sustainability of ART."[168]
- NACC has called for development partners to align their programmes and funding to national response priorities, saying "they must refrain from implementing systems parallel to the Three Ones for M&E and reporting. PEPFAR should follow the example of other development partners and observe the principle of basket funding."[169]
- Similarly, the civil society perspective in the UNGASS report[170] mentions the following challenges in collaboration with development partners:

  > While some development partners recognize the importance of civil society, this does not yet translate to optimal engagement with civil society as equal partners …
  >
  > Development partners should harmonize the way they work with civil society. The different approaches and requirements of individual donors create confusion among CSOs and increase their workload. The requirements related to calls for proposals and reporting should be simplified so that all applicants are able to meet them ...
  >
  > Donors tend to focus their support in the same geographic areas …
  >
  > Because civil society is often represented by big NGOs, development partners tend to overestimate CSO capacity. Development partners could help strengthen CSO capacity by allocating a percentage of each grant for that purpose.
  >
  > Development partners' funding of civil society would be more effective if disbursements were direct rather than through the government.

[164] NACC 2008, UNAIDS 2006a
[165] UNAIDS 2006a
[166] NACC 2008, UNAIDS 2006a
[167] NACC 2008
[168] NACC 2008
[169] NACC 2008
[170] NACC 2008

See box 4.1 below which contains an extract from the 2008 UNGASS report, specifically the civil society perspective on funding and the financial situation in Kenya.

Box 4.1: The civil society perspective on the financial situation in Kenya

Increase government funding: Civil society is responsible for the majority of Kenya's programmes. For instance, FBOs deliver almost 40% of health care services. However, they receive little or no government funding. Exacerbating this problem is the fact that when the government does a survey or sets a target it includes and relies on our programmes but still does not contribute to our operations. The government should give us a formal commitment to work with civil society and to allocate funds to us.

Increase donor funding: We believe that clear expressions of partnership with civil society should be incorporated into all calls for proposals.

KNASP 2005/6-2009/10: CSO budgets should be aligned with KNASP 2005/6-2009/10. Donors should allocate funding to operational research as outlined in KNASP 2005/6-2009/10.

More transparency in funding allocation: Decisions about the allocation of funds are made without clear criteria or proper consultation. Civil society representation in decision-making forums is ensured on paper, but in reality our voices and contributions are often ignored.

More effective regulation of claimant organizations: Organizations that are eligible for grants should be better regulated. It is also important to take note of local mobilization constraints. Regulation should not inhibit genuine applicants from poor and vulnerable groups who are sincere in their intent but find it difficult to meet the demands of bureaucratic procedures.

Promote coordination of funding allocation: Funding mechanisms such as the World Bank's programme of support, constituency development funding and various multilateral and bilateral initiatives must coalesce around one coordinating body to avoid multiplicity of funding to singular components, geographic areas or implementers. *Source NACC 2008*

4.1.5 The key players in the Kenyan HIV and AIDS context

We provide here a listing of some of the key organizations that secondary literature shows are working in the Kenyan multisectoral context. This is in no way a comprehensive listing.[171]

Government structures: National AIDS Control Council (NACC), National AIDS Control Program (NASCOP), Interagency Coordinating Committee for HIV and AIDS (ICC-AIDS), the Joint Interagency Coordinating Committee (JICC), the Country Coordinating Mechanism (CCM) ...

Collaborative networks or networking organizations: Kenya AIDS NGOs Consortium (KANCO), Kenya HIV/AIDS Private Sector Business Council, the Kenya Inter Religious AIDS Consortium (KIRAC), the Christian Health Association of Kenya (CHAK) …

Multilaterals, bilaterals and major donors providing support to address Malawi's HIV and AIDS epidemic: AUSAID, British Council, Canadian International Development Agency (CIDA), Church World Service (CWS), CIDA, DANIDA, Department for International Development (DfID), European Community (EC), Family Health International (FHI), FIDA International, Global Fund to fight AIDS, TB, and Malaria, Government of Finland, GTZ, Hope Worldwide, JICA, Joint United Nations Programme on HIV/AIDS (UNAIDS), Médecins Sans Frontières, Norwegian Church Aid (NCA), Pathfinder, Population Services International (PSI), President's Emergency Plan for AIDS Relief (PEPFAR), SIDA, U.S. Agency for International Development (USAID), UN family (e.g. UNAIDS, UNDP, UNICEF), United States Centers for Disease Control and Prevention (CDC), World Bank (WB), World Health Organization (WHO)…

[171] See NACC 2008, UNAID 2006b, Webster 2005, WHO 2005, World Bank 2008

Christian religious entities engaged in HIV and AIDS: secondary literature does not provide a comprehensive mapping of CREs engaged in HIV and AIDS in Kenya. In 2003, the WCC study concluded that in Kenya there is a, "…glaring lack of involvement of many churches, ecumenical and secular organizations in the mitigation of the socio-economic impacts of HIV/AIDS and also the lack of proper monitoring and evaluation of their HIV/AIDS programmes."[172]

The work undertaken via desk review, as well as in the snowballing sampling process, helped to identify a wide range of CREs that are responding to health generally, and the HIV and AIDS epidemic in particular. A full listing is provided in Appendix 6.1. Please note, this listing is limited and does not capture every organization working in HIV and AIDS in Kenya. Several named here are networks or umbrella bodies that incorporate a number of individual religious entities or programs. Furthermore, some international organizations have local offices and therefore make categorisation difficult. It is our hope that this listing highlights the scope and range of AIDS-engaged religious entities in Kenya, and is a working document that can be utilized and developed further in Kenya.

Figure 4.2 Nairobi, Kenya - 2008

4.2 The findings of the research in Kenya

The participatory research process was designed to identify findings in four key areas:

1. Concerning the context in which Christian religious entities (CREs) are working
2. Concerning the work of CREs in the promotion of Universal Access
3. Concerning the strengths and weaknesses of collaborative partnerships between CREs and other stakeholders
4. Concerning the challenges and potential of collaborative partnerships between CREs and other stakeholders

[172] Molonzya 2003

Within these four areas, the participatory research process produced the following six findings in Kenya:

1. CREs in Kenya perceive themselves to have a long history of participation in national and social life, including responding to the HIV and AIDS epidemic. Furthermore, they recognise the contextual factors in this national and social life that drive the epidemic.
2. CREs in Kenya are committed to, and involved in promoting Universal Access to prevention, treatment, care, and support in a number of significant ways, including education and awareness, provision of ART, care for orphans and vulnerable children and vocational support. This work is aimed at a wide range of beneficiaries, although there is a particular focus on the rural areas, and on women
3. In their contribution to Universal Access CREs in Kenya are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, legitimacy and resources. These strengths represent vital assets that are essential to strengthening multisectoral collaboration
4. CREs in Kenya are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the clarity of the national policy, the collaborative structures that have been established, and the increased funding for CREs. (2) The main weaknesses are perceived to be the lack of collaborative processes, the lack of representation in some forums, the lack of financial commitment from government, and the burgeoning bureaucracy especially around financial reporting.
5. CREs and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges such as competition amongst stakeholders, the dogmatism and conservatism of CREs, and their lack of capacity are balanced by a mutual appreciation of the strengths of each partner, and a shared desire to improve collaboration.
6. There is an obvious commitment to strengthening the partnership between CREs and collaborative stakeholders from both sides. From the CREs there is a desire for greater participation of a range of stakeholders in formulating national policy and donor strategies. From the collaborative stakeholders there is a desire for a stronger commitment to the national M&E process.

We now examine each of these findings in greater detail, drawing from the evidence that emerged in the workshops and questionnaires. Supporting commentary and evidence from secondary literature can be found in the footnotes. The chapter concludes with a set of clear recommendations based on these findings.

4.2.1 Findings concerning the context in which Christian religious entities are working

Finding 1: Christian religious entities in Kenya perceive themselves to have a long history of participation in national and social life, including responding to the HIV and AIDS epidemic. Furthermore, they recognise the contextual factors in this national and social life that drive the epidemic.

In the participatory workshop with CREs, participants were asked to contribute to a communal time line that helped to map the history of their engagement in national and social life, and specifically in responding to the epidemic. The following information emerged from the timeline.

Many of the CREs involved in responding to the epidemic have a long presence in Kenya, some dating back to the nineteenth century such as the Anglican Church of Kenya (1844) and the Presbyterian Church of East Africa (PCEA 1891). Many others pre-date Kenyan independence in 1963 such as the Young Women's Christian Association (YWCA 1912), CRS (1943), CHAK (1946), KEC (1950), St Johns Community Center (SJCC 1957).

Furthermore, Kenya has been a centre for wider Christian involvement for a long time. In 1973 the Protestant churches of Africa established the offices of the All African Council of Churches in Nairobi, and in 1984 the Pope visited Kenya.

CREs perceive themselves to have responded quite early to the HIV and AIDS epidemic, with participants agreeing that there was already a response to the epidemic in the late 1980s and early 1990's. In 1986 the Presbyterian Church of East Africa had a symposium to deal with the emerging crisis and invited the government to partner with them.[173] In the same year the first Catholic bishop wrote a pastoral letter on HIV and AIDS. The Anglicans held a conference in 1997 in Mombasa, where they produced a draft policy on AIDS for the Anglican Church. In 2006, The Kenya Episcopal Conference (Roman Catholic) celebrated 20 years of involvement in responding to HIV and AIDS. Participants in the workshop noted that not only were more CREs responding to HIV and AIDS, but that there had also been a boom of new AIDS-engaged religious entities emerging in Kenya from around 2000.[174]

There is furthermore, a perception amongst CREs that they pioneered in part the response to HIV and AIDS in Kenya.

> CHAK and others started working against HIV and AIDS much earlier, in 1990 CHAK started working in HIV/AIDS ... but the truth is that the churches started much earlier than the government ... in fact some of the programs the churches were running were borrowed by the government[175]
>
> When HIV/AIDS was first recorded in Kenya, in the 1980s, we were in denial, only the churches got involved, saying we have a problem, we have to do something about it, and because of the action of the churches, the government got involved - in 1999 - so the church actually took a lead in lobbying and advocacy to get the government [to respond]

[173] This perception is supported by secondary literature - see Molonzya 2003
[174] This boom appears to have happened in most SSA countries. See chapter 3 for further discussion
[175] All in-text quotations from here on, in this chapter, are from participants in the two Kenyan workshops. Anonymity was assured in order to provide a more participatory discussion

There is also recognition that when the government declared HIV and AIDS a national disaster in 1999, this enabled the churches to find a stronger sense of direction. As access to funding from PEPFAR and the Global Fund became possible, a number of new CREs emerged. Many of these do not have a national footprint, but work locally. However, it was felt that while the government initiative assisted in focusing the energy of the CREs, not much has come from this partnership.

> In 2003 the government called all churches together and we thought more would come from that, that there would be more commitment ... but not much has happened. There hasn't been the finance.

Participants were also very aware of the relationship between the social context and public health, and how this impacts upon the HIV and AIDS epidemic. Two clear periods were identified. The first had to do with the impact of structural adjustment on health care in Kenya as the epidemic was growing. The following statements illustrate this point:

> 1985-1986 structural adjustment took place and poor people suffered. Health collapsed and there was the spread of HIV/AIDS [general agreement]. This opened the floodgates; the poor were laid off, there was expansion of informal settlements, and disease spread.
>
> Companies closed down and donor funding became scarce, and people became poorer.
>
> Fee payment at hospitals started which meant that many people could not access health facilities.[176]
>
> At the same time a drought happened, and people were laid off…
>
> There was a gender dimension; that is when the feminization of poverty happened…when the funds laid off the staff ... mostly mothers laid off, and led to risky sex behaviour ... in our context the women and children ended up suffering more ... at the hospital, if you did not have money you could not go.
>
> [This led to] urbanisation as people moved in search of jobs.

The second period was more recent, with the violence and turmoil following the election in December 2007. This research was not in a position to gain any long-term perspective on the impact of this turmoil, but it was clear that it has disturbed relationships and unsettled many people. Participants were reluctant to speak in much depth about the current violence after the elections, but statements such as the following indicated that the current context needs to be taken seriously for any future initiatives to strengthen multisectoral collaboration.

> We are a very peaceful people … we have wondered in the past, what do we have to do to make [Kenyans] react? ... this goes against the grain of 47 years, revealing things about ourselves … it was a shock.
>
> I'm still crying … we have not said happy New Year this year…it has been a tearful time.
>
> From the faith community … some of our colleagues took sides, and the church never took a position before this …

[176] Kenya introduced user fees in early 1990s but rescinded them in late 90s in response to steeply declining utilisation stats for govt health facilities and inability to administer the user fee system fairly and efficiently

It is clear therefore that within the context of Kenya, CREs perceive themselves to have a well established participation in national and social life, including responding to the HIV and AIDS epidemic. They understand themselves to be key stakeholders in the national response to HIV and AIDS, and that their contribution and insights should be taken seriously in that response. Furthermore, they are aware that there are a range of factors within in the national and social life of the nation that drive the epidemic.

4.2.2. Findings concerning the work of Christian religious entities in the promotion of Universal Access

Finding 2: Christian religious entities in Kenya are committed to, and involved in promoting Universal Access to prevention, treatment, care, and support in a number of significant ways, including education and awareness, provision of ART, care for orphans and vulnerable children and vocational support. This work is aimed at a wide range of beneficiaries, although there is a particular focus on the rural areas, and on women.

The desk review as well as the snowballing sampling process helped to identify a wide range of CREs that are responding to the HIV and AIDS epidemic (see Appendix 6).

While not each and every entity noted here is equally involved in all aspects of Universal Access, it is clear that taken as a whole, CREs in Kenya perceive themselves to be involved in Prevention, Treatment, Care and Support, as well as some 'Other' tasks. Asking the Christian entity participants to depict and describe the three 'main' areas they were each involved in HIV and AIDS work, the following basic table was derived:[177]

Prevention	Treatment	Care	Support	Other
CHAK	CHAK	CHAK	KEC	KIRAC
KEC	KEC	CCSMKE	CCSMKE	ADRA
CCSMKE	DOSS ACK	YWCA	DOSS ACK	*NCCK*
(ACK)	CRS	SJCC	YWCA	*EAA*
DOSS (ACK)	PCEA	ADRA	SJCC	
KIRAC	*SDA*	CRS	CRS	
YWCA		*SDA*	PCEA	
SJCC		*NCCK*		
ADRA		*EAA*		
PCEA		*ITK*		
SDA				
NCCK				
EAA				
ITK				

Figure 4.3: Depiction of participatory exercise, Kenya 2008

A. Prevention

Four kinds of prevention activities predominate:

- The most predominant activity is education and awareness work. Prevention messages tend to focus on abstinence and behaviour change, particularly among the youth. There is,

[177] See Appendix 1 for acronyms. Those in italics in the table above did not have representatives at the workshop, but were added on the strong suggestion of participants.

however, also some reproductive health peer education. Some have adopted a Trainer of Trainers approach and developed training manuals in this process.

- Some organizations are involved in prevention of mother to child transmission (PMTCT). Of note is KEC who indicated that their programme had reached over 100,000 mothers in the last four years.
- In addition, voluntary counselling and testing (VCT) is undertaken. KEC is involved through 170 centres, while PCEA operates 70 centres.
- Capacity building among health workers is recognised as important by CHAK who see this as a way of strengthening their ability to carry out HIV and AIDS education.

B. Treatment

CREs are involved in treatment through a range of church medical facilities in the country. A key aspect is the provision of anti-retroviral treatment (ART) as well as treatment for sexually transmitted infections. Thus for example:

- CHAK is involved in: service delivery, treatment and care of PLWHA through health facilities using ARTs. Management of opportunistic infection (OIs) through health facilities, nutritional care, providing treatment at a national level.
- CRS is involved in: increased access to ARVs. It has 24 mission hospitals where among other things, ART is administered and the management of opportunistic infections takes place. PCEA is involved in treatment through 3 main church hospitals: Kikuyu, Dumutumu, Chogoria. From these hospitals, ART is administered.
- DOSS of the Anglican Church of Kenya also operates hospitals and health centres in which STI's are treated as well as ART administered.

KEC is significantly involved in treatment through 45 hospitals. They estimate that through their programme about 35 000 people are receiving ART which constitutes 16% of the national figure of 180 000, 3 000 of which are children.

Participants noted that the network of mission hospitals have been key to the roll-out of ART in Kenya. They are recognised as having started this work prior to the government with MEDS having started training in 2002.

> In this country, mission hospitals are very important … mission hospitals started ahead of the government roll-out.
>
> A lot of health facilities are faith based and they have some of the best care for HIV and AIDS patients. The church has pushed treatment more than the government.

Treatment is seen by CREs to be an area in which there is significant collaboration with government who use the mission hospitals for training and for the distribution of ART.

> The mission hospitals are very important … that is where we collaborate with the government…and distribute a lot of ARVs here.

C. Care

With regard to care, two activities predominate:

- The home based care networks which provide opportunities for assisting people living with HIV and AIDS.
- Care for orphans and vulnerable children.

The area of caring for orphans consumes much of the energy of CREs.

> We have been abandoned with the children … we do not have the resources … we are overwhelmed … we have no choice … there is no one else [to do this work].
>
> There is another aspect, the churches sponsor schools - and these children are in these schools, and when the teacher says there are these children, the church takes on the responsibility … so you have these children in your institutions … you are sharing the same comfort.

Participants also noted that CREs do not always make a clear distinction between care and support.

D. Support

CREs are involved in a range of 'support' activities for people living with HIV and AIDS, and particularly for orphans and vulnerable children (OVC) and widows.

> We are spending a lot of time and money making sure communities know how to support orphans … and that children have vocational training.

These activities include:

- Promotion of good nutrition
- Education (support for orphans and vulnerable children)
- Credit support
- Agricultural support
- Economic empowerment
- Vocational training
- Psycho-social support

E. Other

The key other aspects that CREs are involved in are:

- Radio Programmes and information and communication technology (ICT) in order to do HIV and AIDS prevention
- Organizational capacity building and support
- Targeting issues of stigma and discrimination
- Advocacy work

Participants admitted that while they were involved in various forms of advocacy work, most were not involved in policy development.

F. Beneficiaries

In promoting Universal Access to Prevention Treatment Care and Support, CREs work with a wide range of beneficiaries.

In terms of **location** while these national entities have their offices in Nairobi, there is a strong commitment to a focus on rural areas.

> We have health facilities in rural centres where there are no government facilities … the government have not been there.
>
> In areas that are very remote with poor infrastructure, even now after 40 years the government has not been able to do much there and only the FBOs are there.

There was also recognition that Kenyan society is characterised by ongoing **migration**. The HIV and AIDS epidemic is strongly felt amongst people on the margins of society, many of whom are rural people, who have moved to the urban slums around cities like Nairobi.

In terms of **gender**, while participants in the research recognised that it is crucial to work with men, they acknowledged that most of the work is with women. When participants at the workshop were asked if any organization had ever run programs for men only, all admitted that they had not saying, “we are not doing much work with men”. But they recognised the crucial role men played in curbing the epidemic, and acknowledged that in some areas men often did not go to church, but “sent their wives”. They further acknowledged that women are bearing the brunt of care. “Most people [doing the] care are women,” and training for HBC took place mainly with women.

In terms of the **religious** constituency and working with people outside the Christian faith, it is clear that CREs are committed, in terms of both principle and policy, to working with all people. However, in reality they recognised that they work mainly with Christians. As one participant said:

> We do not discriminate but at the end of the day we work mainly with Christians, even though we do not discriminate.

Some of the CREs, such as CRS, have non-Christian staff in some of their projects. Furthermore, there is support from CRS for both KCS and CHAK. In addition, there is also direct intentional work together. One such example is the instance where KCS and CHAK run treatment programs together. Participants affirmed that treatment is a key area where collaboration takes place between Christian and non-CREs.

This section has supported our finding that CREs in Kenya are committed to, and involved in promoting Universal Access to prevention, treatment, care, and support. Four key prevention strategies are education and awareness, PMTCT, VCT and capacity building amongst health workers. CREs are involved in treatment through a range of church medical facilities in the country. A key aspect is the provision of anti-retroviral treatment (ART) as well as treatment for sexually transmitted infections to a large number of people. Care is focused on home-based care for PLWHA, and care for orphans and vulnerable children, the latter task consuming much energy. A range of support activities are undertaken including credit support, vocational training and psycho-social support.

In terms of beneficiaries, CREs are strongly committed to working with rural people. While they recognize the importance of working with men, most of the programmes work with women. There is limited engagement with non-Christians, predominantly in the area of treatment.

<u>Finding 3:</u> In their contribution to Universal Access Christian religious entities in Kenya are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, legitimacy and resources. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

As discussed in chapter 3, religious entities are seen to have key strengths that offer leverage for the response to the HIV and AIDS epidemic. In the introduction above, we further presented some of the assets religious entities are said to hold in the Kenyan health system. While this particular study did not focus on identifying the specific assets of CREs that can be leveraged towards providing Universal Access (for example, the number of facilities held or patients served), this capacity was nevertheless clearly demonstrated throughout the discussion and in the organizational documentation collected through the desk review and questionnaire response.

In the workshop, when representatives of collaborative stakeholders such as government, donors and other religions were asked to reflect on the work of CREs they identified three major areas of strength.[178]

(1) The first related to the **reach** of CREs, particularly in the rural areas. It was felt that they were one of the few organs of civil society that were accessible to 'grassroots people' and were therefore in a position to influence communities. Furthermore, they were in contact with large numbers of people within close proximity to their sphere of influence.

(2) This related to the second area of strength, namely their **legitimacy** within communities. This legitimacy stemmed from their history of work in the rural communities of Kenya, but also because they were available and willing to offer psychosocial and spiritual support. They represented a moral authority arising out of their values based on the Bible, which was the driving force behind the implementation of their programmes. Because of a religious imperative to be available to people and to care for them, they represented an important resource for curbing of the epidemic and offered immediate relief, particularly to orphans and vulnerable children. As a result of all of this, they enjoyed significant credibility within communities.

(3) The third area of major strength lay in their **resources**, both human and material. They had committed workers that were able to mobilise people easily. Their structures are defined and well organized which further assists in mobilisation processes, particularly in rural areas where, as it was acknowledged, "even the government does not have structures in the rural areas." Furthermore, human and material resources were plentiful through their large national and international networks.

CREs in Kenya are acknowledged by collaborative stakeholders as having key strengths in three areas: (i) their 'reach' enables them to serve a wide range of people; (ii) their legitimacy, owing to their history of work, their willingness to serve, and their moral authority; and (iii) their

[178] See chapter 3 discussion

human and material resources. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

4.2.3 Findings concerning the strengths and weaknesses of current collaboration between Christian religious entities and other stakeholders

<u>Finding 4:</u> Christian religious entities in Kenya are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the clarity of the national policy particularly around the Three Ones, the collaborative structures that have been established, and the increased funding for Christian religious entities. (2) The main weaknesses are perceived to be the lack of collaborative processes, the lack of representation in some forums, the lack of financial commitment from government, and the burgeoning bureaucracy especially around financial reporting.

Through the desk review and the snowballing approach to the identification of participants for the workshop, it was clear that CREs are involved in a range of collaborative partnerships. (See above and Appendix 5.2 for the selection of key collaborative stakeholders identified by advisors in Kenya.)

In a rough typology, these included: government bodies and structures, national AIDS coordinating mechanisms, international donors (a full range from large internationals to individuals), interfaith bodies or networks, national faith-based health networks (NFBHNs), denominational bodies, other NGOs, other CREs.[179]

This was confirmed in an exercise carried out with representatives from CREs in which they had to draw a 'spidergram' showing their relationships with one another, other faith-based organizations, government, and with collaborative stakeholders. This exercise sparked much animated discussion over lunch and later in the day and indicated that in Kenya:

- Most CREs have a number of relationships with each other, government and donors, although some were not connected to coordinating bodies.
- In Kenya, there was some relationship between CREs and government. Some CREs were connected to several government structures (e.g. NACC, Ministry of Education (MoE), Ministry of Health (MoH), Children's Department).
- Donors in Kenya appeared to mainly work with government (through NACC) and did not seem to dominate this relationship.
- There was some interaction between the CREs present at the workshop and interfaith bodies, mainly CHAK, YWCA and DOSS.

[179] As noted in chapter 2, one of the limitations of this study, and this exercise in particular was the lack of focus on relationships with other NGOs.

A. Perceptions of Christian religious entities about collaboration

In seeking to understand the perceptions of CREs concerning collaboration, time was spent exploring their attitude towards government policy, government practice, and collaborative relationships with funders.

Interaction with Government Policy

The *Kenya National Aids Strategic Plan* (KNASP) was used as a basis for exploration of their perceptions of government policy with regard to the HIV and AIDS epidemic. At the beginning of the session the facilitator checked on the participant's familiarity with the KNASP policy document

Although all participants acknowledged familiarity, not all had actually read it, which meant that many of the responses were not coming from firsthand knowledge of the document. Nonetheless, there was **positive** agreement that the policy:

- Acknowledges the Three Ones as important for an effective response to the HIV and AIDS epidemic.

  The Three Ones is very important…it has made it more effective, people know what they are doing, know what the CBOs are doing.

- Makes a clear statement regarding the impact of HIV and AIDS and what needs to be done to mitigate its effect.
- Lays out clear goals, objectives and targets.
- Makes provision for co-evaluation and includes a M&E framework
- Seeks to involve a number of key stakeholders.
- Puts a number of structures in place: NACC: National AIDS Control Council, DTC: District Technical Committees, CACCS: Constituency AIDS Control Committees, ICC: Inter Agency Coordinating Committee in NACC, MCG: Monitoring and Coordination Group for each priority area.

Further, also important was the issue of the participatory nature of the policy development process. Many participants asserted that there had been involvement in this process by organs of civil society as well as 'grassroots' communities. There were two participants who had directly been involved in workshops leading to the production of the document. When asked by the facilitator if there was a general feeling that people had been adequately consulted, most responded in the affirmative, commenting:

…we own the document … it is ours.

However, it became clear later in the discussion that there was a general lack of familiarity with the document. Towards the end of this discussion, a contradictory discussion arose where some participants voiced a concern that few representative organizations were involved in the policy formation, and that there was a lack of participation from the 'grassroots'. This contradictory response was further demonstrated by the lack of response when the facilitator probed participants about how the document addresses the African context and related issues.

Two major areas of **weakness** in the policy document were identified:

- That the policy assumed KIRAC to be representative of all inter-religious organizations and participants felt this was a misrepresentation of the situation on the ground. “The whole perception that KIRAC represents the interfaith community is a mis-representation … it is referred to all the time like that, but [it is] not.” As a result of this assumption, they felt that problems arose around communication and support being channelled through this one structure.
- That the policy focuses on resource allocation without this being adequately linked to the national budget. Thus, it was felt, that the government is reliant on external funding which leads to gaps in service delivery.

It was noted by one participant that KNASP was not the only relevant document. Other policies such as the National OVC and HBC guides, Kenya Education Sector Strategic Plan, VCT National Policy, National Policy on Condom Distribution, and the Reproductive Health Policy were seen to be more helpful in determining particular strategies for areas of intervention.

Interaction with Government Practice

CREs appreciated the fact that there was a participatory approach to the work of government. As a result, they felt that there is a fair amount of networking with organizations. Important to the work of government was the fact that they recognised the need for information at a district level and invested time and resources into these programmes. Coordinating structures are in place which enable government to liaise with organizations. This resulted in an increasing sense of accountability in resource utilization by the NACC. What was particularly appreciated, was the rapid rollout of ART. This was seen as impressive with 180 000 people out of the 200 000 who need ART receiving treatment.

CREs did feel that there were negative points in government practice relating to the HIV and AIDS epidemic, mostly related to the bureaucratic nature of the NACC which made it difficult to pursue the Three Ones policy. This hampered resource allocation, and hindered open communication with the grassroots. They felt that there is poor implementation of monitoring and evaluation of programmes with channels of communication not being clearly outlined.

> The channels for providing information are not clear … we are happy to feed into the national system, but the problem is in the process.

Some participants felt it was unreasonable of NACC to expect CREs who do not receive national funds to nonetheless report to the national body. This was also related to the expressed concern that there were cases of corruption and incompetence in some parts of the national structures.

> … we have given accounts three times, we give them the documents and after three months they ask again. I have actually told my people to stop accounting, because you don’t know whether we are accounting for other organizations … we give receipts for expenditure, and we have accounted three times.

Furthermore, it was felt that there are inadequate strategies to address the most vulnerable group, namely women in the 25-39 year group. This related to the fact that budget allocation from government seemed to ‘lack conviction’ in the face of the magnitude of the epidemic. In addition, it was felt by some that the HIV and AIDS agenda is not driven by government but by the global donors. This was seen as another form of ‘colonial intervention’.

A key area of tension for CREs when working with government stakeholders was the emphasis on condom promotion as the main prevention tool. In the early years of responding to the epidemic, this issue clearly led to tensions between all religious entities and government.

> We were involved [in responding to the epidemic], but not in a way that the government or funders recognize … because of the condom issues … the government and funders viewed the churches as a stumbling block. The condoms became an issue [between church and government] in that same period [around 1999]. Because I remember, Catholics, bishops and Muslims went to [Urubad] to burn condoms ... in 1995-1996 … so donors and governments saw the church as a stumbling block, and yet we were doing our work, within our power ...[180]

While participants recognised that promoting condom use is an important aspect of prevention, they were clear that CREs themselves generally do not promote condoms as part of their main prevention strategy.

> We are promoting abstinence, but it does not mean we do not recognize condoms … but it conflicts with our policies, so even though we cannot do promotion, we can do referral. This strategy gives room for those who are able to do the work … for us to go around the issue …

There did, however, seem to be a growing consensus that in the case of discordant couples, condoms could be promoted in the counselling situation.

> … in the counselling sessions, correct information is given, and couples are allowed to make what our policy calls 'life-enhancing' choices … and if you are clever you will realize what this means … the couples have to do this for themselves.

Interaction with donors

Many participants acknowledged that having donors as collaborative stakeholders was invaluable, especially as they were increasingly recognising the importance of religious entities in mitigating the epidemic. They also acknowledged the substantial funding that had been given to their organizations over the years. They particularly valued long-term financial support from particular organizations which then enabled CREs to develop a long-term vision for their work. Several participants appreciated that technical support had been provided to build capacity within CREs.

PEPFAR and the Global Fund were recognised as being instrumental in bringing about great change for the better in HIV and AIDS service delivery carried out by CREs. They seemed relieved that these funders had recognised the role of abstinence with less focus on condom promotion. Furthermore, most felt that collaborative relationships were strengthened by partnerships that did not only involve funding, but included mutual sharing of resources, experiences, and ideas.

However, CREs felt that donors did not trust them, particularly in terms of financial management. This is demonstrated in the many instances of placement of their own personnel in project management. The participants also spoke of a perception that CREs lack capacity.[181]

[180] This is not only a past concern. Plusnews reports in 2008 that Muslim leaders in Kenya's North Eastern Province have resolved to actively preach against the use of and public promotion of condoms. PlusNews 2008d.
[181] See chapter 3, secondary literature demonstrates this broad perception that religious entities particularly lack capacity in technical, financial and administrative areas.

> They think FBOs have no capacity, they say these people have just done theology, they are not accountants
>
> The feeling that FBOs can't account for money is wrong …

Participants spoke strongly of a feeling of exploitation arising in some relationships, most notably in situations when particular donors collaborate to raise funds through the CREs for their own agenda and then abandon the original vision.

> Agencies when they are in need they come to us, but when they win, they leave you out.
>
> Yes, international agencies visiting FBOs to raise money for themselves, then you never hear from them again…we are very vulnerable.

Participants felt that often external agendas were forced onto local organizations and if they did not comply, financial support was withdrawn. Furthermore, agendas could change focus without warning and then so did the funding allocation. This was a source of frustration.

> One minute they are talking about a thing, and then they shift to another and do not even tell us - shifting themes, our agendas get driven from outside.
>
> (They) say what needs to be done and give no room for other options … they threaten to pull out if what they want is not allowed.

A further concern was the way funds often have to be utilized within a short time-period which inhibits long-term planning. This situation was exacerbated by the expectation of elaborate and frequent reports which consume energy away from the actual work in communities. In addition, CREs found that procedures for funding applications are often complicated and require particular skills which they did not have. This made it difficult to access funds.

CREs in Kenya are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. On the whole, the collaborative relationships between CREs and collaborative stakeholders (or partners) appear to be well balanced and successful. Participants spoke of the strengths being the clarity of the national policy around the Three Ones, the collaborative structures that have been established, and the increased funding for CREs.

The main weaknesses are perceived to be the lack of collaborative processes, the lack of representation in some forums, the lack of financial commitment from government, and the burgeoning bureaucracy especially around financial reporting.

4.2.4 Findings concerning the challenges and potential of collaborative partnerships between Christian religious entities and other stakeholders

<u>Finding 5:</u> Christian religious entities and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges such as competition amongst stakeholders, the dogmatism and conservatism of Christian religious entities, and their lack of capacity are balanced by a mutual appreciation of the strengths of each partner, and a shared desire to improve collaboration.

A number of key issues were raised in the workshops around the challenges and potential of partnerships.

(1) Asking the question, 'Is multisectoral collaboration happening in Kenya?' with the group of collaborative stakeholders resulted in a range of responses. Some felt that by virtue of the existence of KNASP, collaboration was taking place. However, the more general view was that collaboration was not taking place.

> We share out the resources … and then each goes their own way…each one runs their own programme.

It was further felt that resource allocation was divisive.

> Different interests … once you put resources in the middle, competition comes.

It was generally felt that while structures were in place to ensure collaboration, in practice it was proving difficult to implement.

> At large but it seems elusive … you have the structure … but no one implements … they do their own thing … it's a challenge.
>
> Because different sectors have their own mandate, collaboration around HIV and AIDS is an add-on.

(2) With regard to **inter-religious collaboration**, there was a feeling by some that this did seem to be working.

> … it is in place, there is synergy, people do what they do best.

However, others acknowledged that there were real weaknesses in this aspect of collaboration which was manifest in competition between different religious groups who push their own agendas.

> There is competition between the various interfaith collaborative structures and it is very difficult to include everyone.

A further issue was raised by collaborative stakeholders concerning the relationship that CREs had with their own regional Ecumenical bodies such as the AACC and the Ecumenical AIDS Initiative. They were seen to prioritise these relationships over their relationship with the Inter-religious Council of Kenya (IRCK). The IRCK representative had a refreshingly open attitude towards the limitations of the IRCK network and acknowledged similar weaknesses in this relationship.

> In Kenya we have a problem of duplication of collaborations over HIV/AIDS

(3) The greatest challenge to collaboration was the perception of collaborative stakeholders that CREs display an ethos of **dogmatism and conservatism**. This manifests itself through their patriarchal and hierarchical structures. More importantly, these participants felt that CREs' conservative ethos resulted in their unwillingness to deal with particular high risk groups, such as commercial sex workers.

> … challenge of working with the faith-based community working with vulnerable groups … don't see it changing in the near future.

However, it was also acknowledged that CREs placed a 'theological' emphasis on the poor which was the flipside of their conservatism. Perhaps most significantly, they felt that at times CREs were misrepresenting the epidemic as a result of 'inappropriate theological understandings'. Christian Entity participants themselves, as was discussed in the previous section, acknowledged that the issue of condom promotion continues to be a source of tension between them and other collaborative stakeholders. Their unwillingness to promote condoms does emerge out of a conservative theological position which suggests that this would encourage promiscuity.

(4) Issues relating to organizational structures and functioning was another challenge facing multisectoral collaboration in Kenya. Collaborative stakeholders saw the major weakness of CREs as the **competition** that exists between CREs. This leads to a lack of credibility within their own collaborative relationships. On the other hand, CREs perceived parts of the national structures to be corrupt. There was, therefore, scepticism among Christian entity stakeholders as to how these structures function organizationally.

(5) Collaborative stakeholders indicated that another key weakness of CREs is their **lack of capacity**.[182] They are seen to frequently operate with limited human and financial resources as well as with insufficient skills. This lack of capacity is manifested in their limited reporting to funders, leading to a lack of accountability.

> It is a chicken and egg situation, they don't have the capacity to do it, and they don't have the financial resources to build this capacity.

These problems were exacerbated by the over-emphasis on the 'spiritual' by CREs, rather than dealing with difficult programmatic issues. An example given was the fact that staff appointments were made on the basis of the person being a 'good Christian' rather than a 'good administrator'.

> They hold to a theological value that says the expression of faith is more important than skill.

Christian entity participants, however, saw this as a 'lack of trust' in their ability to deal appropriately with large sums of money. Collaborative stakeholders did acknowledge in this discussion that this 'theological valuing' did have a positive flipside, namely that it encouraged volunteerism. In addition, because of a theological commitment, often the work ethic of CREs is strong despite a lack of capacity. It was acknowledged that this was particularly true with regard to their substantial work with orphans and vulnerable children.

CREs and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges such as competition amongst stakeholders, the dogmatism and conservatism of CREs, and their lack of capacity are balanced by a mutual appreciation of the strengths of each partner, and a shared desire to improve collaboration.

[182] See Chapter 3

Finding 6: There is an obvious commitment to strengthening the partnership between Christian religious entities and collaborative stakeholders from both sides around the Three Ones policy. From the Christian religious entities there is a desire for greater participation of a range of stakeholders in formulating the implications of this policy as well as donor strategies. From the collaborative stakeholders there is a desire for a stronger commitment to the national M&E process.

Despite the challenges noted in finding 5, a great desire was expressed by both sides, for opportunities to improve collaboration.

A. Hopes for stronger collaboration: Christian religious entities

CREs were able to reflect on their hopes for stronger collaboration in three areas, namely: government policy, government practice, and with donors.

In terms of **government policy**, the following were identified as a way forward for multisectoral collaboration:

- Criteria for funding should be more specifically noted in the KNASP document.
- A clear and more detailed policy and strategy on OVCs should be developed (e.g. including free education, free healthcare, and access to basic necessities).
- More obvious voices from people living with HIV should be included in the strategy.

In terms of **government practice**, the following were identified as key issues:

- National coordinating structures should be strengthened.
- Public-private partnership policy should be developed and applied more consistently.
- There should be open forums to discuss policy review.
- Government should involve CREs as partners when they put their policies into practice.
- There should be greater interpretation and dissemination of KNASP to grassroots agencies in the HIV and AIDS epidemic.
- More coordinated events should take place in order to ensure equitable resource allocation and an effective M&E framework.

Christian entity participants were clearly aware of the importance of coordinated efforts to mitigate the epidemic, demonstrated by the high energy-level during this discussion.

In terms of **donors** the following was identified as a way forward for the future:

- There should be a forum to share strategic issues and agree on funding structures and accountability.
- Such a forum should also ensure that resource allocation is equitable and measured according to extent of service delivery.
- Genuine and mutual partnerships should be encouraged with mutually agreed agendas. Financial support should be channelled directly through CREs, rather than through global bodies.

We have dealt with the hopes that CREs have for collaborative partnerships with government and funders. Now we turn to the hopes expressed by these other stakeholders, of working with CREs.

B. Hopes for stronger collaboration: Collaborative stakeholders

Collaborative stakeholders also reflected on suggestions for a way forward in strengthening multisectoral collaboration.

They recognised the need for further dialogue and greater networking between all the stakeholders. This would also facilitate improved channels of communication in relation to information sharing. In order for there to be 'mutual ownership and partnership', there needed to be both 'functional and sustainable coordination' as well as a willingness by all parties to cooperate with one another. This could perhaps be achieved through a forum, as suggested by the CREs, that would ensure 'common evidence based goals' leading to a 'clear vision' of the collaborative relationship to be established. However, the collaborative stakeholders expressed strong concern that an effective forum would only be possible if CREs were willing to engage the national M&E processes (the third of the Three Ones).

There was some disagreement as to whether an additional forum was necessary. Some recognised the weakness of having all communication and resource allocation being channelled through one structure such as KIRAC, while others felt that KIRAC was effective and appropriate and therefore no further forum was necessary.

> In Kenya we need an agreed voice/structure of the faith-based sector.
>
> Kenya Interreligious Council is doing a fantastic job…we have a structure for now.

Nevertheless, an enormous amount of willingness was expressed on the part of government and donor stakeholders to strengthen collaboration with CREs. Also particularly impressive in Kenya, was the willingness of the representatives of key organizations who are seen to be drivers of collaboration (i.e. NACC, IRCK and KIRAC), to openly admit weaknesses in their organizations and listen to the other participants without defensiveness. The researchers felt that this open attitude was itself a strong force in enhancing multisectoral collaboration, and speaks of both the Kenyan collaborative environment, and the importance of having the right people or personalities heading these collaborative efforts.

The potential for future collaboration was further demonstrated by the positive comments in this regard during the closure session of the workshop with CREs. One participant said the following:

> I think that the conceptualization of the idea of having the faith organizations meet and also have this type of sharing of our experiences and what we are doing, and also trying to discover what the public sector thinks of what we are trying to do, and also of the facilitation, guided questioning which prompts us to think and reflect, to me is marvellous, to me this might be the first initiative of its kind - in the process of sharing we are learning from one another, and in this field of HIV and AIDS … getting to this point … that for me is a big beginning, it is a journey we are starting, and we are foreseeing what we could do, and look forward to the future.
>
> Before I came, I did not realize that as partners we had been doing certain things, towards the reduction of the prevalence of HIV and AIDS - we did not know to what

> others are doing, but through this process we have realized how much we are doing … and to think about how we can make our programs more realistic and relevant.

This enthusiasm was further demonstrated by the fact that participants at the CREs' workshop chose to meet for an extended period afterwards to continue discussing a way forward for their collaboration with one another.

It is clear then that both CREs and collaborative stakeholders are committed to the principle and practice of greater partnerships in the struggle against the HIV and AIDS epidemic, and in promoting Universal Access. They have expressed hopes for ongoing participation in the formulation of policies, as well as a common commitment to the national monitoring and evaluation process.

4.3 Recommendations arising from the research findings in Kenya

4.3.1 For the attention of the Christian religious entities

- Assess effectiveness of the various faith-based collaborative structures (e.g. KIRAC and IRCK) and restructure ensuring appropriate representation.
- Strengthen relationships with one another through establishing regular forums for dialogue and information sharing.
- Recognise culpability in hindering relationships with government stakeholders through conservative and dogmatic beliefs, particularly in relation to the condom issue, and be willing to compromise in certain instances.
- Strengthen the commitment to the 'one' monitoring and evaluation process, so that the work of CREs can have greater impact upon the national HIV and AIDS strategies.

4.3.2 For the attention of government

- Communicate the principles of the Three Ones more deliberately and engaging with the practice of CREs more effectively.
- Ensure better representation on coordinating structures used by government to relate to religious entities.
- Involve the faith-based organizations in ensuring that HIV and AIDS information is reaching grassroots communities.

4.3.3 For the attention of donors

- Establish a forum of representatives of all funding partners as a matter of urgency.
- Develop one set of monitoring and evaluating procedures.
- Recognise the importance of long-term relationships with other collaborative stakeholders.

4.3.4 For the attention of all

- Utilize the principles of the Three Ones as an entry-point for greater collaborative efforts.
- Ensure adequate representation in all coordinating structures.
- Establish regular regional forums for all collaborative stakeholders that enable ongoing dialogue, information sharing, and evaluation of strategic interventions.

Chapter 5

Malawi case-study

Chapter overview

This chapter provides a case study of the collaborative situation in Malawi. Firstly, it provides a brief overview of the religious-health landscape in this country in the context of the HIV and AIDS epidemic. It then presents the country-specific findings, followed by recommendations arising from the research.

5.1 Malawi country context

Country Information[183]

Geography: Located in Southern Africa, landlocked Malawi shares borders with Mozambique, Tanzania and Zambia, is 118,480km^2 in total.
Capital: Lilongwe
Language: Chichewa 57.2% (official), Chinyanja 12.8%, Chiyao 10.1%, Chitumbuka 9.5%, Chisena 2.7%, Chilomwe 2.4%, Chitonga 1.7%, other 3.6%.
Politics: Established in 1891, the British protectorate of Nyasaland became the independent nation of Malawi in 1964. After three decades of one-party rule the country held multiparty elections in 1994, under a provisional constitution which came into full effect the following year. President Mutharika, elected in May 2004, struggled to assert his authority against his predecessor, culminating in Mutharika starting his own party, the Democratic Progressive Party (DPP). Reported corruption, population growth, increasing pressure on agricultural lands, and the spread of HIV and AIDS pose major problems for the country.
Administration: 27 administrative districts. These districts all have traditional authorities, or former chieftains, who serve as the local government throughout the country.[184]
Urban Rural Split: The economy is predominately agricultural, with about 85% of the population living in rural areas.

Religion in Malawi[185]

~80% Christian; 13% Muslim; 5% traditional African religions; and 2 % Hindu or other faiths.[186] Major Christian denominations are Catholics(25%), Protestants(20%), and AICs(17%); groups like Evangelicals and Pentecostals are rapidly growing in Malawi, particularly in urban areas, and together account for about 32% of the country's Christians. Muslims comprise the majority in the South and Protestants dominant in the North.

[183] WHO-Afro 2006.
[184] UNFPA 2004
[185] Trinitapoli & Regnerus 2005
[186] UNFPA 2004

WHO Mortality Summary[187]	Year	Males	Females	Both Sexes
Population (millions)	2005	6.4	6.5	12.9
Life expectancy (years)	2004	41	41	41
Under-5 mortality (per 1000 live births)	2004	179	172	175
Adult mortality (per 1000)	2004	663	638	
Maternal mortality (per 100000 live births)	2000		1800	

Other Health Information	Year	%
HIV prevalence among adults (15 - 49) Both sexes	2003	14.2
Total expenditure on health as % of GDP	2003	9.3
Per capita expenditure on health at ave exchange rate $US	2003	13

Top ten causes of death all ages - Malawi 2002	Death (000)	Years Life Lost %
All causes	252	100
HIV/AIDS	86	35
Lower respiratory infections	29	13
Malaria	20	10
Diarrhoeal diseases	19	9
Perinatal conditions	8	4
Cerebrovascular disease	7	1
Ischaemic heart disease	6	1
Tuberculosis	6	2
Road traffic accidents	3	1
Protein-energy malnutrition	2	1

5.1.1 Religious-health landscape in Malawi[188]

A. The history of religious involvement in health

The arrival of Arab merchants and the British in Malawi brought with them Islam and Christianity respectively. Missionary David Livingstone is one of the pioneers of Christianity in Malawi. The early Christian missionaries not only spread their religion but also provided social services such as schools and hospitals. Christian churches grew quickly and, in some cases, were looked upon as vehicles for modernization.

> To this day, religion in Malawi, especially Christianity, has a strong service and development dimension. Christian churches and organizations in Malawi boast over 159 health facilities, 200 schools, numerous successful businesses, farms, recreational facilities and a myriad of churches. The clergy are respected and highly esteemed members of society.[189]

Churches in Malawi play a vocal role in matters ranging from politics and policy to health and development.

> Collectively, they have an infrastructure that is even more vast than that of the government, covering every district, town and village in the country, and functioning as a source of education, health, agricultural and financial information and service delivery.[190]

The HIV and AIDS epidemic has also spurred on religious involvement in health. Religious entities have been involved in the epidemic since its early stages, with religious leaders taking a vocal position (although not unmarred by controversy and failures in understanding the complicated nature of the epidemic and thus fuelling stigma and discrimination). However, as the 2004 UNFPA report notes,

> Faith-based organizations have come a long way since 1985 in helping to care for the spiritual, material and physical needs of those affected by HIV and AIDS. Moreover, this support is growing. In the last five years alone, at least 40 religious institutions have begun responding to the HIV and AIDS epidemic on a national and local level.

[187] WHO-Afro 2006
[188] Unless indicated otherwise, this summary is from Schmid et al 2008
[189] UNFPA 2004
[190] UNFPA 2004

> The potential to expand this support through carefully formed partnerships is enormous."[191]

It is, however, interesting to note that the UNFPA report continues to recognize that despite having a vast coverage and immense *potential*, the majority of 'FBOs' are concentrated in the South and Central regions "making HIV and AIDS-related efforts in the northern part of the country scarce*."*

There is little comprehensive information about the precise location of the AIDS-related work of religious entities, particularly the more community-based or non-facility based efforts that are not tracked through networks such as CHAM. A 2007 survey by CADRE suggests that in general civil society AIDS activities in Malawi are located mainly in rural areas.[192] However, an earlier UNFPA report states that the work of AIDS-engaged 'religious organizations' is said to be concentrated in urban centres, "in part because funds for HIV and AIDS projects are more readily available there."[193] Without comparative typologies or data, this issue cannot be resolved here. However, see 5.2.1 below for further participant discussion on this issue.

As an additional note, several reports have recently used Malawi as the example of a country where religious entities have been partially (yet significantly) responsible for positive behaviour change by promoting AIDS prevention through a variety of methods ranging from the relatively passive (such as inviting or allowing AIDS educators to address congregations), to the more active (such as using the prestige and moral authority of the religion to advocate behaviour such as fidelity or abstinence).[194]

B. Religious entities in the Malawian health sector (or system)

Malawi ranks among the world's least developed countries. It shares many of the same challenges as its neighboring states do. This includes a weakened health system and a variety of public health and development challenges ranging from a rampant HIV and AIDS epidemic, to the technical problems of a medical workforce crisis. The extremely high maternal mortality rate in Malawi can be seen as evidence of the lack of trained midwives and access to care by pregnant women.[195] Health service providers in Malawi can also be separated into the traditional and modern sectors, with a large number of people using the two systems simultaneously or consecutively.

TABLE 3.1 DISTRIBUTION OF HEALTH FACILITIES IN MALAWI, BY OWNERSHIP, 1998

	MOHP	Local Govt.	Other Govt.	CHAM	Firms	Private*	Total
Central hospitals	3	0	0	0	0	0	3
District hospitals	22	0	0	0**	0	0	22
Hospitals	1	0	0	22**	7	3	33
Mental hospitals	1	0	0	0	0	0	1
Rural Hospital	16	0	0	18	0	0	34
Urban Health Centers	8	0	0	0	0	0	8
Health Centers	193	11	33	88	36	10	371
Maternity Units	0	12		4	0	11	27
Dispensaries	45	3	5	13	83	76	225
Closed	2	0		0	0	0	2
Total	291	26	40	146	126	100	729
Percentage share (%)	39.9	3.6	5.5	20.0	17.3	13.7	100

Figure 5.1: Government of Malawi 2001

[191] UNFPA 2004
[192] Birdsell & Kelly 2007
[193] UNFPA 2004
[194] See Green 2003, Liebowitz 2002, Chand & Patterson 2007
[195] Dimmock 2008.

There are two main categories of *traditional health providers*: traditional healers dealing with diseases/spirits, and traditional birth attendants (TBAs). TBAs have more established links with the modern health sector, having been trained to support primary health care since 1992.[196]

Within the *modern health sector* there are three main health service providers namely; the public sector, non-profit private sector and the private-for-profit sector. The Ministry of Health and Population (MOHP) is the largest provider of public health services. The non-profit private sector comprises the mission sector grouped mainly under the *Christian Health Association of Malawi* (CHAM).[197] Secondary literature states that faith-based organizations and networks currently provide between 35-40% of health services in Lesotho.[198]

As can be seen in the table insert (figure 5.1 above), the MOHP has the largest number of facilities (39.9% of the total health facilities), followed by CHAM (20%).[199] Two specialist hospitals have been added to the CHAM membership since this table was produced: St John of God Mental Hospital and Cure Children's Orthopedic Hospital.[200]

5.1.2 The HIV and AIDS epidemic in Malawi[201]

HIV and AIDS Estimates[202]	Estimate
Number of people living with HIV and AIDS	900 000
National HIV prevalence among adults (ages 15-49)[203]	(2003) 14.2 (2005) 14.1
Adults aged 15 and up living with HIV	850 000
Women aged 15 and up living with HIV	500 000
Deaths due to AIDS	78 000
Children aged 0 to 14 living with HIV	91 000
Orphans aged 0 to 17 due to AIDS	550 000

A. State of the epidemic[204]

Malawi's HIV and AIDS epidemic is said to have *stabilized* with declines in some local areas.[205] Several urban areas, such as the capital Lilongwe, have witnessed a decline in HIV prevalence, although some rural areas have seen prevalence increase.[206] In 2005, approximately 14.1 percent of the adult population aged 15 to 49 in Malawi was living with HIV and AIDS - almost twice that of the overall rate for sub-Saharan Africa.[207] New estimates in Malawi place HIV prevalence for the 15-49 age group at 12.0%. "This implies that the universal access target of 14% HIV prevalence rate by 2010 as set in 2006 has since been achieved."[208] Nevertheless, with one of the highest adult prevalence rates in the world, the epidemic has

[196] GoM 2001
[197] GoM 2001
[198] Green et al 2002, UNFPA 2007, UNFPA 2004
[199] GoM 2001
[200] Dimmock 2008
[201] This report emerged as international epidemiological fact sheets were being updated. New figures are expected by August 2008
[202] Unless otherwise stated, these come from UNAIDS 2006a
[203] These surveillance stats from GoM 2007 M&E report
[204] This section acts as an introduction to the case-study to follow, and therefore not all HIV and AIDS statistics and issues are presented. See GoM 2007 for a more complete update of the Kenyan epidemic and national response
[205] UNAIDS 2007
[206] Avert 2008
[207] PEPFAR 2008, UNAIDS 2006a
[208] GoM 2007

exacerbated social problems. There is, however, some evidence of behavioural changes that could have reduced the risk of acquiring HIV infection.[209] Reports on the Malawian HIV and AIDS epidemic highlight a numbers of themes. These include the following:

The Malawian HIV and AIDS epidemic is multi-faceted: The AIDS crisis is one of a multitude of problems currently faced by Malawi. Other challenges that coexist are poverty, food insecurity and other diseases such as malaria. "Equally, efforts to strengthen the country's economy need to be coordinated with the fight against AIDS, as one of the most significant economic problems faced is the lack of human resources caused by AIDS deaths."[210] Malawi is one of the poorest countries in the world and is currently facing the triple threats of HIV and AIDS, food insecurity and poor infrastructure. The economy relies on agriculture and is highly vulnerable to weather conditions.[211]

It has been stressed that Malawi faces a **human resource crisis**, which is exacerbated by a high staff mortality rate caused by HIV and AIDS. This has created a lack of capacity to deliver health services, especially in rural areas, where primary health care has been compromised.[212]

Of increasing concern is the way the HIV and AIDS epidemic affects other health issues. For example, the high levels of HIV infection have resulted in an unprecedented increase in the number of tuberculosis cases, "which rose to over 27,000 cases annually in recent years. The disease burden is also exacerbated by endemic malaria, which affects up to four million people annually, the majority of whom are women and children."[213]

Location: HIV prevalence in Malawi is significantly higher in urban areas than in semi-urban and rural areas. However, there is evidence that while infection rates are slowing in urban areas, HIV prevalence continues to increase in rural areas. The southern region of Malawi is the most densely populated and has the highest prevalence rate among pregnant women.[214]

A gendered epidemic: In Malawi, women are disproportionately affected by the epidemic. In 2005, approximately 500,000 women 15 years and older were living with HIV/AIDS.[215] "The epidemic is increasingly developing a woman's face in Malawi, accelerated by inequitable power relations between men and women, young girls in particular."[216]

Government commitment: Several sources speak of the current Malawian government's high level of commitment to addressing HIV and AIDS.[217] However, others still place high-level commitment as one of the major challenges, saying there has been limited engagement of high-level political leaders in driving the response, compounded by a lack of clear accountability of roles for HIV prevention.[218]

High risk groups: "HIV prevalence among the high-risk groups namely teachers, female cross border traders, estate workers, the police officers, fishermen, truck drivers and female

[209] UNAIDS EU 2007
[210] Avert 2008
[211] WHO 2006b, Kaiser 2005
[212] WHO 2006b, PEPFAR 2008
[213] PEPFAR 2008
[214] PEPFAR 2008
[215] PEPFAR 2008
[216] NAC 2003
[217] See WHO 2005, Avert 2008, GoM 2007
[218] See UNAIDS 2006a

sex workers is above the national HIV prevalence with an exception of male vendors, among whom prevalence was found to be 7.0%."[219]

The ART programme has grown significantly over the years. "In 2003 only 3,000 persons with advanced HIV infection were receiving ART and in 2004 this figure rose to 13,183 when, with support from the Global Fund, Malawi started providing free ART. As of June 2007, a total of 114,375 persons with advanced HIV infection had ever started on ART."[220]

OVC: The National Plan of Action (NPA) on orphans and other vulnerable children (OVC) estimates that there are more than 1 million orphans and other vulnerable children in Malawi and half of these are due to HIV and AIDS. It has been observed that there are more orphans in urban areas than there are in rural areas, which is seen as a result of the high HIV and AIDS prevalence within urban areas as compared to rural areas. According to NAC, 14% of OVCs were supported with impact mitigation interventions in 2003/2004, 38% in 2005/2006 and 53% in 2006/2007. "This demonstrates that a lot of effort has been made by the Government of Malawi with support from civil society and development partners to provide support to OVCs."[221]

This provides only a brief snapshot of a broad and complex epidemic. We will now consider a listing of some of the significant events in Malawi's epidemic history.

B. Timeline of significant events in Malawi's AIDS epidemic

This timeline does not depict every AIDS-significant event in Malawi, but rather is an amalgam of events important to the participants, those listed in government documentation, and responses of participants in the questionnaire. It, therefore, contains events also important to the religious entities.[222]

1900s	Missionaries came to Malawi
1964	Malawian independence
1985	The first case of AIDS was diagnosed at Kamuzu Central Hospital in Lilongwe after which HIV prevalence grew quite rapidly
1985	The Government implemented a short-term AIDS strategy
1988	The Government created the National AIDS Control Programme (NACP) to co-ordinate the country's AIDS education and HIV prevention efforts
1989	Five-year AIDS plan was announced
1992	Political riots
1992	Pastoral letter on AIDS by Catholic bishops recognised as significant by participants
1993	Between 1985 and 1993, HIV prevalence amongst women tested at urban antenatal clinics increased from 2% to 30.5%
1994	Following protests and international condemnation, President Banda agreed to relinquish power and Malawi became a multi-party democracy. Freedom of speech was re-established creating a more liberal climate in which AIDS education could be carried out. New President Bakili Muluzi took office, making a speech in which he publicly acknowledged that the country was undergoing a severe AIDS epidemic and emphasized the need for a unified response.

[219] GoM 2007
[220] GoM 2007
[221] GoM 2007
[222] Sources: Avert 2008, GoM 2007, UNAIDS 2006a, WHO 2005, participant workshops

1996 First public celebration of World AIDS Day by Christian religious entities

1999 Formulation of the National Health Policy, 1999-2004

2000 The Government develops a National HIV/AIDS Strategic Framework (2000-2004) to coordinate the country's response to the epidemic.

2001 The Government forms the National AIDS Commission (NAC) which replaces the National AIDS Control Programme

2001 Malawi commits itself in the Abuja Declaration and Framework for Action for the Fight against HIV/AIDS, Tuberculosis and other Related Infectious Diseases in Africa, of 27 April 2001 and the United Nations General Assembly Special Session Declaration of Commitment on HIV/AIDS, of 27 June 2001

2002 Malawi suffered its worst food crisis for over fifty years, with HIV recognised as one of the factors that contributed most significantly to the famine[223]

2002 A report suggested that 70% of hospital deaths at the time were AIDS related[224]

2002 Interfaith Prayer event on AIDS recognised as significant by participants

2002 Malawi Poverty Reduction Strategy Paper (MPRSP) and HIV/AIDS, April 2002

2003 NAC led by the Minister of State Responsible for HIV/AIDS Programmes

2003 Establishment of Malawi Interfaith AIDS Association (MIAA)

2003 National HIV/AIDS Policy: A Call For Renewed Action. Office of the President and Cabinet, National AIDS Commission. October 2003

2003 National Policy on Orphans and Vulnerable Children

2004 Newly elected President Bingu Wa Mutharika launches Malawi's first National AIDS Policy. This policy set the goal of improving the provision of prevention, treatment, care and support services, and called for a multisectoral response to the epidemic.

2004 A Principal Secretary for HIV and AIDS was appointed within the Government.

2004 World AIDS Day recognised as significant by participants

2004 World Global Prayer Day on HIV and AIDS recognised as significant by participants

2005 The National HIV and AIDS Action Framework for 2005-2009 developed, which guided the national response for the period 2005-2009.

2005 Malawi finalizes frameworks to guide the scale-up of antiretroviral therapy. These include, a national HIV and AIDS policy, the Two-year Plan to Scale Up Antiretroviral Therapy for 2004-2005, a six-year human resource relief programme for the health sector, antiretroviral therapy guidelines and training materials.

2005 Formulation of OVC policy and national plan

2006 In 2000, Malawi was approved to receive relief under the World Bank programme for Heavily Indebted Poor Countries (HIPC). It reached the HIPC completion point during 2006.

2006 HIV and AIDS commemoration day recognised as significant by participants

2007 The development of the 2007 National Monitoring and Evaluation report

2008 World Health Day - call for more HIV and AIDS drugs

[223] Avert 2008
[224] Avert. 2008

C. Malawi's HIV and AIDS national policy:[225]

In the timeline above, it can be seen that several important AIDS-related government policy documents have emerged in recent years. These include policies and guidelines for community and home-based care, voluntary counseling and testing, prevention of mother-to-child transmission, antiretroviral therapy and treatment of sexually transmitted infections, and the care of OVCs. In the following section, which provides a brief outline of Malawi's HIV and AIDS policy, we focus on two documents, namely: the 2003 National HIV and AIDS policy, and the more recent National HIV and AIDS Action Framework 2005-2009.[226] (See box 5.1 below).

Box 5.1: Key elements of the Malawian national HIV and AIDS policies

NAC. 2003. *National HIV/AIDS policy: A call for renewed action.* Office of the President and Cabinet, National AIDS Commission. October 2003.

The goal is to prevent HIV infections, to reduce vulnerability to HIV, to improve the provision of treatment, care and support for people living with HIV/AIDS and to mitigate the socioeconomic impact of HIV/AIDS on individuals, families, communities and the nation.

The objectives

- Prevent HIV infections Improve delivery of prevention, treatment, care and support services.
- Mitigate the impact of HIV/AIDS on individuals, the family and communities.
- Reduce individual and societal vulnerability to HIV/AIDS through the creation of an enabling environment.
- Strengthen the multisectoral and multi-disciplinary institutional framework for co-ordination and implementation of HIV/AIDS programmes in the country.

Guiding Principles

- Political leadership and commitment
- Multisectoral approach and partnerships
- Public health approach
- Promotion and protection of human rights
- The greater involvement of PLWAs
- Good governance, transparency and accountability
- Scientific and evidence-based research

NAC, 2005. *National HIV/AIDS Action Framework.* Lilongwe: National AIDS Commission, Office of the President and Cabinet.

Eight priority areas defined in the NAF for the period 2005-2009

- prevention and behaviour change
- treatment, care and support
- impact mitigation
- mainstreaming, partnerships and capacity building
- research and development
- monitoring and evaluation
- resource mobilization and utilization
- policy coordination and programme planning

Also included as important are: high-level government commitment and leadership, the 'three ones' principle, multisectoral and multi-stakeholder partnerships, greater involvement of PLHIV, gender considerations and evidence-based interventions.

[225] Unless stated otherwise, all quotations in this section C come from the NAC 2003 and NAC 2005 policy documents under discussion.
[226] Participants did also mention the importance of the newer 2005 National AIDS Action Framework.

Some of the key issues emerging from these documents that are important to this research are:

Commitment to a multisectoral approach: The Malawian government's commitment to a multisectoral approach seems to have begun in 2000 and 2001, and reaffirmed in the 2003 and 2005 policies.

> Malawi has committed itself to the development and implementation of multisectoral national strategies and financing plans for combating HIV/AIDS that are resourced to the extent possible from national budgets without excluding other sources, inter alia, international cooperation … strengthen partnerships with civil society and the business sector and the full participation of people living with HIV/AIDS, those in vulnerable groups and people mostly at risk, particularly women and young people…[227]

A participatory process: Both the 2003 national policy, and the 2005 Action Framework were said to have been developed through a wide consultative process including "all the major stakeholders including civil society organizations, the public and private sectors, the media and people living with HIV and AIDS were all involved."[228]

> The government (through the National AIDS Commission) designed a policy development process that would be both participatory and consultative. It realized for the policy to be comprehensive, forward thinking, and widely supported throughout the country, multisectoral, multi-level participation from governmental, non-governmental, and civil society partners was essential. This would require providing sufficient opportunities for meaningful stakeholder orientation to and dialogue on a wide range of HIV/AIDS policy issues ... Meaningful stakeholder participation has resulted in a comprehensive policy that has wide support and greater prospects for successful implementation.[229]

Furthermore, the UNGASS 2008 report, and the 2007 national monitoring and evaluation report for Malawi state that there was "highly consultative and involved the participation of civil society, the public and private sectors and development partners."[230]

The Three Ones: Because these principles were only documented fairly recently, the concept of the Three Ones is only evident in the later 2005 National Action Framework. "In terms of operating structures, Malawi has fully subscribed to the UNAIDS principle of the Three Ones with the National AIDS Commission (NAC) as the national coordination body for the national HIV and AIDS response. Donors and implementing partners have accepted this and they also subscribe to one national monitoring and evaluation framework. There is also only one national action framework that provides a basis for coordinating with all partners."[231]

Existence of a national M&E plan: In line with the concept of the Three Ones, Malawi has instigated one national M&E plan. In the 2007 NAC evaluation, some challenges are noted:

[227] NAC 2003. See NAC 2008
[228] See Sanje et al 2004
[229] Sanje et al 2004
[230] GoM 2007
[231] GoM 2007

> … because of under reporting among stakeholders and differences in data requirements. For example, some donors and development partners include additional indicators for purposes of decision-making for their respective agencies and organizations and often such data is not available in the National M&E reports. The National M & E Plan however, encourages these diversities in order that those who collect data should find it relevant in decision-making and planning and hence improve delivery of quality services.[232]

Training in M & E was conducted last year mainly for those working in Government Departments and Ministries. This was conducted at district level and did not include civil society personnel.[233]

Religious and cultural awareness: The 2003 National Policy makes a strong statement on recognizing the importance of culture and religion.

> Cultural and religious practices further influence HIV/AIDS, governance and poverty. The population of Malawi is diverse in terms of language, religion and ethnicity. There are about nine indigenous ethnic groups, in addition to Asian and Caucasian groups. Moreover, the majority of the African population is Christian, while the Asian population is predominantly Muslim, resulting in a wide range of practices, some of which are detrimental both to development and to an effective HIV/AIDS prevention programme. For instance, certain traditional norms limit access of women to education, thereby increasing illiteracy, decreasing participation in governance and lowering their socioeconomic status.

The policy shows an awareness of Malawian cultural and religious contexts, recognizing that culture and religion have a strong influence on lifestyle and choices of its citizens.

The coordinating structures in Malawi:[234] The HIV/AIDS Unit within the Ministry of Health is responsible for implementing the health sector response to the epidemic. **The National AIDS Commission** was established in July 2001 to coordinate multisectoral implementation of the national response. The National AIDS Commission Statutory body falls under the office of the President and Cabinet. The Cabinet Committee on HIV/AIDS Prevention and Care provides policy and political direction to the National AIDS Commission.

- NAC is led by a multisectoral Board of Commissioners and assisted by a secretariat of over 70 staff.
- Other coordination structures include: (a) Principal Secretaries of the HIV and AIDS committee; (b) Multisectoral District AIDS Committees; (c) Civil Society Forums for International and Local organizations; (d) Umbrella Organizations for community-based organizations and small non governmental organizations at District level; (e) Interfaith Umbrella Organizations; (f) Country Coordination Mechanism; (g) Malawi Business Coalition Against AIDS. All coordination structures are represented in the National Partnership Forum.
- Donor coordination takes place through the HIV and AIDS Development Group.

[232] GoM 2007
[233] GoM 2007
[234] See UNAIDS-RSTESA 2006, WHO 2005, Birdsell & Kelly 2007

The recent evaluation by NAC states that the formation of the *National HIV and AIDS Partnership Forum* is key as it brings together "all stakeholders including international NGOs, L-NGOs, Government, private sector, CSOs, development partners (both bilateral and UN organizations) and organizations of PLHIV is another important development for Malawi as it ensures policy discussions at the highest level of collaboration."[235] With that in mind, we will now consider further themes around multisectoral collaboration that emerges from the literature.

5.1.3 A brief survey of the state of collaboration in Malawi

We will briefly consider some of the key issues emerging from secondary literature on the state of multisectoral collaboration in Malawi, that are most relevant to this research.

A. Collaboration with government[236]

As in Kenya, there appear to be different levels of collaboration between health-providing facility-based CREs such as those represented by CHAM, and those CREs who are grouped as part of 'civil society' and whose relationship is therefore managed mainly through NAC and its umbrella stakeholders structures.

Considering the former group, there are some indications that collaboration between CREs (such as CHAM) and the Malawian government is not as strong as it is in neighboring countries such as Zambia. There is, however, an memorandum of understanding (MOU) between the Government of the Republic of Malawi and CHAM, revised in 2002. This MOU is structured on the understanding that it is the Malawian Government's primary responsibility "to provide health services to the nation and CHAM's role is to complement Government efforts in line with Government policy."[237] Towards this end, the government undertakes to provide financial assistance to CHAM units.

Less is known of the level of collaboration between the other CREs and the Government of Malawi (hence this study), but a 2004 UNFPA study notes (in the context of HIV and AIDS),

> … most faith-based organizations and religious institutions involved in HIV and AIDS prevention and care feel that they have been marginalized to a large extent by the government and NGOs … (hindering) the formation of long-term partnerships. The result is that many faith-based organizations have carried out their work without due attention and recognition.[238]

We will engage with all these matters in the participant discussion below, see section 5.2.

B. Interfaith and ecumenical collaboration

Again, not enough is said in secondary literature of the state of interfaith and ecumenical collaboration around HIV and AIDS in Malawi. However, it is possible that the above feeling of marginalization from government and other civil society organizations has resulted in an interesting situation in Malawi where CREs engaged in HIV and AIDS are *primarily* working in partnership with other CREs. As the same UNFPA study says,

[235] GoM 2007
[236] This section is from the Schmid et al 2008 landscaping study
[237] GoM 2002
[238] UNFPA 2004

> … this has limited the funding that is available to them and kept their efforts out of international view. Some religious institutions have been able to tap funding from sister organizations abroad, usually within the same denomination. Those without international connections have been forced to raise funds from the meagre resources available within Malawi.[239]

Secondary literature also points towards limited *interfaith* relations around HIV and AIDS in Malawi - most evident in the lack of collaboration between CREs and the traditional health sector. For example, in 2004, only one CRE was noted as having activities which involved and targeted cultural leaders and traditional healers.[240] However, anecdotally, there has been improved interfaith collaboration, *driven* by the HIV and AIDS epidemic, and managed through bodies such as MIAA:

> … Christian and Muslim leaders in the Southern Africa country of Malawi have come together to address the problem of (the HIV and AIDS) pandemic … MIAA coordinates religious organizations dealing with HIV/AIDS issues and programs across the country. It currently groups 172 members from both the Islamic and Christian faiths ... Malawi's history of inter-faith relations indicates there was hardly stable relationship when it came to working together on religious matters.… Some donors have been impressed by the Muslim-Christian collaboration … "(says an OXFAM representative) this kind of collaboration between Christian and Muslim organizations is rare" … this according to MIAA … (is based on an increased) common understanding among various religious institutions…[241]

Not enough is yet known of the extent of representation in such interfaith initiatives, or how such collaboration translates into action.

C. Collaboration between funders

There is not sufficient information publicly available on the level of collaboration between donors or funding partners in Malawi around HIV and AIDS. This becomes especially complex in light of the variety and range of organizations providing support in Malawi (see list in section 5.1.5 below). What is known is that at a government level, donor coordination takes place through the *HIV and AIDS Development Group,*[242] which has been termed 'fully functional' by UNAIDS.

5.1.4 A brief survey of the state of funding in Malawi

> *Malawi's efforts to overcome poverty, AIDS and famine are heavily dependent on international donors, with international development assistance totaling around $400 million a year. In the past there have been concerns about political corruption and the mismanagement of funds in Malawi, problems that caused a number of donors to suspend support for the country in 2001. Since President Mutharika took office in 2004, vowing to take a zero-tolerance approach to corruption, these difficulties seem to have been reduced and international support for Malawi has increased.*[243]

[239] UNFPA 2004
[240] See UNFPA 2004. See below for an updated discussion on this
[241] Mnela 2007
[242] See Birdsell & Kelly 2007, GoM 2007
[243] Avert 2008

This research did not set out to provide a full funding breakdown for Malawi or for CREs in Malawi; however, in the surveyed literature, some themes emerge. Malawi is supported through a range of bilateral and multilateral funding agencies, as well as foundations, and other private donors. Such funds are either pooled in what is termed a 'functional basket' managed by NAC or termed as 'discreet'.

- Funds pooled in the functional basket coordinated by NAC (e.g. The Global Fund, CIDA, DfID). NAC disburses grants to NGOs, 'FBOs', private and public sectors.[244]
- Discreet funds (some still to the Government of Malawi, but outside of NAC): e.g. UNDP, CDC, USAID, NORAD, Clinton and Hunter Foundation etc (see 5.1.5 below).

According to a UNAIDS regional report, Malawi has greatly improved donor harmonization.[245]

Official development assistance for AIDS, 2000-2004[61]

US$ millions	Total bilateral ODA commitments for AIDS (2000-2004)	Total multilateral ODA commitments for AIDS (2000-2004)	Total ODA for AIDS (2000-2004)	Rank, overall ODA for AIDS (within sub-Saharan Africa)	ODA for AIDS per capita (US$)	Rank per capita ODA for AIDS (within sub-Saharan Africa)
Lesotho	5,370	18,840	24,210	31	13.49	12
Malawi	101,590	79,070	180,660	9	14.02	11
Mozambique	166,450	94,010	260,920	8	13.18	13
Namibia	59,030	35,820	94,830	14	46.70	1
Swaziland	4,340	33,080	37,420	29	33.09	4
Zambia	236,370	116,540	352,910	5	30.25	5
Total	573,150	377,820	950,970			

Figure 5.2: Source Birdsell & Kelly 2007

Although there are continued efforts towards drawing the national HIV and AIDS response together under the Three Ones (see above), NAC is not yet able to track all 'discreet' funding that happens in Malawi.[246] It is possible that this is particularly the case for CREs who frequently have historical funding partnerships with individuals and other religious entities.[247] In the 2007 national evaluation, it was stated that

> … all external development partners have endorsed the NAF… However, in terms of external development partners aligning and harmonizing HIV and AIDS programmes to the NAF, 60% have done so and effort is being made to achieve 100% alignment and harmonization… What seems to be preventing full alignment and harmonization by some external development partners are some of the requirements of funding and reporting to their respective governments and funding agencies.[248]

What is unclear is whether 'development partners' include the array of funding sources that CREs traditionally tap, such as funding which may not be *directly* classified as aimed at HIV and AIDS response, yet has that effect. Large-scale funding addresses the full spectrum of treatment, prevention, care and support. For example:[249]

[244] See UNAIDS 2006b, WHO 2005
[245] UNAIDS-RSTESA 2006
[246] See UNAIDS 2006a, GoM 2007
[247] See Chapter 3
[248] GoM 2007
[249] GoM 2007, PEPFAR 2008, UNAID 2006b, World Bank 2008 - see list in section 5.1.5 below for more funding partners.

- *The Global Fund to Fight AIDS, Tuberculosis and Malaria*: has so far approved grants of around $228 million to Malawi (since 2003). Among other things this funding has allowed the Malawian Government to implement its ARV treatment programme.
- *The President's Emergency Plan for AIDS Relief (PEPFAR)*: provides Malawi with around $15 million dollars annually. It has funded VCT, condom distribution and mother-to-child prevention programmes, amongst other initiatives.
- *The World Bank's Multi-Country HIV/AIDS Program:* Funding for HIV prevention and care activities includes a commitment of $35 million from 2004 through 2008 (including capacity building, education, and increased support for orphans and vulnerable children.)

This is only a small indication of some of the focus of funding partners. The WHO identifies three main areas of challenge: weak government capacity to coordinate increasing number of partners; lack of clarity of the role of partners and need for better coordination during decentralization and SWAp implementation; need to align multiple initiatives that require coordinated implementation amidst under-financing and critical human resource shortages.[250]

The following extract (Box 5.2) depicts some of the challenges felt by CREs within this funding context.

Box 5.2: MALAWI: Accounting for AIDS funding no small matter

LILONGWE, 14 May 2007: Smaller AIDS organizations in Malawi are in the spotlight after a recent move by the National AIDS Commission (NAC) to suspend their financial aid because many cannot account for the funds allocated to them. But community-based organizations (CBOs) have warned that the NAC's decision could jeopardise their efforts to curb the spread of the epidemic in a country with one of the highest HIV infection rates in the world. Over 30 CBOs have failed to account for money from the Global Fund to Fight AIDS, Tuberculosis and Malaria, distributed by the NAC.

Many CBOs who start local HIV/AIDS interventions have no experience of running an organization, and struggle to write funding proposals or report to donors. Organizations such as the Malawi Interfaith AIDS Association (MIAA), an umbrella body of faith-based organizations (FBOs), are calling on the NAC to assist them in managing their financial resources. Rev Francis Mkandawire, chairman of the MIAA's board of trustees, told IRIN/PlusNews: "We are aware that a number of organizations fail to account for NAC funds, but most of them do not really know how to properly write how the money was spent because they do not have receipts; but this does not mean that they have misused the money."

The donor community and bodies such as NAC, also had a responsibility to build the capacity of CBOs, pointed out Donald Makwakwa, programme officer for the Malawi National Association of People Living with HIV/AIDS (MANASO). "The organizations that are giving the money to the CBOs ... are not training them on how to manage the funds properly ... some of the people managing the funds have no knowledge of how they can account for them," he said … "I would like to call upon NAC to review their funding procedures. Most of our FBOs fail to access funds from NAC because their process takes too long. We cannot wait over five months to have the money from NAC even after the proposal for funding has met all the criteria. People are dying and we need to be on the ground to do the work," said Kettie Gondwe, an MIAA programme officer ...

Source: PlusNews 2007

5.1.5 The key players in the Malawian HIV and AIDS context

We provide here a listing of some of the key organizations that secondary literature shows are working in the Malawian multisectoral context. This is in no way a comprehensive listing.

[250] WHO 2006b

Collaborative networks or networking organizations:[251] Council for Non-Governmental Organization in Malawi (CONGOMA), Malawi Business Coalition Against HIV and AIDS (MBCA), Malawi Interfaith AIDS Association (MIAA), Malawi National Association of AIDS Support Organizations (MANASO), Malawi Network of People Living with HIV (MANET+), National Association of People Living with HIV and in Malawi (NAPHAM), National Association of People Living with HIV in Malawi (NAPHAM), Society of Women Against AIDS in Malawi (SWAM), Youth HIV and AIDS Network …

Multilaterals, bilaterals and major donors providing support to address Malawi's HIV and AIDS epidemic: [252] African Development Bank, British Council, Department for International Development (DfID), Canadian International Development Agency (CIDA), Caritas Internationalis, Clinton & Hunter Foundation, Danish Church AID, European Union, German Agency for Technical Cooperation (GTZ), Global Fund to fight AIDS, TB, and Malaria *(*GFATM), Japan International Cooperation Agency (JICA), Joint United Nations Programme on HIV/AIDS (UNAIDS), NORAD, Norwegian Church AID (NCA), Norwegian foreign ministry, President's Emergency Plan for AIDS Relief (PEPFAR), SWAP, Swedish Development Assistance (SIDA), U.S. Agency for International Development (USAID), Umovo Network (a consortium of Save the Children US, ADRA, Plan International, CARE international and PATH), United Nations (UN) agencies (FAO, UNAIDS, UNDP, UNFPA, UNICEF, WFP and WHO) through the UN Development Assistance Framework (UNDAF) and the World Bank, United States Centers for Disease Control and Prevention (CDC), World Council of Churches.

Christian religious entities engaged in HIV and AIDS: secondary literature does not provide a comprehensive mapping of CREs engaged in HIV and AIDS in Malawi. The work undertaken via desk review, as well as in the snowballing sampling process, helped to identify a wide range of CREs that are responding to health generally, and the HIV and AIDS epidemic in particular. A full listing is provided in Appendix 6.2. Please note, this listing is limited and does not capture every organization working in HIV and AIDS in Malawi. Several named here are networks or umbrella bodies that incorporate a number of individual religious entities or programs. Furthermore, some international organizations have local offices and therefore make categorisation difficult. It is our hope that this listing highlights the scope and range of AIDS-engaged religious entities in Malawi, and is a working document that can be utilized and developed further.

[251] NAC 2007, UNAIDS 2006a
[252] Kaiser 2005, GoM 2007, WHO 2006b, WHO 2005, World Bank 2008

Figure 5.3: Malawi CRE workshop - 2008

5.2 The findings of the research in Malawi

The participatory research process was designed to identify findings in four key areas:

1. Concerning the context in which Christian religious entities (CREs) are working
2. Concerning the work of CREs in the promotion of Universal Access
3. Concerning the strengths and weaknesses of collaborative partnerships between CREs and other stakeholders
4. Concerning the challenges and potential of collaborative partnerships between CREs and other stakeholders

Within these four areas, the participatory research process produced the following six findings in Malawi:

1. CREs in Malawi are proud of the role played by religious leadership in the social life of the country, but recognise that they have only recently begun to respond to the HIV and AIDS epidemic.
2. CREs in Malawi are committed to and involved in promoting Universal Access to Prevention, Treatment, Care and Support including education around abstinence and behaviour change, the provision of ART, home-based care groups and work with orphans and vulnerable children, and psycho-social support services. While the work is aimed at a wide range of beneficiaries, young people, women and rural citizens form the key target groups.
3. CREs in Malawi are acknowledged by collaborative stakeholders as having key strengths, namely, their reach to the grassroots, the resources they have at their disposal, and the

capacity of offer psycho-social support. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

4. CREs in Malawi are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the wide range of funders supporting work in Malawi, the willingness expressed in the national policy to engage with the religious sector, and good working relationships at local and district level. (2) The main weaknesses are perceived to be the lack of engagement by CREs at a national level with NAC and MIAA, competition and conditionalities around funding, and the lack of a common agreement on the efficacy of 'spiritual healing'.
5. Both the CREs and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges include differing belief and value systems, difficulties with adhering to monitoring and evaluation standards, the dissemination of information, adequate representation, funding conditionalities, and inter-faith collaboration. These challenges are balanced by an awareness of the potential for these partnerships amongst both CREs and collaborative stakeholders, given the commitment to the Three Ones policy.
6. There is a desire for stronger multisectoral collaboration in Malawi, without a further proliferation of initiatives. CREs desire a greater focus on local and district level initiatives. Collaborative stakeholders desire a greater commitment to collaborative planning, monitoring and evaluation. All parties hope for a greater focus on cultural and gender aspects of the epidemic.

5.2.1 Findings concerning the context in which Christian religious entities are working

<u>Finding 1</u>: Christian religious entities in Malawi are proud of the role played by religious leadership in the social life of the country, but recognise that they have only recently begun to respond to the HIV and AIDS epidemic.

In the participatory workshop with CREs, participants were asked to contribute to a communal time line that helped to map the history of their engagement in social life, and specifically in responding to the epidemic. The following information emerged from the timeline.

Clearly, the advent of multi-party democracy in the country in 1992 is a significant event in the lives of most of the participants. There is a strong recognition of, and appreciation for, the role played by the Roman Catholic Church in the emergence of multi-party democracy.

> It really affected us, we were in a broken situation, in a one party system…since 1964…so we remember it was one of the key moments, a turn of events, this relationship with religious events, the church united against political system…the pastoral letter of 1992 had an effect, for us the issue of transformation and change of events is a religious and political event.
>
> For a long time the nation was crippled by fear, everyone knew what was going wrong, and we were let loose by the courageous pastoral letter.

What is also evident is that the Catholic church continues to play a significant religious and political role in responding to the epidemic.

The movement from a one-party state to multi-party democracy created an environment where there was a greater visibility of NGOs, religious entities, and involvement of civil society in social issues. This environment also enabled the formation of organizations responding to HIV and AIDS.

CREs have emerged over a broad historical period in Malawi. While missionary activity began over a hundred years ago, it was during the 1960s that health-related CREs, such as Christian Health Association of Malawi (CHAM), were established. Most of the organizations responding to the HIV and AIDS epidemic were formed after 1999. Examples include: Kosi, Episcopal Conference of Malawi, Catholic Health Commission (ECM CHC), Private Schools Association of Malawi (PRISM), African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS (Anerela+), and Partners in Hope (PIH).

The presence of funding from global institutions such as PEPFAR and Global Fund has also had an impact on the formation of these organizations. However, participants were adamant that the response by CREs to the epidemic had already begun prior to the formation of these organizations and the availability of funding.

> … the response was already there…but the organization of the response took longer … facilities and programs were already there, but the organization took longer.

One participant felt funding played little part in their response, specifically because their work was not being recognised by international agencies.

> ... most of the local organizations have been struggling for funds, even if they are doing a lot of work on the ground, there is no credibility, their methods are questioned, in fact, there has been a response to need, but this has not been backed up by resources. After the government change, most of the civil society organizations are very local, and these local ones are really struggling, after surviving a decade on the ground.

However, another participant felt that the reason for the formation of organizations varied, and in some instances they were formed directly as a result of funding.

> It is a mixed bag. Some organizations have been formed because of resources … now everyone thinks they can form their own NGO.

There was some consensus that, generally, CREs were slow in responding to the epidemic. The first public reporting of a case of HIV infection was in 1985 while the first public celebration of World AIDS Day by CREs took place only in 1996. “It is only really in the 2000s that things started to happen”. Most participants admitted that their organizations were only beginning to think through their HIV and AIDS policy in relation to the National AIDS Policy. The exception was the Catholic Church which is in the process of ratifying its 2008 policy. This policy supports and extends the National AIDS Policy.

In summary then, CREs in Malawi perceive themselves to have a well established role in national and social life, and recognise that this must now include responding to the HIV and AIDS epidemic. They acknowledge that a concerted response has only been forthcoming in recent years.

5.2.2. Findings concerning the work of Christian religious entities in the promotion of Universal Access

<u>Finding 2</u>: Christian religious entities in Malawi are committed to and involved in promoting Universal Access to Prevention, Treatment, Care and Support including education around abstinence and behaviour change, the provision of ART, home-based care groups and work with orphans and vulnerable children, and psycho-social support services. While the work is aimed at a wide range of beneficiaries, young people, women and rural citizens form the key target groups.

The work undertaken via desk review, as well as in the snowballing sampling process helped to identify a wide range of CREs that are responding to the HIV and AIDS epidemic (see Appendix 6.2).

Whilst not each and every entity noted here is equally involved in all aspects of Universal Access, it is clear that taken as a whole CREs in Malawi perceive themselves to be involved in Prevention, Treatment, Care and Support, as well as some 'Other' tasks. Asking the Christian Entity participants to depict and describe the three 'main' areas they were each involved in HIV and AIDS work, the following basic table was derived:[253]

Prevention	Treatment	Care	Support	Other
ECM	ECM	ECM	SUM	ECM
KOSI	SDA	CHAM	KOSI	PIH
ELDS	PIH	ELDS	ELDS	ANERELA
WRM	CHAM	WRM	WVM	CHAM
PIH	*Word Alive*	WVM	CHAM	EAM
LISAP		SDA	TSA	SDA
WVM		EAM	ANERELA	ECC
EAM		LISAP	WRM	*Word Alive*
ANERELA		TSA	LISAP	
CHAM		*CRWC*		
TSA				
SCOM				

Figure 5.4: Depiction of participatory exercise, Malawi 2008

A. Prevention

The most predominant activity is education and awareness work, particularly amongst the youth. Messages seem to focus on abstinence and behaviour change, although World Vision and Scripture Union also include life-skills training in their prevention programme. The Salvation Army has notably specifically targeted Traditional Healers in its prevention programmes. All are expected to promote the ABC (abstinence, be faith, correct and consistent condom use) approach. But an agreement was made in 2005 through the state-faith dialogue that Government would not force the faith community to distribute condoms. Conversely the faith community was expected not to condemn condom use for HIV prevention. Responses by some participants indicated that they would encourage condom use in the case of discordant couples. ANERELA seemed to be the only exception given that their broad message included the use of condoms.

> We use the SAVE message ... enhancing the ABC… [Our approach is that] not all condom use is immoral; many who abstained are now positive because they did not know the status of their partner; not all who are faithful are negative because their

[253] See Appendix 1 for acronyms. Those in italics in the table above did not have representatives at the workshop, but were added by fellow participants.

partner is unfaithful. The SAVE message of ANERELA: Safer sexual practices; Access to medication: Voluntary testing and Counselling; Empowerment education.

It was noted that a 'Mutual Faithfulness' (MF) national plan of action is in place which seeks to address one of the key drivers of HIV in the country, which is multiple sexual partners-vs-partner reduction.

B. Treatment

CREs in Malawi play a crucial role in the provision of anti-retroviral treatment (ART). Three organizations are particularly significant in this regard namely, CHAM, Seventh Day Adventist (SDA, and ECM. CHAM's network provides up to 40% of healthcare in Malawi, and about 20% of the provision of ART.

C. Care

Almost all the participants present at the workshop indicated that they were involved in two activities involving care:

- The home-based care networks which provide opportunities for assisting PLWHA.
- Care for orphans and vulnerable children.

Of note is World Vision which has established 'Community Care Coalitions' that are involved in training and mobilising communities to be involved with care of those living positively with HIV.

D. Support

CREs are involved in a range of 'support' activities for people living with HIV and AIDS, and particularly for OVCs and grandmothers caring for children. These activities include:

- Ensuring food security through the establishment of gardens
- Material support in the form of food
- Micro-credit support
- Income generating activities
- Psycho-social support

E. Other

The key other aspects that CREs are involved in are:

- Radio Programmes that broadcast HIV and AIDS prevention messages
- Advocacy work through organizing forums to which CREs are invited
- Capacity building and resource mobilisation

F. Beneficiaries

In promoting Universal Access to Prevention Treatment Care and Support, CREs work with a wide range of beneficiaries.

Participants felt that they worked with beneficiaries across all **age** groups but probably predominantly with young people in the 15-24 age group. In terms of **gender**, they recognise that it is crucial to work with men but acknowledge that most of their work is with women. In terms of **location,** participants felt strongly that most of their work was carried out in rural areas and that government recognised this aspect as a key contribution they were making to mitigating the epidemic.

The participants were asked for their response to the findings of a 2004 UNFPA report that stated that in Malawi, the majority of 'religious institutions' are concentrated in the South and Central regions, that HIV and AIDS efforts in the northern part of the country are scarce, and that the work of these religious organizations are concentrated in urban centers where funds are more readily available.[254] All participants rejected these findings and indicated that they might apply to Christian NGOs, but not to churches as local communities of faith. In fact, some argued that,

> ... there has been an outcry that the urban is being neglected, so a deliberate movement to get into the urban areas … from program assessment people.

Nonetheless, it was recognised that in Malawi, the poorest of the poor live in rural areas and still have difficulty accessing services. This could be related to a poor road and transport system, but was also seen partly as related to cultural taboo and traditional practices.

> It also has something to do with literacy levels, in very rural areas where the poorest of the poor live, when the sick comes, they still run away … around VCTs they run away … they say blood suckers have come.

CREs that are not local churches felt that in some instances people rejected their services in favour of 'denominational interests'.

Some suggested that CREs in Malawi are to a large extent not engaged in inter-faith interventions even though the Malawi Interfaith AIDS Association (MIAA) was established for this purpose. Others felt that this was happening at grass roots level, more than at national level.

When probed about their relationship with the traditional health sector, it became clear that there are few established initiatives that actively seek to work with traditional health practitioners. .

> We try to work with traditional healers and leaders, consciously and purposively…in reality it doesn't work out that good.
>
> We distinguish between traditional healers, traditional leaders, and traditional religious leaders - traditional leaders, no problem … traditional healers, there is resistance from FBOs because their practice is not altogether Christ-like … traditional indigenous religious leaders, the mainline churches are not making a deliberate effort to work with them (although I stand to be corrected) … because that would compromise their faith … the only point of working with those people is with the traditional leaders.

[254] UNFPA 2004

> Indigenous religious leaders - traditional ones - are not as influential in society as they used to be, so when you are working with traditional leaders, you are working with someone who still has influence … so we work with them … our target is children and youth, but they come from villages and parents, so we still meet with traditional leaders … so these people who are custodians to tradition, know who we are. When we sit down and talk about these issues, it works very well. The religious leaders are very scarce now, there are places where you can't even find traditional religious leaders … they shy away.

As was noted earlier, the one evident exception was the Seventh Day Adventist Church,

> For example in our programme in areas like Nsanje where acknowledged cultural practices are driving the epidemic, there is a deliberate approach to get traditional leaders to influence their culture and influence the other two groups and their subjects.

It was noted by the facilitators and is obvious from the above discussion that participants held strong negative convictions concerning inter-faith work.

In summary then, CREs in Malawi are committed to and involved in promoting Universal Access to Prevention, Treatment, Care and Support. Prevention activities focus on education around abstinence and behaviour change. In terms of treatment, CHAM provides 20% of the ART delivery in the country. In terms of care, the focus is on home-based care groups and work with orphans and vulnerable children. There is a range of support services including food security, micro-credit and psycho-social support services.

While the work is aimed at a wide range of beneficiaries, it seems clear that young people, women and rural citizens form the key target groups. There is quite a bit of uncertainty around inter-religious cooperation.

<u>Finding 3</u>: In their contribution to Universal Access Christian religious entities in Malawi are acknowledged by collaborative stakeholders as having three key strengths, namely, their reach to the grassroots, the resources they have at their disposal, and the capacity of offer psycho-social support. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

As discussed in chapter 3, religious entities are seen to have key strengths that can be leveraged in the HIV and AIDS epidemic. In the introduction above, we further presented some of the assets religious entities are said to hold in the Malawian health system. While this particular study did not focus on identifying the specific assets of CREs that can be leveraged towards providing Universal Access (for example, the number of facilities held or patients served), this was nevertheless clearly demonstrated throughout the discussion, in the organizational documentation collected through the desk review and through the questionnaire response.

A. Perceptions of collaborative partners with regards to the work of Christian religious entities

When representatives of other stakeholders such as government, donors and other religions were asked to reflect on the work of CREs they identified three major areas of strength.

(1) The first related to the **reach** of CREs, particularly in the rural areas. It was felt that they were one of the few organs of civil society that were accessible to and trusted by 'grassroots people'. Their leadership is hardworking and committed and furthermore, they were in contact with large numbers of people within close proximity to their sphere of influence.

(2) The second area of major strength lay in their **resources**, both human and material which are plentiful through their large national and international networks.

(3) The third area of strength lay in their **capacity to offer psycho-social support** through counselling, home-based care, and their work with OVCs.

CREs in Malawi are acknowledged by collaborative stakeholders as having these three key strengths. They represent vital assets that are essential to strengthening multisectoral collaboration in the promotion of Universal Access.

5.2.3 Findings concerning the strengths and weaknesses of current collaboration between Christian religious entities and other stakeholders

<u>Finding 4:</u> Christian religious entities in Malawi are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the wide range of funders supporting work in Malawi, the willingness expressed in the national policy to engage with the religious sector, and good working relationships at local and district level. (2) The main weaknesses are perceived to be the lack of engagement by Christian religious entities at a national level with NAC and MIAA, competition and conditionalities around funding, and the lack of a common agreement on the efficacy of 'spiritual healing'.

Through the desk review and the snowballing approach to the identification of participants for the workshop it was clear that CREs are involved in a range of collaborative partnerships. (See section 5.1.5, Appendix 6.2 and Appendix 5.3 for the selection of key collaborative stakeholders identified by advisors in Malawi).

In a rough typology, these included: government bodies and structures, national AIDS coordinating mechanisms, international donors (a full range from large internationals to individuals), interfaith bodies or networks, national faith-based health networks (NFBHNs), denominational bodies, other NGOs, other CREs.[255]

This was confirmed in an exercise carried out with CRE participants during which they had to draw a 'spidergram' showing their relationships with one another, other faith-based organizations, government, and with donors. This exercise sparked much animated discussion and was embraced enthusiastically. Participants engaged in critical dialogue with one another. The exercise uncovered a number of key issues:[256]

- There are an enormous numbers of diverse funders (at least 22 were noted) within such a geographically small country.

[255] As noted in chapter 2, one of the limitations of this study, and this exercise in particular was the lack of focus on relationships with other NGOs

[256] Note that this only speaks of the relationships between the participants and a few other key partners they choose to include in the exercise. Furthermore, unlike Kenya, the MIAA representative attended the collaborative stakeholder workshop, so was not present to represent MIAA in this exercise.

- There were few funding relationships *between* the local CREs present at the workshop.
- CHAM was the only organization present at the workshop that raises funds on behalf of others.
- CHAM was the only organization present that was in relationship with many of the other organizations.
- All CREs relate to NAC, but few have formal relationships with one another.
- All funding from NAC is channelled through MIAA to the participant organizations. MIAA does not receive funds for dispersal at the moment, as this role has been suspended. MIAA recommends to NAC for funding of organizations.
- CREs did not report a strong relationship with MIAA.

In discussion, the participants identified the large number of donors as a problem both for their relationships with one another and for the long term sustainability of their projects.

> … we have a problem … if the Christian organizations don't fund other Christian organization. … What if the donors get tired of us? … 5 years back the red circles [i.e. those representing donor relationships] would have been more. These have stopped, got tired and left us … so what would happen if the others stopped too?
>
> The majority of these FBOs are not indigenous … they have links to the first world, and the first world dictates, if you indicate such things your proposal is stopped. We wanted to become a member of CHAM, but CHAM wanted us to be a church … and we are not … the criteria limits how you can collaborate or join. NAC will tell you, you have to operate along these lines and you have to do what they tell you to do.

There was also a general feeling that funding was not reaching projects at the grassroots level because NAC was the centralised conduit and this structure was not accessible to this group. Adding to this problem was the lack of strong relationship with MIAA who receives the funding for dispersal from NAC. Despite their recognition that as a group they had a large funding base, financial constraints still dominated their agendas.

While engaging in the exercise enthusiastically, there were no clear strategies as to the way forward in improving collaboration amongst each other.

While the facilitators noted that there was no opportunity to map their relationships with non-governmental organizations, it was pointed out by the participants that many were in relationships with universities carrying out research projects. These relationships were often fairly long-term and imbued with large financial grants. There was general agreement that this often created unnecessary competition amongst each other, particularly in relation to staffing issues.

A. Perceptions of Christian religious entities about collaboration

In seeking to explore the perceptions of CREs about collaboration, time was spent exploring their understanding of government policy, government practice, and collaborative relationships with funders.

Interaction with Government Policy

The 2003 Malawi National AIDS Policy was used as the basis for discussion on views relating to government policy. Most were aware of the document, but few seemed to have read it or

were familiar with its contents. There was a resistance to discuss the policy document without having being alerted before the workshop giving sufficient time to prepare a response. There was great sensitivity to this matter and it was finally agreed to discuss only the section on Religious and Traditional practices and services (see box 5.3 below).

Box 5.3: Excerpt from Malawi National AIDS Policy utilised in Christian Entity workshop

Religious and Cultural Practices and Services

Rationale: Religious groups have an important role to play in promoting behaviours that reduce the risk of HIV infection, such as abstinence before and faithfulness within marriage, and the use of VCT prior to marriage and during marriage reconciliations (after divorce or separation). These groups can also provide care and support for PLWAs. However, certain religious practices, such as refusal to seek medical care and treatment or belief in miracle cures, increase vulnerability to HIV infection.

Policy Statements: Government, through the NAC, undertakes to do the following:

- work closely with religious leaders to facilitate the provision of accurate HIV-related prevention information and education, as well as care and support for PLWAs.
- sensitize religious leaders to HIV/AIDS and discourage them from making false claims of miracle HIV/AIDS cures. *NAC 2003*

The discussion indicated that CREs were supportive of the contents of this section of the policy document and felt that the facilitator was interpreting it in a way that cast religious leaders in a negative light.

> My response is VERY positive … I have problems that you read it in a critical way … of course there are differences … but it is a positive approach … we won't fight each other, we work in partnership.

Despite the earlier discussion which indicated that CREs were not working with traditional healers, but only with traditional leaders, participants indicated that they were positive about the recognition of cultural practices in the document. One participant stressed the importance of this recognition,

> We've been writing the HIV and AIDS policy of ECM … we've acknowledged that Catholics … everyone is double-faced … they are coming to church, but have roots in culture … we need to relate to that in our fight against HIV and AIDS … we can't leave that separate in our fight against HIV and AIDS.

The discussion on healing and 'miracle cures' proved controversial.[257] Many participants felt that it was important to acknowledge that God could heal people from HIV infection, and in fact had done so. This was tempered by another participant who confessed his positive status and argued that healing is more than physical; it included spiritual and emotional healing.

> There is all sorts of healing … I have been emotionally and spiritually healed, but am still HIV/AIDS positive … I do not have to doubt God even though I am taking ARVs … should not say that those who are HIV positive are not believers.

Yet another declared,

> We have realized, in our policy … there are still taboo … in our marriage counselling we still leave out HIV/AIDS sometimes … we have not been able to talk about it … we

[257] See chapter 3 for more on this discussion

> have not been able as a church, to co-ordinate … to discuss what are our standards, in some cases there were some churches who say that if you pray you will be cured - some have spoken of miracle cures … the policy should state clearly otherwise.

Furthermore, it was felt by some that they, as religious leaders, were not seen by government to be key stakeholders in mitigating the epidemic.

> That's where the policy lacks - it takes the religious leaders or FBOs as an annex to the solution of the problem, but if you look at ABC, that is a Christian principle … to be solidly founded on Christian principles would be a good thing.

Interaction with Government Practice

Overall, Christian Entity participants felt positive about the political will of government in dealing with the epidemic as expressed through the National AIDS Policy. Furthermore, they were seen to be seriously engaged in the roll-out of ART and offering technical support when necessary.

However, responses in this session seemed to contradict what participants had indicated earlier with regard to their collaborative relationship with government. Many felt that this partnership is strong and there is recognition of CREs in mitigating the epidemic. This partnership included the sharing of resources and information and collaborative consultations. In the previous two exercises participants were suggesting otherwise, particularly in relation to access to funding and with regard to how they were perceived by government stakeholders. One way of understanding the contradictory response is that perceptions vary at different levels of government. At a District level in rural areas, CREs do enjoy a good relationship with government and in many instances their leaders are members of district committees. In addition, as was argued by participants earlier, local communities of faith are often the only organized structure in rural areas through which government can facilitate programmes.

> The initiative of the government to dialogue with the church is very positive, their initiative … but that needs to grow, and not just using the church … there needs to be a mutual partnership…

But the dialogue does indicate that the issue of values and belief systems was seen as a stumbling block.

> Although there are big efforts to sit down together, we have not yet appreciated each other's values … and so that is why we still have the negatives … what we need is that mutual understanding where we as the faith-based can be [clear] about our values and standards … so we can be complementary to each other.

The issue of condoms has clearly been a bone of contention and continues to colour how CREs experience their collaborative relationship with government.

> ... if we say we are very strong in A & B, we should not be forced to go and do C … when they come and do their C part, we should say they are complementing our A and B part, especially when it comes to youth, children and married people.

As was the case in the discussion about work with traditional healers, the conversation turned to a conservative theological position that sets CREs apart from other collaborative stakeholders, including government.

> The pandemic, HIV and AIDS, is more of a spiritual problem, not a scientific problem … NAC has a scientific focus … but in fact everything has a spiritual aspect … we think of HIV/AIDS as a virus, but everything that man is encountering has a spiritual side to it. The condom is a spiritual issue, abstinence is a moral issue.

Furthermore, the participants felt that it was unhelpful for government stakeholders to make blanket statements about CREs. This was particularly so because they felt 'used' by the ad hoc way in which CREs were drawn into government programmes.

A particular concern with regard to government practice related to their bureaucratic structures which implemented stringent conditionalities in accessing funding. Government's focus on "managing funds" detracted from what they saw as government's prime role, namely "to manage the epidemic". Because of their structures and conditions, resources were not reaching the grassroots speedily as there were long procedures and delays in responding to urgent needs.

> What is there practically, while the system is supposed to be that way, centralization, the experience is that it is not as effective as it is supposed to be [general agreement] … .there are many, many issues such as capacity in the FBOs, capacity at a district level, DAC, it is overwhelming for many of the districts. One of the meetings NAC was saying we want to coordinate with you … if the centralization was working very well, they would not have to send us a form to fill in every quarter.

Interaction with donors

CREs were appreciative of their partnership with donors because of their willingness to assist and fund programmes and for the fact that this relationship was flexible. This flexibility enabled a more timely response to urgent needs. In addition to financial resources, participants valued the capacity building opportunities offered by these partnerships as well as the technical expertise they gain.

Having said this, participants once again reiterated their frustration that donors always set the agenda for action. CREs often feel 'dictated to' and feel at times there is an inability to appreciate 'local realities'.

> ... when the developed world gathers to decide what happens … they are so rigid … developed by the brains of the developed world, they have put one goal for themselves, and seven for the developing world, I am just expressing a frustration.

Conditions and expectations from donors are in some instances seen as a burden. The participants highlighted the need for greater coordination between donors themselves which would ease the differing expectations placed upon CREs.

> ... the donors should move out of this way of doing things … they are not networking at the donor level … and this is trickling down and creating competition and fighting, and one organization is saving one community and funded by one donor … and this lack of networking, this fighting is beginning to create problems.

Intensive discussion amongst the participants at both workshops suggests that CREs in Malawi are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. Furthermore, these partnerships are perceived to

have a number of strengths and weaknesses. The main strengths are perceived to be the wide range of funders supporting work in Malawi, the willingness expressed in the national policy to engage with the religious sector, and good working relationships at local and district level.

The main weaknesses are perceived to be the lack of engagement by CREs at a national level with NAC and MIAA, competition and conditionalities around funding, and the lack of a common agreement on the efficacy of 'spiritual healing'.

5.2.4 Findings concerning the challenges and potential of collaborative partnerships between Christian religious entities and other stakeholders

Finding 5: Both the Christian religious entities and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges include differing belief and value systems, difficulties with adhering to monitoring and evaluation standards, the dissemination of information, adequate representation, funding conditionalities, and inter-faith collaboration. These challenges are balanced by an awareness of the potential for these partnerships amongst both Christian religious entities and collaborative stakeholders, given the commitment to the Three Ones policy.

The discussions in both participatory workshops highlighted the following concerns around the challenges to partnerships.

(1) While discussion in both workshops highlighted the general lack of meaningful collaboration, all participants seemed to agree that it worked best at district level. It is as this level that government stakeholders acknowledge the significant contribution of CREs. Likewise, it is at this level that CREs feel most positive about government practice.

However, there are clearly ongoing overt tensions between CREs and government stakeholders in areas such as condom promotion and monitoring and evaluation procedures. As was noted in finding 4, CREs reject government assumptions concerning their promotion of 'miracle cures' as well as their emphasis on condom use. On the other hand, collaborative stakeholders identified 'conservatism' as one weakness of collaborative relationships with CREs. This is expressed as differing belief systems and values by both parties.

> We have different backgrounds with different beliefs … and sometimes not easy to come together.

Collaborative stakeholders also experience their conservatism as expressed by a resistance to change and an unwillingness to adopt new approaches. They perceive that CREs tend to be inflexible in their attitudes, and this hinders collaboration.

> The church is not running with the time, the government has decentralized, but the church has not.

(2) Furthermore, collaborative stakeholders acknowledge with concern that there is limited female representation of CREs at collaborative forums. In the discussion with CREs about who benefits from their services from a gender perspective, they acknowledged that most of their programmes were created by men for a largely female audience. This poses a further challenge to collaboration.

(3) While collaborative relationships between government and CREs seem to operate best at a district level, both groups also acknowledge that there are problems at this level. Government stakeholders feel that CREs lack capacity at this level which is one reason why monitoring and evaluation procedures are not adhered to. On the other hand, CREs have indicated the inadequacy of communication filtering down to the grassroots. This reality was acknowledged by government stakeholders who suggested that this could be remedied by strengthening the district implementation plans (DIP) and ensuring that report back sessions of the findings of Annual Reviews take place at a district level.

(4) A further challenge relates to representation. Government stakeholders and CREs both acknowledge that representation at the collaborating forums is often not balanced and representative of all stakeholders. Government stakeholders see this as a result of a lack of clear guidelines on representation.

> Sometimes representation is haphazard…with inconsistent representation.

On the other hand, CREs feel that because MIAA was set up with government funds as a coordinating and representative body without adequate consultation, problems exist in collaborative efforts. Many are at best in an informal relationship with MIAA and at worst have no relationship at all. Clearly several CREs feel resentful or at least disinterested in the fact that this body is seen to be their representative and yet they had little say in its inception.

(5) Funding continues to evoke strong feelings in both parties. However, there seems to be little sympathy for one another in the particular challenges each face with regard to funding.

Government stakeholders pointed out that there is an unpredictability of funding levels and timing from international donors which makes planning collaboration difficult. They further find it difficult that certain CREs receive funding directly from their own national and international networks. This often means that their outcomes are not reflected in the national reporting mechanism, as they do not feel any obligation to report to this body because they are not being funded through the national funding mechanism.

> They feel they don't have to [feed into the national M&E framework].

CREs, on the other hand, experience a great deal of pressure from their donors with regard to reporting procedures which often differ from donor to donor. They often find themselves in the position of having to spend so much time in monitoring and evaluation procedures that they have little to time "to get on and do the necessary work".

(6) A further challenge relates to inter-faith collaboration. It was noted by collaborative stakeholders that CREs isolate themselves from other faiths. This was evidenced in the discussion with CREs on which other religious communities benefit from their services. Their collaborative stakeholders felt that the different religions had different approaches in their programs and because there was poor communication between religious entities, this hindered a collaborative approach to planning. Collaborative stakeholders raised a concern about a lack of engagement with Traditional Healers by all stakeholders, including themselves. This was confirmed by the CREs' views on this matter as recorded earlier in the report.

> There is no official representation of indigenous churches at a national level…there are so many faith groups not represented at a national level … such as Pentecostals and indigenous churches … and they are the ones not wanting ARVs.

Despite these challenges to meaningful collaborative relationships, the workshops also pointed to the potential for the future collaboration of all stakeholders. Given that there are a number of existing structures and forums for evaluation, collaborative stakeholders felt that there is enormous potential for strengthening multisectoral collaboration in Malawi.

Those noted by participants included the fact that:

- They have a commitment to the Three Ones principles.
- There are national, regional, and district structures in place to foster collaboration.
- There is a delegated coordination strategy in place that enables various stakeholders to participate, including the faith-based sector.
- Regular National Reviews are conducted.
- Technical working groups are in place.
- Local NGO forums exist, such as the Malawi Partnership Forum.

It is clear then, that both the CREs and their collaborative stakeholders see challenges and potential in such partnerships. Specific challenges include differing belief and value systems, difficulties with adhering to monitoring and evaluation standards, the dissemination of information, adequate representation, funding conditionalities, and inter-faith collaboration. These challenges are balanced by an awareness of the potential for these partnerships amongst both CREs and collaborative stakeholders, given the commitment to the Three Ones policy.

Finding 6: There is a desire for stronger multisectoral collaboration in Malawi, without a further proliferation of initiatives. Christian religious entities desire a greater focus on local and district level initiatives. Collaborative stakeholders desire a greater commitment to collaborative planning, monitoring and evaluation. All parties hope for a greater focus on cultural and gender aspects of the epidemic.

Despite an expressed desire for the stronger multisectoral collaboration, researchers felt there was a certain level of saturation in the number of collaborative initiatives and efforts that had already been put in place.

A. Hopes for stronger collaboration: Christian religious entities

CREs were able to reflect on their hopes for stronger collaboration in two areas, namely, government practice, and with donors.

In terms of **government practice**, the following were identified as key issues:

- Decentralization should be encouraged with less weight placed on national structures.
- There is a need to focus on strengthening district level structures so that they are able to cope with the demands of decentralization.
- There is a need to strengthen district level capacity and collaborating mechanisms enabling them to access funds more readily.
- Build capacity within the grassroots so that they are more accountable to the district structures in terms of M&E frameworks.

In terms of **donors** the following was identified as a way forward for the future:

- Donors should form their own collaborative forums, particularly at district level. Better monitoring of donors commitment to signed MOUs by government.

In addition to the above two key areas, the issue of gender and cultural issues were recognised as a stumbling block to collaboration (as was indicated by their collaborative stakeholders in the previous section). Some discussion took place as to how this matter could be addressed in order to improve future collaboration and at the same time acknowledge the feminized nature of the epidemic. Christian Entity participants indicated that there is existing legislation within a number of their structures that ensures gender equity in all committees. This legislation needed to be implemented more rigorously in the future. They felt that Government needed to ensure that gender and cultural issues were discussed within primary education. In addition, all Collaborative-stakeholders needed to strengthen existing NGOs that address gender and cultural issues.

B. Hopes for stronger collaboration: Collaborative stakeholders

Collaborative stakeholders also reflected on ways forward in strengthening multisectoral collaboration. The following suggestions were made:

- Stakeholder meetings should be conducted at all levels of government.
- Ensure better communication and information sharing, particularly at a district level
- Strengthen joint planning and M&E structures.
- Ensure more user-friendly M&E frameworks
- Strengthen umbrella organizations such as MIAA.
- Undertake to conduct more research at a grassroots level in order to better understand their needs.
- Conduct a bi-annual conference on collaboration between the religious entities and government.

Donor stakeholders were not that forthcoming in suggesting ways forward in terms of their role in multisectoral collaboration.

It is clear then that there is a desire for stronger multisectoral collaboration in Malawi, without a further proliferation of initiatives. CREs desire a greater focus on local and district level initiatives. Collaborative stakeholders desire a greater commitment to collaborative planning, monitoring and evaluation. All parties hope for a greater focus on cultural and gender aspects of the epidemic.

5.3 Recommendations arising from the research findings in Malawi

5.3.1. For the attention of the Christian religious entities

- Assess effectiveness of the Malawi Inter-faith AIDS Association and restructure ensuring appropriate representation.
- Strengthen relationships with one another through establishing regular forums for dialogue and information sharing.
- Recognise culpability in hindering relationships with government stakeholders through conservative and dogmatic beliefs, particularly in relation to the condom issue, and be willing to compromise in certain instances.

5.3.2. For the attention of government

- Communicate the principles of the Three Ones more deliberately and effectively, particularly at a district level.
- Ensure better representation within their coordinating structures.
- Involve CREs in ensuring that HIV and AIDS information is reaching the grassroots communities

5.3.3. For the attention of donors

- Establish a forum of representatives of all funding partners as a matter of urgency.
- Develop one set of reporting and M&E procedures
- Recognise the importance of long-term relationships with their collaborative stakeholders

5.3.4. For the attention of all

- Prioritise the principles of the Three Ones as a way forward for collaborative efforts.
- Ensure adequate representation in all co-ordinating bodies
- Establish regular regional forums for all collaborative stakeholders that enables ongoing dialogue, information sharing, and evaluation of strategic interventions.

Chapter 6

The Democratic Republic of Congo case study

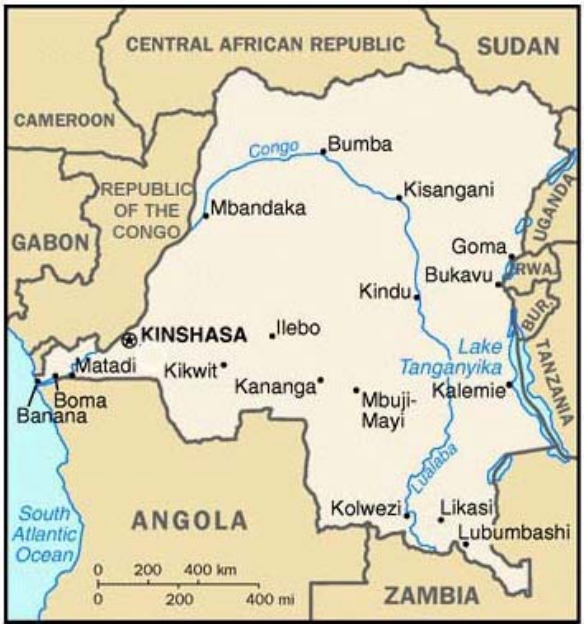
Chapter overview

This chapter provides a case study of the collaborative situation in the Democratic Republic of the Congo (formerly Zaire). First it provides a brief overview of the religious-health landscape in that country, in the context of the HIV and AIDS epidemic. Then it presents the country-specific findings, followed by recommendations arising from the research.

6.1 DRC country context

Country Information[258]

Geography: DRC is located in Central Africa, bounded to the West by the Republic of Congo and Gabon, to the North by Central African Republic and Sudan, to the East by Uganda, Rwanda and Burundi, to the South by Angola, Zambia and Tanzania. DRC is geographically vast with a total area of 2,345,000 km^2 but sparsely populated.
Capital: Kinshasa
Language: French (official), Lingala (lingua franca trade language), Kingwana (dialect of Kiswahili or Swahili), Kikongo, Tshiluba.
Politics: Because of the civil war prevailing in the country since 1998, almost 1/3 of the country is under rebel occupation.
Administration: DRC is divided into 11 administrative provinces.
Urban Rural Split: Of the 60 million people living in the DRC, the majority (70%) live in rural areas, while 10 million of the population are living in Kinshasa the capital city.



Religion in DRC[259]

Roman Catholic 50%, Protestant 20%, Kimbanguist 10%, Muslim 10%, other (includes syncretic sects and indigenous beliefs) 10%

WHO Mortality Summary [260]	Year	Male	Female	Both Sexes
Population (millions)	2005	28.5	29.0	57.5
Life expectancy (years)	2004	42	47	44
Under-5 mortality (per 1000 live births)	2004	217	192	205
Adult mortality (per 1000)	2004	576	446	
Maternal mortality (per 100000 live births)	2000		990	

Other Health Information [19]	Year	%
HIV prevalence among adults (15 - 49) Both sexes	2003	4.2
Total expenditure on health as % of GDP	2003	4.0
Per capita expenditure on health at ave exchange rate $US	2003	4

Top ten causes of death all ages - DRC 2002 [19]	Deaths (000)	Years Life Lost %
All causes	978	100
Diarrhoeal diseases	112	13
HIV/AIDS	111	11
Lower respiratory infections	108	13
Malaria	97	12
War	44	4
Perinatal conditions	39	5
Measles	37	5
Tuberculosis	33	3
Cerebrovascular disease	26	1
Ischaemic heart disease	24	1

[258] CIA 2007, Lusey-Gekawaku 2003, WHO-Afro 2006
[259] CIA 2007
[260] UNAIDS 2006a. See also WHO-Afro 2006

As a general note to this introductory section, there is little up-to-date and reliable information on the social and economic sectors of the DRC. Some data are of limited value since most are derived from small scale studies, or based on specific locations within the DRC. This is demonstrated visually with the following map from the latest UNAIDS EpiUpdate 2007 (see figure 6.1 below):

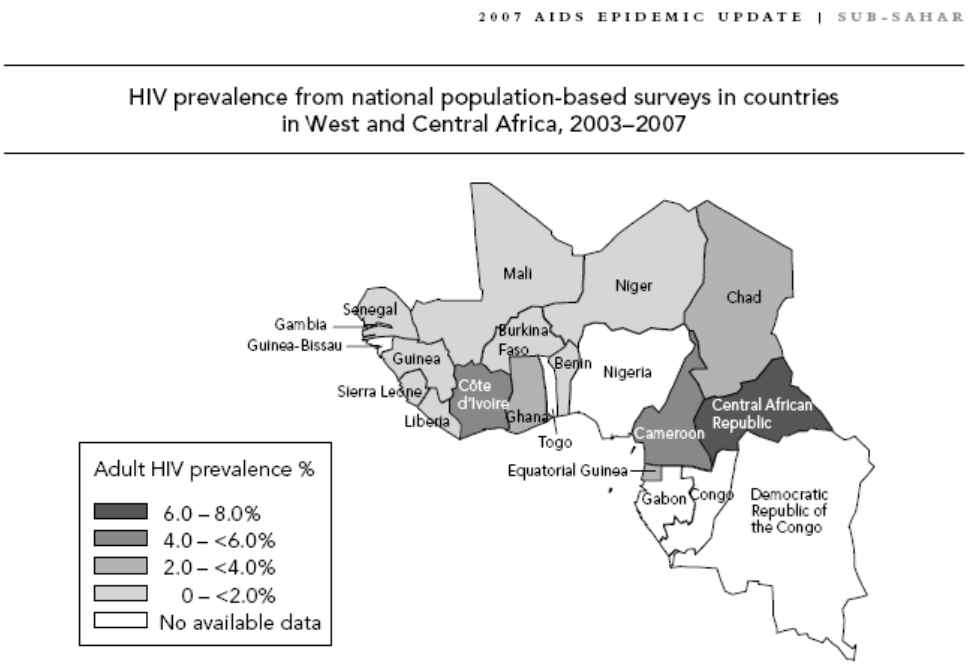


Figure 6.1: Source UNAIDS 2007

6.1.1 Religious-health landscape in the DRC[261]

A. The history of religious involvement in health

In the DRC, the history of medical mission and health professionals working with religious entities goes back more than a hundred years. The Protestant medical mission began in 1882 and the Catholic mission in 1889, both enabling the creation of hospitals and health services. Protestant missionaries thus led the way in establishing the first hospitals in the DRC. We know less about the efforts of other religious groups in health at this time. A significant event took place in 1928 in an effort to improve the coordination of services.[262]

Significantly in 1999 the Ministry of Health turned over responsibility for health care in 60 health zones to a coalition of mostly faith-based non-governmental health organizations.[263] In the face of political and economic crisis and instability, religious entities have continued to play a long-term and obvious role in healthcare at a national level. The DRC thus demonstrates a unique situation of public-private partnerships in health. The large Christian majority in the country means that most of the religious entities are from a Christian background, with Protestant and Catholic efforts being most prominent according to secondary literature.

[261] Unless indicated otherwise, this summary is from Schmid et al 2008
[262] Baer 2007
[263] IDT 1998, Baer 2001

International 'FBOs' have also played a critical role, often providing assistance during times of conflict and to remote locations even after other organizations have pulled out. More research is needed on faith-based efforts in health at a local and community level.[264]

B. Religious entities in the DRC health sector

The DRC national health system is currently based on 515 Decentralized Health Zones. Secondary literature states that faith-based organizations and networks currently provide between 50%-70% of health services in the DRC. This range is depicted by the following statements:

> …70% of health services are delivered by churches and church related institutions with meaningful results.[265]
>
> 50% of hospitals in the DRC are owned and managed by local churches.[266]
>
> In the DRC virtually the whole health care infrastructure is currently provided by faith organizations as the government health system has practically collapsed. It is estimated that the Roman Catholic Church alone provides 25% of all HIV/AIDS care including home based care and support of orphans.[267]

It is possible that this predominantly facility-based contribution of CREs to the public health systems has shaped the nature of the response of CREs to the HIV and AIDS epidemic in the DRC. The participatory research indicated a very strong *medical* focus on the epidemic, with surprisingly less attention given to what are traditionally seen as 'spiritual or pastoral' matters.

C. Religious entities involvement in HIV and AIDS

Less is currently known of the history of the religious sector's involvement in HIV and AIDS specifically, rather than health generally. The 2005 Congolese UNESCO study, noted:

> For several years, religious bodies have remained passive. It is only in 2003 that the religious sector made a move by setting up a committee, *le comité interconfessionnel* (The Interfaith Council to Fight AIDS - CIC) to coordinate its actions against HIV/AIDS. Other charitable organizations, religious or otherwise, are contributing to the national response largely through the provision of psychosocial support to people affected by the epidemic.[268]

This statement does not perhaps adequately reflect the health-services-related response to HIV and AIDS delivered through the substantial facility-based religious health sector as described above. In the participant discussion below (section 6.2), we will engage with this issue further.

[264] See CCIH 2007, Lusey-Gekawaku 2003, SANRU 2007
[265] ECC 2007
[266] Baer 2001
[267] CCIH 2007
[268] Doupe 2005

6.1.2 The HIV and AIDS epidemic in DRC[269]

HIV and AIDS Estimates[270]	Estimate
Number of people living with HIV	1 000 000
National HIV prevalence among adults (ages 15-49)	(2005) 3.2
Adults aged 15 and up living with HIV	890 000
Women aged 15 and up living with HIV	520 000
Deaths due to AIDS (during 2005)	90 000
Children aged 0 to 14 living with HIV	120 000
Orphans aged 0 to 17 due to AIDS	680 000

A. State of the epidemic[271]

The Democratic Republic of the Congo is in the grip of what can be termed a 'widespread' epidemic. Prevalence varies from 1.7 to 7.6% depending on the region, and may be as high as 20% among women who have suffered sexual violence in areas of armed conflict.[272] The epidemic is strongest among young people between the ages of 15 and 24, and women consulting at antenatal clinics. Figures suggest that prevalence rates within these two groups are increasing. [273]

> In the Democratic Republic of the Congo HIV prevalence among antenatal clinic attendees has remained relatively stable in the capital, Kinshasa (between 3.8% in 1995 and 4.2% in 2005), but prevalence has risen in the country's second-largest city, Lubumbashi (from 4.7% to 6.6% between 1997 and 2005), as well as in Mikalayi (from 0.6% to 2.2% between 1999 and 2005) (Kayembe et al., 2007). Prevalence is also high in the cities of Matadi, Kisangani and Mbandaka (where 6% of women using antenatal services were HIV-positive in 2005), as well as in Tshikapa (where prevalence was 8%) (Programme National de Lutte contre le SIDA, 2005).[274]

HIV and AIDS as one of many problems: It is clear that the DRC faces a plethora of development and health issues which the HIV and AIDS epidemic compound. The epidemic in the DRC is further complicated by extreme poverty and weak or nonexistent public health infrastructure.[275]

Conflict history: The country has suffered numerous conflicts, which have dashed development efforts and given rise to disastrous humanitarian consequences. Some of the direct health impacts include disease spread and death, violence (both physical and sexual), refugees and internal displacement requiring the provision of emergency health services, often in the context of the collapse of social and physical infrastructure, and high HIV prevalence in military personnel.[276] The armed conflicts in the DRC have prompted large scale population movements within the country. An estimated 1.4 million people have been

[269] This report emerged as international epidemiological fact sheets were being updated. New figures are expected by August 2008.
[270] Unless indicated otherwise, these figures come from UNAIDS 2006a
[271] This acts as an introduction to the chapter, not all HIV estimates are presented - such as the effect of the epidemic on social and economic sectors. See PNMLS 2008 for a more complete update.
[272] UNAIDS 2006a
[273] UNAIDS 2006a
[274] UNAIDS 2007
[275] WHO 2005
[276] See Schmid et al 2008

displaced from their home province to another by the conflicts. About a quarter of the Congolese population live in the two economically strong provinces of Kinshasa, the capital and Katanga, the mining hub.[277]

> The DRC is categorised among the poorest countries in the world … The country is in a post-conflict period following two successive wars (1996-1997 and 1998-2003), which led to the collapse of the economic and social infrastructure. Poverty, the lack of appropriate medical system and migration of the population because of the war may have fuelled the spread of HIV/AIDS.[278]

The Democratic Republic of Congo (DRC) has seen the end of large-scale conflict only recently. Areas of unrest remain, for example, in June 2008, the United Nations Security Council renewed a push for civilian rule in the DRC's militia-plagued eastern (Goma) region

> … the country's hilly eastern border area - the scene of the worst fighting and a humanitarian crisis in the Central African nation - has been lawless for so long that citizens have given up on any sort of government … the DRC's UN peacekeeping force is the world's largest with 17 000 troops, more than 90% of those stationed in the east.[279]

At the same time, the country is now seen to be in a process of national reconstruction with AIDS control as part of the Poverty Reduction Strategy Paper (PRSP).[280] Major reconstruction plans have been drawn along the so called presidential '5 axes', including the health sector.[281] The HIV and AIDS epidemic is caught in the middle of these dualities of conflict and reconstruction.

B. Timeline of significant events in DRC's AIDS epidemic

This timeline does not depict every AIDS-significant event in DRC, but rather is an amalgam of events important to the participants, recorded in government documentation, and participant responses to the questionnaire. It therefore also contains events important to the religious entities.[282]

1889	Appointment of Dr. Adrien Atiman, the first medical doctor to work in Congo for Catholic missions.
1928	40 protestant missionary societies from 12 countries create the Protestant Council of the Congo
1971	The Mobutu 'authenticity movement' required all protestant groups to unite within one authorized national church. The Protestant Church of Zaire (ECZ, currently ECC)) is formed with around sixty member communities, and a medical office (the Direction des Oeuvres Médicales - DOM) to interface with the Ministry of Health.
1974	Zairianism introduced which stressed that Congolese need to manage their own affairs.
1975	ECC DOM and the Catholic Church co-sponsor a national conference in collaboration with the Ministry of Health which establishes a national consensus for the concepts of 'decentralized health zones' and 'primary health care.'
1977	Social programmes handed over to churches as a result of the Zairianism ideology.

[277] CIA 2007
[278] Kayembe 2005
[279] Lederer 2008
[280] UNAIDS 2006a, WHO 2005
[281] Participant correspondence - 2008
[282] See Baer 2007, Kayembe 2005, Lusey-Gekawaku 2003, PNMLS 2008, SANRU 2007, UNAIDS 2006a, WHO 2005, participant workshops

1980 Based on requests from Protestant health services for assistance, USAID with ECC/DOM designs a project to create fifty health zones around Protestant hospitals. ECC chosen to manage this multi-million dollar bilateral project called the Basic Rural Health Project, one of the first projects of this size to be managed by an umbrella organization of any Church body.

1981 (1981-1991): The Basic Rural Health Project becomes better known as SANRU (Projet Santé Rurale), the project is opened to health zones created around Catholic, governmental, and other NGO-managed hospitals. This approach transforms SANRU into a national health project.

1982 Arrival in Congo of Dr. Aaron Sims, the first in a long list of medical doctors to work in Congo for Protestant missions.

1983 The DRC one of the first African countries to acknowledge the existence of HIV and AIDS in its territory. The first case was reported by an international team that worked with Congolese researchers.

1984 Creation of AIDS Project to collect epidemiological data in order to implement HIV prevention and AIDS control.

1984 (1984-1987): ECC accepts the management of an additional project for the physical rehabilitation of 200 health centers across Congo. Working in collaboration with the Organization for Rehabilitation by Training (an NGO of the Jewish faith) and USAID.

1985 Government allows establishment of 'Projet SIDA' in Mama-Yemo hospital (Kinshasa General Hospital), as a joint project between the CDC, the National Institutes for Health (NIH), The Institute of Tropical Medicine of Antwerp (IMT), and the Government of the DRC. The mission of the project was to conduct epidemiological and clinical research to better understand the patterns of the disease, the modes of transmission and its natural history.

1985 Creation of the National AIDS Control Commission (comité national de lutte contre le Sida - CNLS).

1987 The DRC officially reported its first cases of AIDS to the World Health Organization (WHO).

1987 The Government established a central office to coordinate the national response (*Bureau central de coordination SIDA*, BCC-SIDA) and the National Committee on HIV/AIDS (PNLS). A steering committee whose members were from different sectors including public and private sectors, civil society, was also established. During this initial period, the MoH was primarily involved in the response to the epidemic, because HIV and AIDS was perceived essentially as a medical problem. BCC-SIDA elaborated several plans of action, including short-term plans and a mid-term plan.

1987 (1987-1991): SANRU becomes SANRU II. By 1987, more than 200 decentralized health zones are functioning throughout Congo. Between 1982 and 1987 access to primary health care services in SANRU assisted health zones increases from 10% to around 50%.

1990 In the 1990s, NGOs joined the national response - some established to address different HIV-related issues such as education, psychosocial support and assistance to OVC.

1991 Ransacking and looting of resources and public offices.

1991 Elaboration of revised Medium Term Plan 1991-1994. Adoption of the revised MTP submitted to funding agencies.

1991 (1991-2001): The political disruptions in Congo in 1991 force USAID to close its offices and discontinue funding for the SANRU project. However, projects continue through a variety of projects and funding sources.

1993 Ransacking and looting of resources and public offices.

1994 Government announces a protocol signature between the WHO and the National AIDS Control Programme (NACP). "Subsequently, the need to coordinate the NGOs was felt. In 1994, BCC-SIDA established Forum SIDA, or FOSI in 1994, a coordinating body for all NGOs involved in HIV/AIDS programmes. For a very long time, the other components of the public and private sectors and the religious sectors were not involved. Even though the religious sector was represented at the National Committee on HIV/AIDS, this sector did not undertake specific actions against HIV/AIDS."[283]

1995 AIDS Forum created in Kinshasa.

1996 Civil war, President Mobutu leaves.

[283] Kayembe 2005

1996 2 years emergency Short Term Plan of UNDP, WHO and UNAIDS to strengthen the NACP.

1996 Ebola outbreak: SANRU offices at ECC become the coordination center for all NGO and governmental agencies.

1997 End of civil war. Meeting of the National AIDS Council to strengthen the NACP and mobilisation of all national sectors in the struggle against HIV and AIDS. (The National AIDS Council had not held meetings since 1991.)

1998 National Interdisciplinary Task force and National Strategic Plan adopted on HIV and AIDS.

1999 A 10 year strategic plan (1999-2008) adopted that stressed prevention, care, advocacy activities that highlight community participation, human rights and ethics, and needs of persons living with HIV and AIDS.

1999 The National Strategic Plan for HIV/AIDS for 1999-2008

2000 Presbyterian and other protestant churches begin to engage the HIV and AIDS epidemic.

2000 National AIDS Control Programme restructured.

2001 Death of President Laurent Kabila.

2001 (2001-2006): Funders such as USAID return to Congo as conflict ends.

2001 In conjunction with U.S.-based Interchurch Medical Assistance, a five-year $25 million SANRU III project is funded to assist sixty health zones throughout Congo.

2002 Peace project to fight the HIV and AIDS epidemic.

2002 Acceptance of a HIV and AIDS project by synod of CEK.

2002 Creation of the Interfaith AIDS Council - CIC (*le comité interconfessionnel*).

2002 Antiretroviral therapy (ART): The MoH signed an agreement with a private company, “la Générale Congolaise des Services de Santé, GSS” to import and distribute generic antiretroviral dugs throughout the country. Under this agreement, the imported medicines are cleared from customs free of charge and GSS has the obligation to sell them at a lower price agreed upon with the MoH.

2002 The National AIDS Control Programme developed national guidelines for antiretroviral therapy and the treatment of opportunistic infections in adults in collaboration with the German Gesellschaft für Technische Zusammenarbeit (GTZ).

2003 President Joseph Kabila attends a United Nations (UN) special session on HIV and AIDS, inaugurates a blood bank building in Kinshasa and starts to talk about HIV and AIDS in his public speeches.

2004 President Kabila signs a decree establishing the National Multisectoral Programme on HIV/AIDS (PNMLS), which operates under the coordination of his cabinet.

2006 Partnership between the Presbyterian organization APCS and the Global Fund

2006 Elections take place.

2008 Law to protect the rights of HIV positive people will be finalised at the end of 2008.

2008 New national strategic plan to be completed at the end of 2008 for the period 2009-2014.

C. DRC’s HIV and AIDS national policy

> *The lack of a national strategic plan which has been updated and budgeted for and of long-term vision is a hindrance to the involvement of civil society and of the different sectors, as well as to the harmonization and integration of interventions by all stakeholders.*[284]

In the timeline above, it can be seen that the government’s response to the HIV and AIDS epidemic has been tied to the country context. The current national strategic HIV and AIDS plan, created in 1998-1999 is outmoded, and the new one should be emerging at the end of this year (2008). The National Strategic Plan for HIV/AIDS for 1999-2008 has been the primary guiding document. There have also been subsequent policy documents, such as the national

[284] UNAIDS 2006b

guidelines for ART developed in 2002 (with GTZ), or the 2005 National Strategic Plan for Scaling Up Access to Antiretroviral Therapy for the Period 2005-2009. We will therefore not provide any description here of the older one, but provide instead a few observations emerging from secondary literature on the national HIV and AIDS policy environment.[285]

Political involvement: An area of critical challenge is to increase the level of political commitment and leadership around HIV and AIDS. There are some indications that with the end of hostilities and the establishment of a transitional government in 2003, a renewed commitment to the fight against HIV and AIDS was witnessed. However, others have noted that the general public has been critical of the Government's "inadequate response, lack of prioritisation and inability to address the stigma, discrimination and rejection attached to HIV/AIDS."[286]

Government structures: There are several government structures dealing with HIV and AIDS work. The two main structures are PNLS and PNMLS: [287]

- **PNLS (NACP): Programme National de Lutte contre le SIDA (National AIDS Control Programme):** Established early in the epidemic (around 1987), by presidential decree PNLS holds national responsibility for the HIV response. PNLS is specifically seen to lead the national effort to scale up access to antiretroviral therapy in the country, to provide leadership in the health sector response to HIV/AIDS, and provide leadership in surveillance, monitoring and evaluation.
- **PNMLS: Programme National Multisectoriel de Lutte contre le VIH/SIDA (National Multi-Sector Program against HIV and AIDS):** Established in 2004, PNMLS is made up of the public sector represented by the Ministry of Public Health, the private and enterprise sectors and the NGO and faith communities in the DRC. PNMLS is tasked with national coordination of all sectors involved in HIV/AIDS and STI prevention and is assisted in this effort through provincial and local representation. There are national, provincial and local committees within PNMLS (Le Comité National Multisectoriel de lutte contre le VIH/SIDA, Les Comités provinciaux multisectoriels de lutte contre le VIH/SIDA, Les Comités locaux multisectoriels de lutte contre le VIH/SIDA). PNMLS has four components: 1) the public sector which includes all ministries including the Ministry of Higher Education; 2) the private sector; 3) the community; and 4) the monitoring and evaluation component. The first three components are expected to implement services (prevention, treatment, care and support for their personnel and/or clients). The fourth component is coordinating M&E activities implemented by the three components.

It has been noted that in the DRC, the division of labor between these structures, committees and bodies is not always clear. The WHO notes that in the presidential decree which places national responsibility for the HIV response with PNLS, the decree does not clearly determine the operational or structural links between PNLS and PNMLS, saying, "this situation is

[285] Because of DRC's lack of national strategic policy at the time of writing this report, this chapter is differently structured from the preceding two country case-studies. There is little currently shown in secondary literature about DRC's multisectoral collaboration, how participatory the current process is, to what extent the Three Ones play a role in the new strategy, what form of national M&E will emerge in the future, and whether the new policy is informed by culture and religious contexts in the DRC. See participant discussion below.
[286] Lusey-Gekawaku 2003
[287] See PNMLS 2008, UNAIDS 2006b, WHO 2005

responsible for a weak national leadership which is detrimental to coordination of programmes."[288]

This unclear division between a medical and multisectoral response to HIV and AIDS is reflected elsewhere, where it has been noted that in the initial response, HIV and AIDS were perceived essentially as a 'medical' problem.[289] The more recent push for a multisectoral response (since around 2004) - not just multisectoral in terms of involving multiple parties, but multisectoral as in seeing HIV as a disease of 'development' - has had less time to impact on the national response, which has been heavily medical for a long time. The grey area between PNLS and PNMLS could be as a result of an established expectation for medical disease response and guidance now coming into conflict with international encouragement of multisectoral collaboration in the context of HIV and AIDS (see below for further participant discussion on this).

6.1.3 A brief survey of the state of collaboration in DRC[290]

Multisectoral collaboration around HIV and AIDS in the DRC is a hugely complex and under-researched area.

As in Kenya and Malawi, secondary literature suggests that collaboration between CREs and government happen through two main avenues: the collaboration of CRE-owned health facilities with the government health services (e.g. through the MoH and PNLS), and the collaboration of CREs as part of 'civil society' (e.g. through PNMLS). However, that is where any similarity ends, as CREs in the DRC seem to be involved in a web of complex collaborative relationships.

For example, the Catholic Church notes a complex HIV and AIDS intervention strategy, which is done in close collaboration with international and national partners such as CORDAID, Trocaire, CAFOD, CRS, local dioceses, *Bureau Diocésain des Oeuvres Médicales* (Diocesan Office for Medical Works - BDOM) and Caritas etc.[291]

A second example of this complexity is the unique SANRU project (see timeline above). Since 1980 the *Basic Rural Health Project* (later known as SANRU *Projet Santé Rurale*) has worked towards the creation of health zones around Protestant, Catholic, governmental, and other NGO-managed hospitals in partnership with USAID.

> (altogether) FBO networks in DRC currently not only provide 50% of health services, but also co-manage around 40% of Congo's 515 health zones.[292]
>
> …of the 515 health zones, 65 are currently co-managed by the ECC.[293]

This collaborative relationship is built on a highly complex layer of collaborative partnerships. For example, a strong partnership is said to exist between this project and the government (again, in relation to health services provision),[294] which results in the HIV and AIDS context, results in a strong partnership in the promotion of preventative medicine and the provision of care in the HIV and AIDS context.

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[288] UNAIDS 2006b
[289] See Kayembe 2005
[290] This section is from Schmid et al 2008
[291] Participant correspondence
[292] Baer 2007
[293] Baer 2007, Dimmock 2005, Lusey-Gekawaku 2003
[294] See CCIH 2007

Furthermore this project requires interfaith collaboration - not only between the more prominent Catholic and Protestant groups, but also the other faith groups involved, such as the Kimbanguists. It also requires collaboration between REs and secular organizations,[295] and further collaboration between funders.[296] "The fragile and sometimes volatile political situation in the DRC has created an unusual, and by all appearances, effective collaborative partnership in a time of crisis,"[297] although not enough is known of its collaborative strengths and weaknesses, and how this plays out in the context of HIV and AIDS.

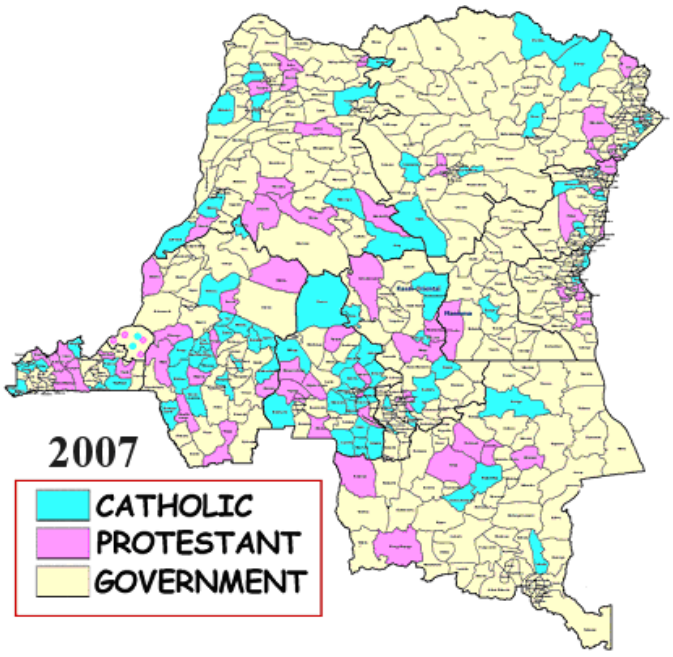

Figure 6.2: Healthzones managed by CREs, Baer 2007

6.1.4 A brief survey of the state of funding in DRC

It was not the purpose of this study to do a complete assessment of the national funding situation. However, during the desk review, certain key issues emerged that are most relevant to this study, and speak to general funding trends in the DRC.

- The government of the DRC was unable to adequately finance the national response against HIV/AIDS for many years. This was largely due to the lack of sufficient funds. Therefore, the Government of the DRC has had to rely largely on outside funding arrangements.[298]
- There is a large funding community involved in the DRC - and funding is still balanced more towards 'humanitarian' than towards 'development' assistance.
- The political disruptions in the DRC from 1991 to 2001 caused several significant funding organizations to withdraw from the country. However, many have returned as the conflict has dwindled, and funding support has increased during this period of reconstruction.[299]

See the following section for a list of some of the key funding partners present in the DRC. Again, not enough is known of the entire HIV and AIDS funding situation.

[295] See Lusey-Gekawaku 2003, Schmid et al 2008
[296] Project AXxes (within the SANRU project), focused on health-systems strengthening, is funded in collaboration between USAID, IMA World Health, ECC, CRS, WVI and Merlin
[297] Schmid et al 2008
[298] Kayembe 2005
[299] See SANRU - CCIH, Kayembe 2005

6.1.5 The key players in the DRC HIV and AIDS context

We provide here a simple listing of some of the key organizations that secondary literature shows are working in the DRC multisectoral context. This is in no way a comprehensive exercise.

Collaborative networks or networking organizations: the *National Council of Interfaith-based Alliance* (CIC) comprised of religious leaders is a structure for HIV/AIDS-related discussion and lobbying. This council is set up to integrate the religious and government responses to HIV/AIDS; [300] *The Health NGOs National Council* (Conseil National des ONG de Santé, CNOS); *The National Business Coalition against HIV/AIDS in the DRC* (The Comite Inter Entreprises de Lutte Contre le VIH/SIA, CIELS), *Association of Women Living with AIDS* (Fondation Femme Plus)

Multilaterals, bilaterals and major donors providing support to address DRC's HIV and AIDS epidemic:[301] Belgian Technical Cooperation (BTC), CAFOD, Caritas Internationalis, Catholic Relief Services, CORDAID, European Union, French Cooperation, German Agency for Technical Cooperation (GTZ), Global Fund to fight AIDS, TB, and Malaria *(*GFATM), IMA World Health, Médecins Sans Frontières, Merlin, SWAA, Trocaire, U.S. Agency for International Development (USAID), United Nations (UN) agencies (UNAIDS, UNDP, UNFPA, UNICEF, WFP and WHO), United States Centers for Disease Control and Prevention (CDC), World Bank (WB) Multi-Country AIDS Program (MAP), World Vision International.

Christian religious entities engaged in HIV and AIDS: secondary literature does not provide a comprehensive mapping of CREs engaged in HIV and AIDS in the DRC. The work undertaken via desk review, as well as in the snowballing sampling process, helped to identify a wide range of CREs that are responding to health generally, and the HIV and AIDS epidemic in particular. A full listing is provided in Appendix 6.3. Please note, this listing is limited and does not capture every organization working in HIV and AIDS in the DRC. Several named here are networks or umbrella bodies that incorporate a number of individual religious entities or programs. Furthermore, some international organizations have local offices and therefore make categorisation difficult. It is our hope that this listing highlights the scope and range of AIDS-engaged religious entities in the DRC, and is a working document that can be utilized and developed further.[302]

With the above in mind, we will now turn to the findings based on the information gained from the participant workshops held in the DRC.

[300] See Lusey-Gekawaku 2003, WHO 2005
[301] See Kayembe 2005, PNMLS 2008, WHO 2005. PEPFAR is notably absent from the DRC
[302] There have been several reports that religious entity (or FBO) mapping has been occurring on a large scale in the DRC. However nothing was accessible in time for this report. See Capacity Project and CCIH. (Personal report Frank Baer 2008).

Figure 6.3: Kinshasa, DRC - 2008

6.2 The findings of the research in DRC

The research process was designed to identify findings in four key areas:

5. Concerning the context in which Christian religious entities (CREs) are working
6. Concerning the work of CREs in the promotion of Universal Access
7. Concerning the strengths and weaknesses of collaborative partnerships between CREs and other stakeholders
8. Concerning the potential and challenges of collaborative partnerships between CREs and other stakeholders

Within these four areas, the participatory research process produced the following six findings in the DRC:

1. CREs in the DRC perceive themselves to have had a long engagement with the epidemic from a medical perspective. However, it is only since 2000 that there has been a significant pastoral engagement. CREs also perceive the HIV and AIDS epidemic to be strongly related to other social and political crises in the country, and acknowledge that initiatives have been hampered, until recently, by the civil war.
2. CREs in the DRC are committed to and involved in promoting Universal Access to prevention and treatment, and to a lesser extent care and support. Prevention involves education and the distribution of condoms, and there is an extensive involvement in the provision of ARVs. CREs recognise that their beneficiaries are women and Christians. Work is undertaken in both urban and rural settings.

3. *In their contribution to Universal Access,* CREs in the DRC are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, credibility and well-developed structures. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.
4. CREs in DRC are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths but a large number of weaknesses. (1) The main strengths are perceived to be the relationships that CREs have with their funding partners and particularly the Global Fund, relationships with government departments. (2) The main weaknesses are perceived to be the lack of relationship between and coordination of work amongst CREs, the different levels of knowledge and value systems between the partners, the difficulty of producing and administering a national policy in the midst of wider political crises, and a lack of government funding together with the vulnerability caused by reliance on external donors.
5. CREs and their collaborative stakeholders see both challenges and potential in such partnerships. The challenges have to do with the fragile state of the country and of coordinating structures, the dependency syndrome with funders, the lack of knowledge about HIV and AIDS amongst CREs, and the conservative doctrinal emphases of certain churches. Yet it was also acknowledged that the potential for partnerships lies in the relationships that both government and CREs have with international donors, the recognition of mutual strengths, and a desire to work together.
6. There is an obvious commitment to strengthening the partnership between CREs and collaborative stakeholders from both sides. From the CREs there is a desire for greater participation in the decision making around the control of funds. From the collaborative stakeholders there is a desire that CREs be drawn into the National Plan, its policy formulation and implementation.

We now examine each of these findings in greater detailing, drawing from the evidence that emerged in the workshops and questionnaires. The chapter concludes with a set of clear recommendations based on these findings.

6.2.1 Findings concerning the context in which Christian religious entities are working

<u>Finding 1:</u> Christian religious entities in the DRC perceive themselves to have had a long engagement with the epidemic from a medical perspective. However, it is only since 2000 that there has been a greater pastoral engagement. Christian religious entities also perceive the HIV and AIDS epidemic to be strongly related to other social and political crises in the country, and acknowledge that initiatives have been hampered, until recently, by the civil war.

In the workshop with CREs, participants were asked to contribute to a communal time line that helped to map the history of their engagement in social life, and specifically in responding to the epidemic. The following information emerged from the timeline.

There is relatively little awareness of the role of the church in social life prior to the 1970s. In 1974 the government policy of Zairianism meant that the Congolese were to manage their own

affairs "whether they were ready or not". As part of this policy, all social services were handed over to the churches in 1977.

In the 1990s, when the HIV and AIDS epidemic was starting to become a factor in social life, there was the outbreak of civil war upon the death of President Mobutu Sese Seko. This severely dislocated the ability of the state and the CREs to respond to the epidemic. However, it was also felt that in times of conflict, people do turn to CREs for help.

> Collaboration between government and others just stopped…the state was not able to provide care and support … here the churches through the medical and health departments were already involved … when the state fails it is through the churches that people receive care and support.

Owing to the fact that CREs had taken over much of the health services in the DRC, they were involved at a very early stage in working with people living with HIV. However, as was noted earlier, the fact that it was left to Christian medical officers to manage meant that for CREs the epidemic was primarily seen as a medical problem to be dealt with by medical services. Participants acknowledged that the more pastoral aspects of dealing with people living with HIV were not dealt with until fairly recently. This was the case even though some attempts were made to offer HIV and AIDS education to leaders of non-medical CREs in the early 1990s.

What also became clear was that the issue of condom promotion was contentious. Some participants suggested that the sexual nature of the epidemic meant that it quickly became a taboo subject within the religious sector. The fact that many CRE participants in the research workshops were medical practitioners, suggests that the epidemic is still primarily seen as a medical concern.

The context of war and conflict in DRC makes it difficult to focus exclusively on the HIV and AIDS epidemic, because there are pressing public health issues that need to be addressed. This could be one of the reasons why much of the current work around HIV and AIDS only began after 2000 when the country gained relative peace through the ending of the civil war. It was also at this time that non-medical CREs were drawn into talks concerning multisectoral collaboration. UNAIDS appears to have been instrumental in ensuring involvement from the national government. As a result, a number of CREs focusing on HIV and AIDS were formed during this period. In the past four years some of the denominational CREs such as the Presbyterian, APCS and CEK, have developed policy statements on the HIV and AIDS epidemic. Since 2006, free ART has been more readily, although there is some uncertainty as to the extent of the roll-out of this programme throughout the country. Legislation protecting the rights of people living with HIV is currently under review and is expected to become law before the end of 2008.

There was a general feeling by Christian Entity participants that the response to the epidemic is not well co-ordinated. This is partly related to the fact that "funding is provided in a disparate way".

> We are doing our best … but the national strategy of 1998 will be reviewed, and by the end of 2008 we will have another strategy.

The new strategy will include a National AIDS Council and a National Aids Programme. Participants felt that as a result of this strategy, there will be improved national co-ordination.

> Because there was a misunderstanding … Forum of partners put in place PNMLS (National Aids Council) was funded by the World Bank … now more Congo owned … Represented by all sectors of the nation.

In summary, CREs in the DRC perceive themselves to have had a long engagement with the epidemic from a medical perspective. However, it is only since 2000 that there has been a greater pastoral engagement. CREs also perceive the HIV and AIDS epidemic to be strongly related to other social and political crises in the country.

6.2.2. Findings concerning the work of Christian religious entities in the promotion of Universal Access

Finding 2*:* Christian religious entities in the DRC are committed to and involved in promoting Universal Access to prevention and treatment, and to a lesser extent care and support. Prevention involves education and the distribution of condoms, and there is an extensive involvement in the provision of ARVs. Christian religious entities recognise that their beneficiaries are women and Christians. Work is undertaken in both urban and rural settings.

The work undertaken via desk review, as well as in the snowballing sampling process helped to identify a wide range of CREs that are responding to the HIV and AIDS epidemic These include: National Ecumenical Structures, Denominational bodies and their AIDS programmes, Denominational programmes and initiatives, AIDS Collaboratives, Health and development projects and a variety of other organizations. See Appendices 5.5, 5.6 and 6.3 for listings of organizations found through this research.

While not each and every Christian Entity noted here is equally involved in all aspects of Universal Access, it is clear that taken as a whole, CREs in DRC perceive themselves to be involved in Prevention, Treatment, Care and Support, as well as some 'Other' tasks. Asking the Christian Entity participants to depict and describe the three 'main' areas they were each involved in HIV and AIDS work, the following basic table was derived:[303]

Prevention	Treatment	Care	Support	Other
Salvation Army CEK ECC Presbyterian church Conerela BDOM Kimbanguiste ECC BDOM Anerela+ Vorsi CEK Conerela Presby church EPS	Salvation Army Kimbanguste ECC BDOM Vorsi	Salvation Army Kimbanguiste ECC BDOM Vorsi *EMAUS* *Catholic* *Magnificat*	Salvation Army Kimbanguiste ECC BDOM Anerela+ CEK Conerela	Salvation Army Anerela+

Figure 6.4: Depiction of participatory exercise, Kenya 2008

[303] See Appendix 1 for acronyms. Those in italics did not have representatives at the workshop, but were added by fellow participants.

A. Prevention

In prevention, four kinds of activities are undertaken. Firstly, as with Kenya and Malawi, CREs are predominantly involved in education and awareness work. Of note is the fact that some are engaged in training of trainers through peer education programmes. The Salvation Army also engages their leaders in training in order to ensure that they are not encouraging stigma and discrimination through their theological messages. Anerela+ is active within networks of religious leaders and, as in the other countries, adopts the SAVE approach in their prevention messages. Some CREs see condom promotion as a point of conflict with government, while others are engaged in condom promotion in a targeted way.

> We distributed condoms with the Global Fund ... not easy as a religious organization. The strategy is to go to places where the need is greatest. We went to areas where there was a need … hotels, military camps, police stations … We said, we know that the churches are preaching abstinence, but we cannot be the safeguards of those who cannot be faithful. We are not encouraging immorality, but saving those who can still be saved from infection.
>
> Our project distributed condoms for 5 years. It was not easy for churches to get the green light … but we are trying to help them understand through training.

In DRC, unlike Kenya and Malawi, it seems condom distribution is carried out by some CREs.

> Some Christian groups backed off [distribution of condoms] because it was seen as an immorality problem and others were pushing for condoms.

Distribution of condoms to target groups such as "those who will not abstain, discordant couples in the church, those who are HIV positive" also seems to be quite widespread. It appears that there is not as a dogmatic approach to the matter as was the case in Kenya and Malawi. The reason for this more pragmatic approach to condom distribution could be related to the fact that, to a large extent, it is medical practitioners that are engaged in mitigating the epidemic.

B. Treatment

CREs play a major role in the distribution of ART. See section 6.1.1 above.

C. Care and Support

Christian Entity participants were reluctant to distinguish between 'care' and 'support' which could have been because, unlike Kenya and Malawi where this was not the case, many were medical practitioners and not pastors. Clearly, some CREs are to an extent engaged in micro-credit activities and in developing networks of HIV positive support groups. One impressive example of such a network consists of over 1500 people who meet informally in church halls.[304] The area of care and support is seen to be carried out, without exception, by CREs.

> When collaboration between government and others was just stopped … the state was not able to provide care and support … here the churches through the medical and health departments were already involved … when the state fails it is through the churches that people receive care and support.

[304] However, initiated by *Médecins Sans Frontières*

D. Other

Anerela+ is particularly engaged in capacity building through the establishment of networks of HIV positive people. The Salvation Army is involved in a unique project that addresses sex trafficking and issues facing commercial sex workers. This project attempts to deal with the question of poverty that underlies why young girls become involved in sex work.

> One of the key issues is that of gender, because of the feminization of HIV and AIDS. Sexuality is still taboo in our country … so how do you deal with this in a patriarchal society like the DRC? We still have more questions than answers.

It is important to note, also, that a number of CREs work in very close cooperation with other CREs in sharing the engagement in Universal Access. So for example, Catholic Relief Services works with a range of international Catholic relief services such as Cordaid, Trocaire, CAFOD, and Caritas. While each one has specific tasks, the partnership provides for a comprehensive approach.

E. Beneficiaries

In terms of **age**, Christian Entity participants were reluctant to specify one particular age group that were the dominant beneficiaries of their services. Most felt that they work with all age groups. The two exceptions were Vorsi, who worked primarily with people under the age of 15 years, and Anerela+ whose constituency tends to be primarily those older than 40 years.

In terms of **gender**, most participants recognised that their work was mainly with women.

> Although they would like to work with everyone, they are working mainly with women.

> The people coming forward for help are mostly women.

None of the CREs specifically target men with the exception of Conerela+ who do work with large numbers of men.

In terms of **location**, most participants acknowledged that their work was mostly in urban areas. However, they also indicated that there were many CREs working in rural areas; these include amongst others, Caritas and *Bureau Diocesain Des Oeuvres Medicales* (BDOM). This is confirmed by secondary literature. Participants felt that the majority of work carried out in rural areas is done so by CREs and that there is little involvement of government at this point.

In conclusion then, CREs in the DRC are committed to and involved in promoting Universal Access to prevention and treatment, and to a lesser extent care and support. Prevention involves education and the distribution of condoms, and there is an extensive involvement in the provision of ARVs. CREs recognise that their beneficiaries are women and Christians. Work is undertaken in both urban and rural settings.

Finding 3: In their contribution to Universal Access, Christian religious entities in the DRC are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, credibility and well-developed structures. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

As discussed in chapter 3, religious entities are seen to have key strengths that can be leveraged in the HIV and AIDS epidemic. In the introduction above, (see section 6.1.1 above) we further presented some of the assets religious entities are said to hold in the DRC health

system. While this particular study did not focus on identifying the specific assets of CREs that can be leveraged towards providing Universal Access (for example, the number of facilities held or patients served), this was nevertheless clearly demonstrated throughout the discussion and in the organizational documentation collected through the desk review and questionnaire response.

A. Perceptions of collaborative stakeholders with regard to the work of Christian religious entities

When representatives of other collaborative stakeholders such as government, donors and other religions were asked to reflect on the work of CREs, they identified three major areas of strength.

(1) The first related to the **reach** of CREs, particularly in the rural areas. It was felt that they were one of the few organs of civil society that were accessible to 'grassroots people' and therefore were in a position to mobilise and influence large groups.

> Most important is the churches capacity to reach the grassroots.

(2) The second major strength of CREs in the DRC is the fact that they have **credibility within communities** and are therefore trusted. Additionally, they are a moral voice and thus in a position to integrate HIV and AIDS information into their teachings. Participants saw this as an enormous asset which could be harnessed in the future.

(3) The third major strength is the fact that many CREs have **well developed structures** which enable them to work in an organized way in the rural areas. The example given in this regard, was that of the Catholic Christian entity, Caritas.

In summary, then, the three key strengths of CREs in their promotion of Universal Access are reach, credibility and well-developed structures. These strengths represent vital assets that are essential to strengthening multisectoral collaboration. From this we can make a finding that CREs represent vital assets with whom collaboration with other stakeholders is recommended in the interest of people infected and affected by HIV and AIDS in DRC

6.2.3 Findings concerning the strengths and weaknesses of current collaboration between Christian religious entities and other stakeholders

<u>Finding 4</u>: Christian religious entities in DRC are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths but a large number of weaknesses. (1) The main strengths are perceived to be the relationships that Christian religious entities have with their funding partners and particularly the Global Fund, relationships with government departments. (2) The main weaknesses are perceived to be the lack of relationship between and coordination of work amongst Christian religious entities, the different levels of knowledge and value systems between the partners, the difficulty of producing and administering a national policy in the midst of wider political crises, and a lack of government funding together with the vulnerability caused by reliance on external donors.

Through the desk review and the snowballing approach to the identification of participants for the workshop it was clear that CREs are involved in a range of collaborative partnerships. See 6.1.3 above and Appendix 5.6 for the selection of key collaborative stakeholders identified by advisors in DRC.

In a rough typology, these included: government bodies and structures, national AIDS coordinating mechanisms, international donors (a full range from large internationals to individuals), interfaith bodies or networks, national faith-based health networks (NFBHNs), denominational bodies, other NGOs, other CREs etc.[305]

This was confirmed in an exercise carried out with representatives from CREs in which they had to draw a 'spidergram' showing their relationships with one another, other faith-based organizations, government, and with donors. The exercise indicated a number of key issues:

- CREs have extensive relationships with a large number of external donors.
- Many CREs are funded by a number of different external donors.
- The relationships between CREs are not as strong as the relationships they each have with external donors.
- There is no strong relationship with a coordination body.
- There are no inter-faith relationships.
- Most CREs seem to have some kind of relationship with relevant government departments.
- Relationships with government departments are less significant than with external donors.
- There is no one government body channelling funds to CREs.

A. Perceptions of Christian religious entities about collaboration

In seeking to explore the perceptions of CREs about collaboration, time was spent exploring their understanding of government policy, government practice, and collaborative relationships with donors.

In the discussion on the spidergram exercise, participants felt that the strength of their collaboration lay in the fact that many of them operated using a common funding source, such as the Global Fund.

> There are lots of funding interventions … less collaboration between Christian organizations.

Despite this recognition, there was no real engagement in the discussion with the fragile nature of their operations, given their heavy reliance on this external funding. Some did, however, acknowledge their financial dependency on these external sources.

With regard to their relationships with government, they did feel that, despite not having a strong co-ordinating body, some collaboration did exist as a result of government policy. There are many government departments committed to mitigating the epidemic, such as PNLS (adopting a medical approach), PNMLS (adopting a multisectoral approach), MSL, PNTS, National Program of Blood Security and TB, PNT, Reproductive Health, PNSR.[306]

[305] As noted in chapter 2, one of the limitations of this study, and this exercise in particular was the lack of focus on relationships with other NGOs.
[306] See Appendix 1 for acronyms and abbreviations.

With regard to interfaith collaboration, there was recognition that while "we know each other, but we are not working together". The Interfaith AIDS Council (CIC) was formed by the mainline churches, but it was felt that it "doesn't really bring everyone together".

> CIC was formed, but there has been a problem of leadership ... there was a small group … this should be the collaborative structure, but it is not working.

Arising out of the discussion, participants evaluated their own strengths and weaknesses as CREs. They felt their major strength lay in the fact that they have a broad community base and they are firmly part of the social structure of their society. CREs are seen to have credibility which enables them to mobilise resources and have a moral voice within their communities. They acknowledged "that the church is best placed to reach people". However, participants also acknowledged their weaknesses. They felt that there is a lack of scientific knowledge about HIV and AIDS which leads to a lack of ownership of responsibility in mitigating the epidemic. Within their organizations there are inadequate material resources such as medical equipment and drugs, and in some cases an underutilization of resources. There was also recognition that there are divergent doctrinal and cultural practices, demonstrated in differing views on condom promotion and attitudes to the practices of polygamy and circumcision.

At the end of the discussion on the spidergram exercise, there was general consensus that there is a need for a national plan which includes a coordinated financial strategy that has been drawn up in a participatory manner. The participants expressed a desire for a multisectoral forum where these issues could be discussed in a more in-depth way.

Interaction with Government Policy

In trying to assess participant's views on **government policy**, it became clear that while a policy exists, it was drawn up in the late 1990s and largely focuses on a medical multisectoral response. It is also not widely known or understood, hence the desire for a different and more participatory process to be established in order to draw up a more current and inclusive national plan.

> The HIV and AIDS policy was distributed a long time ago, with the new tools and info we are getting the policy is outdated…it was before 2004 - around 1999.
>
> Because it was outdated and other issues needed to be included, the distribution process was stopped. There is a new commission working on it, a new version which should come out at the end of 2008.

This new initiative is generally viewed positively as the following comments indicate.

> Norms and regulations would give uniformity ...
>
> This would be a unique framework of doing action, leading to co-ordination.

There were some reservations expressed, such as:

> ... there are legal questions that need to be addressed. Allocated resources need to be challenged … you lose creativity with a national framework.
>
> Most importantly, political will needs to be confirmed otherwise nothing will be implemented.

While a desire was expressed to be part of such an initiative, it appeared that participants were sceptical as to whether sufficient time and energy will be invested in making sure this National

Action Plan is implemented, given the overwhelming problems facing the health system in general in the DRC.

Interaction with Government Practice

In the discussion on **government practice**, participants felt that there was some emphasis on a multisectoral approach and that some training as well as the distribution of ART is taking place. These actions are viewed positively. However, concern was expressed that insufficient funding is being allocated to the HIV and AIDS epidemic. When probed about limited resources in the DRC given the enormity of the process of stabilising the society, there was general consensus that there is sufficient funding, but the issue is that of political will. In addition, allusions were made to corrupt use of funds which needed to be rooted out within government practice.

> [I want to] stress that it is a problem of political will … the senator can correct me … we have a lot of resources in this country … if there was a will we could do it … we know where the money is going ...

This comment evoked heated debate.

> A government should be responsible for issues arising in a country … so government can have internal/external resources. The problem is how to make a fair distribution … how can we make sure that the resources for HIV and AIDS are where they are needed. I do not agree that the country is wealthy … but yes, potentially wealthy.
>
> It is a problem of priority … where do you start? Everything is a priority, that is the challenge … a chicken and egg situation … a question of how the little we have can be used efficiently.

In addition to government not allocating sufficient funding in order to mitigate the epidemic, it was also felt that there is insufficient engagement with NGOs and communities at a grassroots level.

Interaction with donors

In resuming the discussion on the interaction of CREs with **donors**, participants reiterated their appreciation for the extensive support offered by international agencies by way of funding and technical assistance. However, it was noted that as a result of programmes being heavily funded externally, this resulted in agendas being driven by the donors.

> Funders are dictators, they tell you what to do rather than let your see what needs to be done.
>
> There is no alignment between funding and priorities; they just withdraw the funding while the project is running.

Some also indicated that the heavy reliance on external funding rendered their programmes unsustainable in the long term. This was an important acknowledgment, as earlier in the spidergram discussion, they had not been willing to engage this matter.

Funding, more often than not, is given to a project for a limited period which makes long term planning difficult. This exacerbates the problem of a lack of ownership of the project by the local Christian Entity.

> When funding dries up, churches stop their involvement, no ownership of programme.

It also appears that local, indigenous CREs find it difficult to access funds, while those that already have international links, such as the Catholics with Caritas or CAFOD, are at an advantage and directly benefit from these networks.

Many participants felt funding application procedures were complex which hindered access to funding. This is particularly true for CREs working in the rural areas.

> The rules of funding are not well known, some institutions don't know how to access such funding.

In addition, monitoring and evaluation procedures are time consuming.

> It is all very stressful, all the red colours (pointing to the donors on the spidergram) … each organization has different forms, different M&E procedures, and different ways of reporting. At the end of the day we do not have time to do any work!

From the discussion, there appears to be competition between donors which hampers effective action in mitigating the epidemic.

> There is a lot of competition between each other and funders … they open the door and then keep it to themselves … they want tangible results.
>
> Funders want results for themselves … there is competition between funders … don't like [to give to organizations with] multiple funders.

There was also a feeling amongst participants that funding from large international agencies was not reaching grassroots communities.

> [The] Global Fund recipient in the DRC is the UNDP ... they already have some funds and it goes to salaries of experts, rather than to the grassroots.
>
> USAID, FNUAP etc take the money, even though they have their own money.

These comments either indicate ignorance on the part of the CREs, or that there is a lack of transparency as to how monies from the Global Fund are being used by donor agencies.

In summary, it is clear that CREs in DRC are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths but a large number of weaknesses. (1) The main strengths are perceived to be the relationships that CREs have with their funding partners and particularly the Global Fund, relationships with government departments. (2) The main weaknesses are perceived to be the lack of relationship between and coordination of work amongst CREs, the different levels of knowledge and value systems between the partners, the difficulty of producing and administering a national policy in the midst of wider political crises, and a lack of government funding together with the vulnerability caused by reliance on external donors.

6.2.4 Findings concerning the challenges and potential of collaborative partnerships between Christian religious entities and other stakeholders

<u>Finding 5</u>: Christian religious entities and their collaborative stakeholders see both challenges and potential in such partnerships. The challenges have to do with the fragile state of the country and of coordinating structures, the dependency syndrome with funders, the lack of knowledge about HIV and AIDS amongst Christian religious entities, and the conservative doctrinal emphases of certain churches. Yet it was also acknowledged that the potential for partnerships lies in the relationships that both government and CREs have with international donors, the recognition of mutual strengths, and a desire to work together.

As was noted at the beginning of the previous section, there are a number of existing structures and forums that already exist and offer enormous potential for strengthening collaboration. However, it is clear that existing co-ordinating structures are fragile in the DRC. Structures such as 'ABCS' were identified in one workshop as a key network for government and "all partners" to work within, but was not mentioned by the participants at the other workshop. On the other hand, the collaborative stakeholders assume that inter-faith work is happening through the Inter-faith Council, yet the participants from CREs acknowledged that this body is effectively not functioning and does not represent all interested parties.

Clearly while there is currently no effective multisectoral collaboration taking place, there are foundations on which to build in the future. The most important of these is the relationship that both CREs and government have with international donors. The challenge is to ensure that structures are in place that bring all three parties into relationship with one another.

In order to better understand future collaboration with CREs, it is important to assess what potential exists in such a relationship and what are some of the challenges that would need to be taken into account.

There is no doubt that collaborative stakeholders see CREs as crucial in mitigating the HIV and AIDS epidemic. They are seen to be deeply rooted in grassroots communities and therefore provide access to this important constituency. Because of their credibility in communities, they have the potential to mobilize large groups of people.

> The church has the capacity to mobilize.

Within these communities, CREs have credibility and are also seen to have a moral voice. In addition, they have infrastructure which enables them to organize programmes in rural areas.

There is a perception among some collaborative stakeholders, however, that currently there is ignorance within a large number of the CREs with regard to HIV and AIDS knowledge. This is linked to a feeling that CREs do not currently have the resources to be strategically involved in mitigating the epidemic. As a result they do not 'own' HIV and AIDS work. However, there was no consensus on this matter, as others felt that the lack of ownership is simply related to a lack of knowledge.

> I think it is mostly a lack of scientific information. When FBO leaders know how HIV and AIDS is spread, they might not consider adultery as the main way it is spread ... Therefore training of the trainers is important in order to pass on the information.

But, collaborative stakeholders acknowledged that the potential of CREs has not yet been harnessed. They also realise that if the assets of CREs are not harnessed, then this potential strength can turn into a weakness in collaborative efforts. For if CREs 'sit back' and do not get

involved, as some participants felt was the case, then huge groups of people will not be influenced.

> In this country, certain church leaders speak, but there is little will [generally].

Having said all of this, it also became clear through the discussion that the perception of Christian Entity participants that collaborative stakeholders do not have much communication with grassroots communities is correct. Perhaps CREs are more involved in small, local community initiatives than these collaborative stakeholders are aware of.

Furthermore, some donor stakeholders admitted that, because of the dependency on funding, their relationship with CREs was often not a mutual one. Financial dependency prevents real partnership.

> There is financial dependency of the Christian organizations … we can't talk about partnership … we pretend it is a partnership … this is the ideal … it is what it works but in reality it is not like that.
>
> Financial dependency is really a threat, especially sustainability once the funds have stopped.
>
> We pretend we want the partners to decide, but it is not so easy to practice what you preach.

A further key challenge relates to doctrinal differences amongst CREs and between CREs and their collaborative stakeholders. 'Revival churches' are considered mainline and have a large following in DRC. Thus, the extent to which they are involved in mitigating the epidemic becomes an important issue.

> In this country, revival churches do not see HIV and AIDS as part of their mission. For them, HIV and AIDS is a medical or hospital problem, not a spiritual problem.

A further doctrinal issue relates to the promotion of condom use. This issue remains a source of contention amongst CREs and, as was noted earlier, there are divergent views regarding this matter. Some large CREs such as the Catholic church will not promote condom use in their prevention messages. This can be a source of conflict in collaborative efforts.

> The discussion on condoms is outdated … in terms of the Interfaith Council … the entry point is that we agreed that HIV/AIDS is not a punishment from God, and then said HIV/AIDS is one of many challenges … we won't promote condoms, only a way to preserve human life.

Collaborative stakeholders felt that the conservatism of CREs is deeper than the condom issue, as it relates to a particular kind of theology that leads to HIV and AIDS stigma and discrimination.

This perception of CREs as being unwilling to be involved in the HIV and AIDS epidemic through their conservative and dogmatic doctrinal beliefs, remains a key challenge to multisectoral collaboration.

A further challenge relates to perceptions of the role of government in mitigating the epidemic. As was noted earlier, CREs feel that government coordinating structures, such as PNLMS, are not functioning well. Monies from international donors drive the agendas rather than the national government. In addition, the National AIDS Plan is currently no longer relevant. On the other hand, collaborative stakeholders perceive CREs as not wanting to align themselves with

government policy, and some even suggested that they were ignorant of this policy. To a certain extent this ignorance was displayed in the CREs' workshop.

This situation highlights, yet again, the breakdown in communication between the three groups of collaborative stakeholders. This is despite a joint initiative between CIC (Interfaith Council), UNAIDS, CORDAID working on behalf of PNMLS (National Aids Council) and UNAIDS. This initiative sought to mobilize and share resources. A declaration was signed in December 2007 by these parties as well as leaders of CREs, including the Revival Churches.

In summary, clearly collaborative efforts are not sufficiently coordinated so as to maximise the enormous potential that lies within the key stakeholder groups namely, religious entities, Government, and international donors. Through discussions as to a way forward for more effective collaboration in the future, participants of both workshops indicated a desire to work towards this goal. CREs want to be in a mutual partnership with the other collaborative stakeholders and these stakeholders want to see CREs playing a more significant role in mitigating the epidemic.

Finding 6: There is an obvious commitment to strengthening the partnership between Christian religious entities and collaborative stakeholders from both sides. From the Christian religious entities there is a desire for greater participation in the decision making around the control of funds. From the collaborative stakeholders there is a desire that Christian religious entities be drawn into the National Plan, its policy formulation and implementation.

Despite the challenges noted in the previous finding, the researchers felt a desire expressed by both sides, for opportunities to improve collaboration.

A. Hopes for stronger collaboration: Christian religious entities

Issues of coordinating structures and the place of a National AIDS Plan was important to Christian Entity participants. However, of far more importance were the funding relationships. They felt for collaborative efforts to improve in the future, the contentious issues around donor engagement with CREs needed to be reassessed. Funding needed to be context-specific and include the recognition of Congolese expertise, if it is to reach the targeted grassroots communities.

B. Hopes for stronger collaboration: Collaborative stakeholders

Collaborative stakeholders also reflected on suggestions for a way forward in strengthening multisectoral collaboration.

Collaborative stakeholders, in addition, felt that funding issues were important, but for different reasons than Christian Entity participants. They felt that CREs needed to be far more accountable and transparent in their use of funds so that in the long term, their mitigation of the epidemic would be more effective. However, this view needs to be tempered by the fact that international donor agencies, such as UNAIDS, have enormous influence and control of agendas that it is crucial that this is acknowledged in any collaborative relationship with CREs.

On a positive note, one participant at the collaborative stakeholders' workshop summarised the way forward as follows,

There is a need for a National Plan with clear outputs, a platform to include all FBOs and educate the leaders, FBOs should be included in planning, a national co-ordinating body [needs to be put in place], and improved collaboration and co-ordination leading to mutual respect.

6.3 Recommendations arising from the research findings in DRC

6.3.1. For the attention of the Christian religious entities

- Assess effectiveness of the National Inter-faith AIDS Council (CIC) and restructure ensuring appropriate representation.
- Strengthen relationships with one another through establishing regular forums for dialogue and information sharing.
- Strengthen relationships with government stakeholders by inviting them to these faith-based forums.

6.3.2. For the attention of government

- Involve all collaborative stakeholders in the process of updating the National Action Plan.
- Plan strategic interventions that operate from the premise that HIV and AIDS is a development issue and not simply a medical issue.
- Involve religious entities in ensuring that HIV and AIDS information is reaching the grassroots communities.

6.3.3. For the attention of donors

- Establish a forum of representatives of all funding partners as a matter of urgency.
- Develop one set of reporting and monitoring and evaluating procedures.
- Work with government and CREs in establishing priorities for strategic interventions.

6.3.4. For the attention of all

- Prioritise the principles of the Three Ones as a way forward for collaborative efforts.
- Build on the existing agreement signed by all parties in December 2007.
- Establish regular regional forums for all collaborative stakeholders that enable ongoing dialogue, information sharing, and evaluation of strategic interventions.

Chapter 7

Key Findings and Recommendations

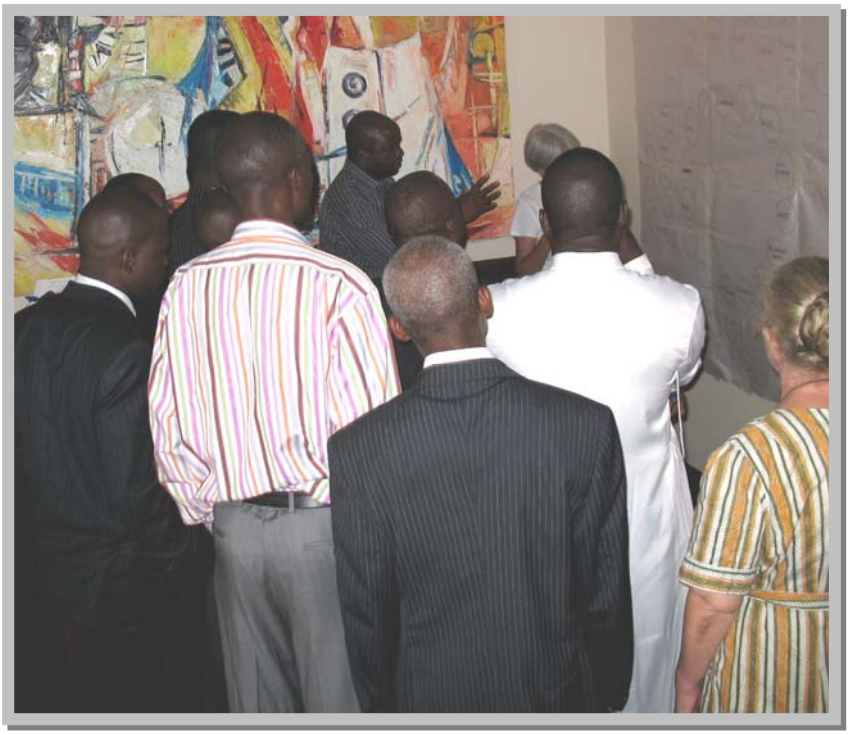

Figure 7.1: Participants in the DRC - 2008

Chapter overview

This final chapter engages with the findings of the preceding report, drawing conclusions across the three countries, and moving towards broader recommendations.

7.1 Introduction: similarities

In conducting this three-country study, it was clear that there were certain similarities between the countries. Rather crudely stated, these were three countries of sub-Saharan Africa, they all have established HIV and AIDS epidemics, and are countries with a Christian majority. Before moving into the concluding discussion, we shall consider some other basic similarities between the three countries:

- Kenya, Malawi and the DRC are all faced with complex epidemics that are tied into issues of poverty, socio-economic challenges, and other diseases such as malaria and TB.
- They all face particular national challenges that exacerbate the epidemic, for example, in Malawi poverty and food security are key, in the DRC conflict and security, in Kenya the challenges of development and financing of ART (as well as more recent political turmoil).
- They all have severely weakened health systems and, among other challenges, are faced with a seemingly insurmountable human resource crisis in the health sector.

- They all have a mission history of religious involvement in health and education, which has resulted in religious entities 'owning' significant percentages of the health sectors. In all three countries 'religious entities' comprise a complex array of international organizations, national organizations, ecumenical or denominational bodies, health desks, networks, community organizations, congregations and congregational programs.
- They have all experienced a boom of religious entities engaging in HIV and AIDS since 2000.
- They all recognize that these religious entities are a crucial partner in the struggle against HIV and AIDS, and that they need to be significantly involved in national AIDS policies and programmes.
- They all have a complex donor-partner environment, with some funding being driven through funding pools, and others arriving directly from donors.
- They all work in a context of what is termed 'multisectoral collaboration' in each of their countries.
- Finally, all three countries are committed to collaboration driven by the principles of the Three Ones.

7.2 Findings from the country chapters

Before introducing broader findings across the three-country study, we briefly reiterate the findings from the three preceding chapters, grouping them in broad thematic categories:

Findings concerning the context in which Christian religious entities are working

Kenya: CREs in Kenya perceive themselves to have a long history of participation in national and social life, including responding to the HIV and AIDS epidemic. Furthermore, they recognise the contextual factors in this national and social life that drive the epidemic.

Malawi: CREs in Malawi are proud of the role played by religious leadership in the social life of the country, but recognise that they have only recently begun to respond to the HIV and AIDS epidemic.

DRC: CREs in the DRC perceive themselves to have had a long engagement with the epidemic from a medical perspective. However, it is only since 2000 that there has been a significant pastoral engagement. CREs also perceive the HIV and AIDS epidemic to be strongly related to other social and political crises in the country, and acknowledge that initiatives have been hampered, until recently, by the civil war.

Findings concerning the work of Christian religious entities in the promotion of Universal Access

Kenya: CREs in Kenya are committed to, and involved in promoting Universal Access to prevention, treatment, care, and support in a number of significant ways, including education and awareness, provision of ART, care for orphans and vulnerable children and vocational support. This work is aimed at a wide range of beneficiaries, although there is a particular focus on the rural areas, and on women

Malawi: CREs in Malawi are committed to and involved in promoting Universal Access to Prevention, Treatment, Care and Support including education around abstinence and behaviour change, the provision of ART, home-based care groups and work with orphans and vulnerable children, and psycho-social support services. While the work is aimed at a wide range of beneficiaries, young people, women and rural citizens form the key target groups.

DRC: CREs in the DRC are committed to and involved in promoting Universal Access to prevention and treatment, and to a lesser extent care and support. Prevention involves education and the distribution of condoms, and there is an extensive involvement in the provision of ARVs. CREs recognise that their beneficiaries are women and Christians. Work is undertaken in both urban and rural settings.

Kenya: In their contribution to Universal Access CREs in Kenya are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, legitimacy and resources. These strengths represent vital assets that are essential to strengthening multisectoral collaboration

Kenya: CREs in Malawi are acknowledged by collaborative stakeholders as having key strengths, namely, their reach to the grassroots, the resources they have at their disposal, and the capacity of offer psycho-social support. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

DRC: In their contribution to Universal Access, CREs in the DRC are acknowledged by collaborative stakeholders as having three key strengths, namely, reach, credibility and well-developed structures. These strengths represent vital assets that are essential to strengthening multisectoral collaboration.

Findings concerning the strengths and weaknesses of current collaboration between Christian religious entities and other stakeholders

Kenya: CREs in Kenya are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the clarity of the national policy, the collaborative structures that have been established, and the increased funding for CREs. (2) The main weaknesses are perceived to be the lack of collaborative processes, the lack of representation in some forums, the lack of financial commitment from government, and the burgeoning bureaucracy especially around financial reporting.

Malawi: CREs in Malawi are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. (1) The main strengths are perceived to be the wide range of funders supporting work in Malawi, the willingness expressed in the national policy to engage with the religious sector, and good working relationships at local and district level. (2) The main weaknesses are perceived to be the lack of engagement by CREs at a national level with NAC and MIAA, competition and conditionalities around funding, and the lack of a common agreement on the efficacy of 'spiritual healing'.

DRC: CREs in DRC are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of

strengths but a large number of weaknesses. (1) The main strengths are perceived to be the relationships that CREs have with their funding partners and particularly the Global Fund, relationships with government departments. (2) The main weaknesses are perceived to be the lack of relationship between and coordination of work amongst CREs, the different levels of knowledge and value systems between the partners, the difficulty of producing and administering a national policy in the midst of wider political crises, and a lack of government funding together with the vulnerability caused by reliance on external donors.

Findings concerning the challenges and potential of collaborative partnerships between Christian religious entities and other stakeholders

Kenya: CREs and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges such as competition amongst stakeholders, the dogmatism and conservatism of CREs, and their lack of capacity are balanced by a mutual appreciation of the strengths of each partner, and a shared desire to improve collaboration.

Malawi: Both the CREs and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges include differing belief and value systems, difficulties with adhering to monitoring and evaluation standards, the dissemination of information, adequate representation, funding conditionalities, and inter-faith collaboration. These challenges are balanced by an awareness of the potential for these partnerships amongst both CREs and collaborative stakeholders, given the commitment to the Three Ones policy.

DRC: CREs and their collaborative stakeholders see both challenges and potential in such partnerships. The challenges have to do with the fragile state of the country and of coordinating structures, the dependency syndrome with funders, the lack of knowledge about HIV and AIDS amongst CREs, and the conservative doctrinal emphases of certain churches. Yet it was also acknowledged that the potential for partnerships lies in the relationships that both government and CREs have with international donors, the recognition of mutual strengths, and a desire to work together.

Kenya: There is an obvious commitment to strengthening the partnership between CREs and collaborative stakeholders from both sides. From the CREs there is a desire for greater participation of a range of stakeholders in formulating national policy and donor strategies. From the collaborative stakeholders there is a desire for a stronger commitment to the national M&E process.

Malawi: There is a desire for stronger multisectoral collaboration in Malawi, without a further proliferation of initiatives. CREs desire a greater focus on local and district level initiatives. Collaborative stakeholders desire a greater commitment to collaborative planning, monitoring and evaluation. All parties hope for a greater focus on cultural and gender aspects of the epidemic.

DRC: There is an obvious commitment to strengthening the partnership between CREs and collaborative stakeholders from both sides. From the CREs there is a desire for greater participation in the decision making around the control of funds. From the collaborative stakeholders there is a desire that CREs be drawn into the National Plan, its policy formulation and implementation.

7.3 Multisectoral collaboration in the context of HIV and AIDS

In light of these findings, we will now draw recommendations across the three-country context. We use as our framework the principle of the Three Ones. In April 2004, a consultation process undertaken by UNAIDS was set up in order to build a common ground around what is known as the Three Ones. "The Three Ones principles are specifically developed to cope with the urgency and need to ensure effective and efficient use of resources and focus on delivering results - in ways that will also enhance national capacity to deal with the AIDS crisis long term".[307] The principles of the Three Ones include:[308]

- **One** agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners
- **One** National AIDS Coordinating Authority, with a broad based multisector mandate
- **One** agreed country level Monitoring and Evaluation System

In seeking to understand the extent and effectiveness of collaborative partnerships in the three countries under study, Kenya, Malawi, and DRC, these principles are a useful framework for the discussion.

7.4 Recommendations for improved collaboration

> *Collaboration, dialogue and partnership should be on an ongoing basis, rather than for a single programme or event. Mature relationships and partnerships would then mature, and create possibilities for other joint activities*.[309]

What is clear from these findings and recommendations offered for each country is that, while there are some differences in each context, there are seven broad findings about collaboration and partnerships that emerge out of the research process. These seven findings will be discussed in more detail in this concluding chapter, so as to enable more deliberate future discussion on the outworking of the Three Ones principles in different contexts in Africa.

<u>Finding 1:</u> Different contexts in Africa are at different stages of multisectoral collaboration as expressed in their commitment to the Three Ones principles. The implementation of the Three Ones principle is a development strategy, and not simply a response to a medical problem

Each of the three countries is at a different stage of multisectoral collaboration which is a result of a number of factors, both internal and external.

The *Kenyan* case-study revealed that of the three countries, it is the most committed to the Three Ones principles. There is a clear National AIDS policy, a National AIDS committee, and a Monitoring and Evaluation system is in place. Christian religious entities seem to feel valued for their work in mitigating

[307] UNAIDS 2004
[308] UNAIDS 2004
[309] UNFPA 2004

the epidemic by government stakeholders and generally there is a 'context of openness' to collaboration by all. This openness is related to the efficient way in which the principles have been targeted and applied, but also because civil society has been drawn into the process. Until recently, the socio-political context has been stable and Kenyan society has enjoyed a proactive response to the epidemic on the part of all the stakeholders.

The *Malawian* case-study revealed that despite a commitment on the part of government to the Three Ones principles, there is a great deal of fragmentation amongst the stakeholders in their response to the epidemic. Christian religious entities are not collaborating well together which is, to a large extent, the result of the extensive donor partners that operate in isolation from one another. This context of an 'AIDS industry' has meant that even though the faith sector has a coordinating body, it has not represented the interests of all involved. While Malawi has put a culturally relevant National AIDS policy in place it is not owned by all stakeholders, including Christian religious entities. Yet, there remains a reluctance to engage with the policy critically.

The *DRC* case-study highlights not only the importance of adherence to the Three Ones principles, but also how difficult it is to do so in a fragile context, and possibly a context where 'suspicion' is stronger than trust. Collaborative stakeholders were by far the most fragmented in their response to the epidemic and least able to engage in depth with the issues of multisectoral collaboration. Clearly, the socio-political situation of conflict for over a decade has hampered a coordinated response, exacerbated by the over-burdened health system. The implementation of the Three Ones principles needs to be understood by the collaborative stakeholders in this context as a development strategy, and not simply as a response to a medical problem.

Finding 2: One national action framework, one coordinating body, and one monitoring and evaluation system, in and of itself, does not promote better collaboration between government, donors, and Christian religious entities. Trust is an important element in making the Three Ones work.

This three country study has revealed that, despite a commitment to the Three Ones principles (albeit to varying degrees in each country), Christian religious entities seemed to own these principles to a greater or lesser extent in different contexts.

The DRC case study demonstrated the least commitment on the part of the national government to these principles, while Malawi had a well structured policy, national body, and a monitoring and evaluation system. However, there was not substantially more commitment to these structures by Christian religious entities in Malawi than in the DRC. In both countries, the relationship between government and Christian religious entities was not as trusting as is the case of Kenya. *It is this trust relationship that is far more important to collaboration than structures and systems.*

It is important that Christian religious entities are not simply 'blamed' for the lack of trust because the contextual reality identified in the first finding (above) has an impact upon levels of trust. There may be good reasons why Christian religious entities do not trust government leaders and government policy. The wider framework of transparency, accountability and good governance provides an important context in which trust is to be understood.

Finding 3: The Three Ones principles can only be effective if there is recognised and effective representation on the co-ordinating structures through which government operates, and a common commitment to monitoring and evaluation.

The Three Ones principles require a commitment to representivity and a commitment to a common vision for monitoring and evaluation. In terms of the first concern, this research has revealed that co-ordinating structures used by national governments in order to communicate with particular sectors (such as the religious sector) has to be perceived to be truly representative of their particular interests.

In both Kenya and Malawi, the two contexts where the Three Ones principles are most closely adhered to by the national governments, the co-ordinating structures of the faith-based religious sector are not functioning optimally. In both instances the government stakeholders assume that the existing faith based co-ordinating structures are a legitimate structure through which to channel resources and information. However, this is not experienced to be the case. Both of these bodies are not seen to be representative of all stakeholders within this sector. This means that government needs to ensure that when electing representatives for these bodies, it must adopt a participatory process in order to avoid relating to particular individuals who prove unhelpful to an overall strategic response to the HIV and AIDS epidemic. That is, the establishment of a co-ordinating interfaith AIDS structure should not be the culmination of, or replace a broad-scale participatory process, but should continue to be challenged and examined in terms of representivity. This is particularly the case with the 'religious sector' which as a category contains a broad and complex range of organizations and individuals.

Attention must also be given to one common monitoring and evaluation system, for the collaborative stakeholders see this as a crucial aspect of an effective partnership. However, this research suggests that there is often a discrepancy between what the collaborative stakeholders wish to monitor and evaluate, and what Christian religious entities understand themselves to be doing. While the former focus on observable outcomes, the latter are often driven by religious principles and intentions which are difficult to evaluate. This underlying difference in values or conceptions of what is 'good', illustrated in all three countries around the ABC strategy, needs to be brought into the open.

It is clear that if CREs are to become helpful partners with other public health actors in responding to HIV and AIDS, there is a need to embrace a focus on actual observable health outcomes. This move will involve the development of a standardised and uniform reporting system around key outcomes and indicators. This will involve the building of M&E capacity within the religious sector as part of the promotion of public health literacy for religious leaders.

Finding 4: For multisectoral collaboration to be an effective response to the AIDS crisis, each group of collaborative stakeholders needs to be in existing collaborative relationships within their sectoral grouping.

The three country study revealed that for multisectoral collaboration to be effective, stakeholders need to have good relationships within their own groupings.

All three countries displayed fragmentation of relationships within the Christian religious entities and within the donor groupings. This leads to competition within each group and between these two groups. This context of competition hinders effective collaboration. If this is the case, then commitment to the Three Ones principles is limited, particularly in relation to monitoring and evaluation. It is important that in contexts where there are a large number of donors, forums are established for donors to liaise, strategise, and develop systems of monitoring and evaluation that are consistent with those put in place by the national government.

Likewise, Christian religious entities need a forum where different aspects of their work are discussed, information is shared, and co-ordinated action plans are made. The Three Ones provides a national framework, but one that also needs to be realised on the ground where concrete steps are being taken towards responding to the epidemic. Thus it is important to recognise that such collaboration needs to happen at district and local levels However, local Christian religious entities may themselves not have the capacity or competency to drive such collaboration, and attention may have to be given to legitimate and recognised intermediary bodies to support this inter-sectoral collaboration.

Finding 5: The nature of donor involvement is crucial to national governments and Christian religious entities 'owning' the agendas of strategic plans to mitigate the epidemic.

The three country study revealed that donor agencies play a powerful role in driving strategies set up to mitigate the epidemic. Despite moves to talk of 'partnership' rather than 'donors', the reality of the power dynamics in the relationship and the need for funding, creates tension and sometimes breeds resentment that can only be shared in contexts where anonymity is ensured. Feelings by the Christian religious entities that external agendas are being imposed on the local context are strong in all three countries, and the withdrawal of funding becomes a tool of power that often renders local stakeholders impotent. Furthermore, the number of financial reporting requirements for each donor, and the bureaucracy surrounding access too and accountability for funding, contributes to this sense of power discrepancies.

This issue of donor involvement was highlighted in all three countries but is particularly the case in Malawi, a context where the response to AIDS has developed to 'industry' levels; and in the DRC where donors are already heavily involved in the stabilisation of the society after the years of conflict. The shifting of decision-making from international donor agencies to national structures and civil society is a process which needs to be addressed in order for multisectoral collaboration to improve.

Finding 6: Christian religious entities need to be recognised by national governments as having vital assets necessary to mitigating the HIV and AIDS epidemic, including reach, legitimacy, resources and structures. The leverage of these assets in this task necessitates ongoing collaboration

The three country study revealed that in each context Christian religious entities have vital assets which are being used to mitigate the epidemic. The leverage of these assets for public health provides the basis upon which collaboration becomes possible.

In all three countries, Christian religious entities are engaged in activities that foster Universal Access to Prevention, Treatment, Care and Support. Beneficiaries vary in terms of age, location, gender, and religious constituency, but all activities make a contribution to the mitigation of the epidemic. In all three countries, collaborative stakeholders spoke of the legitimacy and credibility which the Christian religious entities have in this work.

Further, representatives of national governments acknowledge that Christian religious entities have an extensive 'reach' through their durable network of relationships at the grassroots level. Christian religious entities are strategically placed to communicate with local communities, and particularly those in far-flung rural areas. A particular area of influence is in their engagement with youth, and on a continent where 40% of the population is under the age of 15 years, this too is vital. In the case of Kenya, where government has overtly embraced the services of Christian religious, there is greater trust leading to an openness to further collaboration. This is not that evident in the DRC and Malawi where Christian religious entities do not enjoy the same level of recognition by government.

A key matter of concern that emerged from the research concerned the experience that many Christian religious entities have of being overwhelmed with responsibility for orphans and vulnerable children. Some organizations are stretched to breaking point. A collaborative response to the epidemic will both recognise the work undertaken by Christian religious entities and seek to mitigate such experiences. This indicates that if Christian religious entities are to leverage their assets towards playing a stronger role in responding to the epidemic then they will need access to greater financial resources.

Finding 7: Christian religious entities need to acknowledge their conservative belief systems as being a hindrance to an effective collaboration and be willing to build a contextual theological response that recognises poverty as a key driver of the HIV and AIDS epidemic.

This three country study revealed that many Christian religious entities continue to be perceived by collaborative stakeholders as being conservative, dogmatic, and intransigent on certain issues such as the promotion of condoms. This ethos of many Christian religious entities continues to hamper collaborative efforts by entrenching the long held view that they fuel stigma and discrimination through incorrect theology that suggests that 'AIDS is a punishment from God', and through messages that continue to suggest that promiscuity is the leading cause of HIV infection.

The promotion of public health literacy (finding three above) is a crucial aspect of this task. Christian religious entities often approach issues of health and disease from an individualistic perspective, and so move quickly to moralism, or see the solution lying in individual healing. A greater appreciation of the social determinants of health would open Christian religious entities to crucial social aspects in the

struggle against HIV and AIDS. Thus the fact that poverty is one of the key drivers of the epidemic in all three countries needs to be overtly embraced by Christian religious entities leading to a more contextual approach to both their theology and to their ethics.

7.5 Conclusion

This research project carried the following three main objectives (see 1.1.3):

1. To identify the kinds of AIDS work being undertaken by religious entities (in the initial stage specifically *Christian religious entities* with a national presence) - in *Malawi*, *Kenya* and the *DRC*.
2. To examine the relationship between this work and the National AIDS strategies in those countries, with a view to examining the nature of the relationship between the government and its donors, and these religious entities.
3. To propose strategies for strengthening the collaboration between the health assets held by the religious entities, and the government and donors.

It was recognised in the research design that meeting these three objectives would require a two phased approach (see 1.2.). The research findings in each country (chapters 4, 5 and 6), and the seven findings about collaboration in this final chapter relate to Phase I. Here the importance of the *Three Ones* approach has emerged as crucial.

In order to strengthen this approach, this chapter has noted the importance of

- Taking the unique context of each country seriously as it impacts upon the adoption and progress of the Three Ones.
- Understanding 'trust' as a crucial element in the success of the Three Ones.
- Strengthening a commitment to wide representation, and a common framework for monitoring and evaluation, as fundamental to the success of the Three Ones.
- Strengthening intra-sectoral collaboration as a key element of the multisectoral collaboration envisaged in the Three Ones.
- Focusing on the power dynamics amongst collaborative partners that might militate against local ownership of the Three Ones.
- Continuing to leverage the assets of Christian religious entities as a crucial component of the Three Ones.
- Encouraging Christian religious entities to reflect on the impact that their (conservative) theology might have on their ability to participate in the Three Ones.

It was envisaged that Phase I would culminate in an Interim report. This report and these findings provide the foundation for phase II, which involves the following two further steps:

- To make the findings of the research and the proposed policy implications available to key actors in the field of AIDS work, and to gain their perspectives. It was agreed that this would take place at the International AIDS conference in Mexico in August 2008.
- Thereafter to work with a representative gathering of key leaders from both the Christian religious entities and the collaborative stakeholders to establish ways of strengthening their partnerships, and their alignment around the National AIDS Strategy.

It is our hope that this report and that these two steps will contribute to the wider vision of the defeat of the HIV and AIDS epidemic in our generation. It is clear that if we are to get anywhere near to meeting this goal, then a solid and creative partnership must be forged between all the key stakeholders identified in this report. Such a task will involve ongoing dialogue, mutual understanding and trust.

> *Building partnerships is about working with others to achieve what we cannot achieve on our own. A partnership is a special kind of relationship, in which people or organizations combine their resources to carry out a specific set of activities. Partners work together for a common purpose, coherence and for mutual benefit. The advantage of working in partnerships is that different people and organizations have a wide range of resources to offer each other.*[310]

[310] Doupe 2005

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APPENDIX 1: Acronyms and Abbreviations[2]

AACC	All Africa Conference of Churches
ABC	abstinence, be faith, correct and consistent condom use
ACK	Anglican Church of Kenya
ADRA	Adventist Development & Relief Agency
AfDF	African Development Fund
AIDS	acquired immune deficiency syndrome
ANC	antenatal Care
ANERELA+	African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS
APCS	Action Presbyterian Contre SIDA
ARHAP	African Religious Health Assets Programme
ART	antiretroviral therapy
ARV	antiretroviral treatment
BCC	behaviour change communication
BDOM	*Bureau Diocésain des Oeuvres Médicales* (Diocesan Office for Medical Works)
BoD	burden of disease
CA	Christian AID
CAPA	Council of Anglican Provinces in Africa
CBO	community-based organization
CCAP	Church of Central Africa Presbyterian
CCCS	community care coalitions
CCIH	Christian Connections for International Health
CCM	Country coordinating mechanism
CCSMKE – ACK	Christian Community Services of Mt Kenya East (Anglican Church of Kenya)
CHAK	Christian Health Association of Kenya
CHAL	Christian Health Association of Lesotho
CHAM	Christian Health Association of Malawi
CHAs	Christian health associations
CHW	community health worker
CIC	*conseil interconfessionnel de lutte contre le SIDA* (Interfaith Council to Fight Aids)
CONGOMA	Council For Non-Governmental Organization In Malawi
CORDAID	Catholic Organization for Relief & Development Aid
CNMLS	*conseil national multisectoriel de lutte contre le sida* (National Multisectoral Council To Fight Aids)
CNOS	*Conseil National des ONG de Santé* (Health NGOs National Council)
CRE	Christian religious entity
CRS	Catholic Relief Services
CRWC	Christian Reformed World Church
CS	collaborative stakeholder
CSG	community support group
CSO	civil society organisation
CSW	commercial sex workers
CT	counselling and testing services
CUAHA	Churches United Against HIV and AIDS in Southern and Eastern Africa

[2] These are abbreviations and acronyms used in the report. See Appendix 6 for further organisational acronyms in each country.

CWS	Church World Service
DAPP	Development Aid from People to People
DATF	District AIDS Task Force
DFID	Department for International Development
DHO	District Health Office
DOSS	Directorate of Social Services - Anglican Church of Kenya
DOT	directly observed therapy
DP	Development Partners
DRC	Democratic Republic of the Congo (*République Démocratique du Congo - RDC)*
EAA	Evangelical Alliance of Kenya
EAM	Evangelical Association of Malawi
EC	European Commission
ECC	Ecumenical Counselling Centre
ECC	*Eglise du Christ au Congo* (Protestant Church of Congo)
ECC-DOM	*ECC-Direction des Oeuvres Médicales* (Department of Medical Works)
ECM	Episcopal Conference of Malawi
EHAIA	Ecumenical HIV and AIDS Initiative in Africa (WCC)
ELCM	Evangelical Lutheran Church in Malawi
ELDS	Evangelical Lutheran Development Service
EPN	Ecumenical Pharmaceutical Network
FBO	faith based organisation
FGM	female genital mutilation, also female circumcision or cutting
FHI	Family Health International
UNFPA	United Nations Population Fund
GoK	Government of Kenya
GFATM	The Global Fund to fight AIDS, TB, and Malaria
GTZ	*Deutsche Gesellschaft für Technische Zusammenarbeit* (German Cooperative Group)
HBC	home based care
HIMS	health information management system
HIV	Human Immuno-deficiency Virus
HR	human resources
ICASA	International Conference on AIDS and STIs in Africa
ICC	Inter-agency Coordinating Committee (for HIV/AIDS)
ICT	information and communication technology
IDP	internally displaced person
IEC	information, education and communication
IGA	income generating activities
IMF	International Monetary Fund
IMR	infant mortality rate
IRCK	Inter-religious Council of Kenya
IS	information system
ITK	Indigenous Tabernacle of Kenya
JAPR	Joint HIV/AIDS Programme Review
JICA	Japan International Cooperation Agency
KANCO	Kenya AIDS NGOs Consortium
KDHS	Kenya Demographic Health Survey

KEC	Kenya Episcopal Conference - Catholic Secretariat
KEMRI	Kenya Medical Research Institute
KIRAC	Kenya Inter-Religious AIDS Consortium
KNASP	Kenya National HIV/AIDS Strategic Plan
LISAP	Livingstonia Synod AIDS Programme (CCAP)
LISP	Lifeskill Promoters
M&E	monitoring and evaluation
MASHAP	Malawi Adventist Church HIV/AIDS program
MCC-PAC	Malawi Council of Churches: Public Affairs Committee
MDG	Millennium Development Goal
MEDS	Mission for Essential Drugs and Supplies
MF	Mutual Faithfulness
MIAA	Malawi Interfaith AIDS Association
MNCR	maternal, newborn, child and reproductive health
MoH	Ministry of Health (*Ministère de la Santé*)
MOU	memorandum of understanding
MSF	*Médecins Sans Frontières*
MTCT	mother-to-child transmission
NAC	National AIDS Council
NACC	National AIDS Control Council
NACC	National AIDS Coordinating Committee
NAPCP	National AIDS Prevention and Control Program
NASCOP	National AIDS (and STD) Control Program
NASP	National AIDS Strategic Plan
NCA	Norwegian Church Aid
NCCK	National Council of Churches of Kenya
NEPAD	New Partnership for Africa's Development
NFBHNs	national faith based health networks
NGO	non-governmental organization
NHS	national health system
OAIC	Organisation of African Instituted Churches
OI	opportunistic infection
OVC	orphans and vulnerable children
PCEA	Presbyterian Church of East Africa
PE	partner entity
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	primary health care
PIH	Partners in Hope
PIRHANA	Participatory Inquiry into Religious Health Assets, Networks, and Agency
PLWHA	person living with HIV/AIDS
PMTCT	prevention of mother to child transmission
PNFP	private-not-for-profit
PNLS	*programme national de lutte contre le SIDA* (DRC National AIDS Control Programme)
PNMLS	*programme national multisectoriel de lutte contre le SIDA* (DRC National Multisectoral Programme to Fight AIDS)
PRISAM	Private Schools Association of Malawi
PSI	Population Services International

QMAM	Quadria Muslim Association of Malawi
RCC	Roman Catholic Church
RE	religious entity
RHA	religious health asset
SA	The Salvation Army, *(armée du salut)*
SANRU	Santé Rurale
SCOM	Student Christian Organisation of Malawi
SDA	Seventh Day Adventist Church
SJCC	St Johns Community Center
SSA	sub-Saharan Africa
STD	sexually transmitted disease
STI	sexually transmitted infection
SU	Scripture Union
SWAp	sector-wide approaches
TB	tuberculosis
TBA	traditional birth attendant
TICH	Great Lakes University of Kisumu
TOT	training of trainers
UCT	University of Cape Town
UKZN	University of KwaZulu-Natal
UNAIDS	Joint United Nations Programme on HIV/AIDS *(ONUSIDA)*
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
USG	US Government
VCT	voluntary counselling and testing
WB	World Bank
WCC	World Council of Churches
WCRP	World Conference of Religions for Peace *(conseil inter religieux de RDC)*
WFP	United Nations World Food Programme
WHO	World Health Organization
WR	World Relief
WV	World Vision
YWCA	Young Women's Christian Association

APPENDIX 2: Glossary of selected terms[3]

Access to health services: Percentage of the population that can reach appropriate local health services by the local means of transport in no more than one hour. (UNICEF)

Acquired Immunodeficiency Syndrome (AIDS): the late stage of the infection caused by the Human Immunodeficiency Virus (HIV). A person living with HIV can look and feel healthy for a long time before signs of AIDS appear. However, HIV weakens the body's defence (immune) system until it can no longer fight off diseases such as tumours and cancers, and infections such as pneumonia, diarrhoea, TB and other illnesses.

Adherence: Closely following (adhering to) a prescribed treatment regimen. This includes taking the correct dose of a drug at the correct time, exactly as prescribed. Failure to adhere to an anti-HIV treatment regimen can lead to virologic failure and drug resistance.

African Religious Health Assets Programme (ARHAP): An international network of scholars and practitioners dedicated to developing a better understanding of, and greater appreciation for, the role of religious health assets for public health in sub-Saharan Africa.

African traditional healer (TH) denotes a complex typology and is constituted differently across Africa. For the purposes of this report, three types of indigenous health providers, or traditional healers, are indicated. They are constituted by (i) diviners, (ii) herbalists and (iii) traditional birth attendants (TBAs). Diviners practice on the basis of engagement with ancestral and spirit forces. Some herbalists distinguish themselves as working solely with herbal remedies. TBAs are community-based pregnancy and childbirth care providers, but often provide health advice, education and care beyond the field of maternity.

Agency: The capacity to "do", to move into action, to utilize the assets one has, to seek and achieve desired goals, as affected by social and environmental conditions. In the context of dramatic health challenges such as HIV and AIDS (and conditions of poverty), human communities have assets and the capacity to exert agency. Agency rests within individuals, but even more so in communities, organizations. The common assumption that poor people are "not able to do" is untenable. Poor people are always engaged in strategies and struggles for survival, adaptation and freedom.

AIDS-competent church: A church whose teaching and practice indicate clearly that stigma and discrimination against PLWHAs is sin and against the will of God; which, along with its ecumenical partners, has a full understanding of the severity of the HIV and AIDS epidemic in Africa; which reaches out and responds to collaborative efforts in the field of HIV and AIDS; which find its role in prevention of HIV and AIDS, taking into consideration pastoral, cultural and gender issues; and which use its resources and structures to provide care, counselling and support for those affected.

Alignment: In this report used to signify the drawing together of religious and public health systems for better mutual articulation of their respective strengths and, hence, for more effective health interventions.

Antiretroviral (ARV) therapy, (ART): consists of drugs used in the treatment of HIV infection. They work against HIV infection itself by slowing down the reproduction of HIV in the body but are not a cure.

Antiretroviral treatment (ARV): A medication that interferes with the ability of a retrovirus (such as HIV) to make more copies of itself.

Appreciative inquiry approach: Our research attitude is one of respect for the insights and perspectives of ordinary people, community and religious leaders, and health workers, and in doing this we draw from the approach of appreciative inquiry

Assets: Assets refer to a range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a context, by which people endogenously engage in activities that respond to their experienced situation.

Assets-based approach: An assets-based approach takes as its starting point the concern that people and their communities should be viewed as having assets, which can be effectively mobilised or leveraged in order to empower communities, rather than as having deficits, which hamper their development.

Bophelo: A Sesotho word, bophelo has a rich lexical range. Its meanings range from biological life (of humans, animals and plants) to the social life of individuals, families, villages and nations. Religion and health are an integral and integrated dimension of the social dimension of bophelo.

Burden of disease: The total significance of disease for society beyond the immediate cost of treatment. It is measured in years of life lost to ill health as the difference between total life expectancy and disability-adjusted life expectancy. (UNESCO)

[3] The definitions given here apply to terms as used in this publication; they are not necessarily applicable in other contexts. See ARHAP 2006, Schmid et al 2008

CD4 cell count: A measurement of the number of CD4 cells in a sample of blood. The CD4 count is one of the most useful indicators of the health of the immune system and the progression of HIV/AIDS.

Church: Aware of the problematic elements (especially in inter-religious writing), this term has been used as sparingly as possible. However, in the context of this report, the term has occasionally been used to indicate Christian denominational structures at a regional/ national/international level. For example, a localized gathering of congregations of the same nature would be a church – or in terms of such denominational structure as "The Catholic church" or "The Anglican church".

Community health workers (CHW): A general term referring to a peer educator, outreach worker, community health advisor, lay health worker, volunteer, community health representative, or promotora. Community health workers are often selected from the intended audience and thus serve as a bridge between a community and its available health care services. By training local people, the community is empowered to act toward its own health promotion.

Community-based organization (CBO): Generally, a service organization that provides social services to local clients.

Complementary and alternative medicine (CAM): Therapies are termed as complementary when used in addition to conventional treatments and as alternative when used instead of conventional treatment.

Condoms: used consistently and correctly male latex condoms provide a high level of protection against HIV infection and also stop the transmission of other sexually transmitted infections. Male condoms are usually made out of latex, they should be stored carefully avoiding prolonged exposure to heat, and should be used with a water-based lubricant. A female condom is available, which is used by a woman and fits inside the vagina.

Congregation: A locally organized religious or faith-based entity, meeting regularly for specifically religious purposes, whose primary function is the formation of faith. This term is not intended to indicate only Christian groups but is used to signify all such gatherings of any faith.

Congregational health initiative: health work linked to local congregation(s), with differing levels of formality and organisation.

Development studies: The academic discipline which addresses issues of concern to developing nations.

Directly observed therapy (DOT): A treatment strategy in which a health care provider or other observer watches a patient take each dose of a drug. This strategy is used with diseases like tuberculosis (TB) and HIV infection, where adherence is important for effective treatment and to prevent emergence of drug resistance.

District health system: This is comprised of a well-defined population, living within a clearly delineated administrative and geographical area, and including all organisations and individuals promoting health or providing health care. (WHO 1998)

Effectiveness: The measure of the success of a treatment for a particular disease or condition.

Efficacy: The ability of a treatment to produce the desired effect on the disease or condition being treated.

Epidemic: A disease that has spread rapidly through a segment of the human population in a given geographic area.

Epidemiology: The study of how disease is distributed in population groups and of the factors which influence its distribution.

Facility-based/non-facility-based: 1) health services such as hospitals, clinics, surgeries, dispensaries – that are run from a facility, and usually provide formal health services; 2) health services such as support groups, home-based care, health education – which are taking place in communities and homes; such services are as a rule more informal and less dependant on external expertise and funding. There are exceptions, where high-tech interventions are operated from community groups.

Faith based organisation (FBO): Those religious entities that have a structured nature as well as religious support. This includes organisations and loose initiatives tied to religious groups (such as mission hospitals or faith-based CBOs and NGOs); as well as community networks (ARHAP WHO). The term excludes groups formed for the purpose of forming / developing / promoting a religious commitment, such as congregations or denominations.

Grounded theory: Emergent methodology, or theory developed inductively from a corpus of data.

Health care providers: Individuals who are trained to provide various health services.

Health system: A health system includes all actors, institutions and resources that undertake health actions, where a health action is defined as one where the primary intent is to improve health. Although the defining goal of a health system is to improve population health, other intrinsic goals are: to be responsive to the population it serves, determined by the way in which people are treated and the environment in which they are

treated, and to ensure that the financial burden of paying for health is fairly distributed across households. (WHO, in HSP 2007)

Health workers: Individuals who are trained and employed to provide various health services.

Health: The state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Healthworld refers to people's conceptions of health and their health-seeking behaviour as framed by the background store of inherited or socialised knowledge that defines their being in the world. It is shaped by the health policies of governments, the variety of health practices available to them, and the interaction between health and religious practices, as well as questions of social development and environmental realities. (ARHAP)

High-risk behaviour: A term used to describe certain activities, like frequent change of sex partners, which increase the risk of transmitting the human immunodeficiency virus. These include anal and vaginal intercourse without a condom, oral-anal contact, semen or urine in the mouth, sharing intravenous needles or syringes, intimate blood contact, and sharing of sex toys contaminated by body fluids. These behaviours are also referred to as "unsafe" activities.

High-risk groups: Those groups in which epidemiological evidence indicates that there is an increased risk of contracting HIV. Highrisk groups include: commercial sex workers, people with promiscuous behavioural patterns, homosexuals, bisexuals, intravenous drug users, haemophiliacs, and the sexual partners of anyone in these groups.

Human Immunodeficiency Virus (HIV): the virus that causes AIDS or Acquired Immunodeficiency Syndrome. HIV attacks the body's immune system – the system that fights against infections.

Immune deficiency: Describes the condition where a person's immune system cannot protect the body, resulting in an increased susceptibility to various infections and cancers.

Incidence: The number of new cases in a surveyed population reported over a specified period of time.

Intangible religious health assets *(See also tangible religious health assets):* The volitional, motivational and mobilizing capacities that are rooted in vital affective, symbolic and relational dimensions of religious faith, belief, behavior and ties. Local knowledge, access, reach, participation, trust and accompaniment are just some of these "intangible" religious health assets.

Interdisciplinary: An effort or team that draws on insights, concepts, knowledge, or experience from several disciplines.

Intersectoral action for health (IAH) is 'a recognized relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone' (WHO 1997). This definition is interpreted to include collaborative action between different departments and bodies within government, as well as between actors within and outside government, such as civil society, including REs.

Leverage: First level: moving 'resting' religious health assets through the human agency for health interventions; Second level: strategically enhancing RHAs to help religious entities realize their potential more effectively, to encourage the replication of promising practices among religious entities, and to promote meaningful ties between such religious entities and public health services in strengthening health systems.

Malaria: a life-threatening parasitic disease transmitted by mosquitoes from person to person through the bite of a female Anopheles mosquito, which requires blood to nurture her eggs. Today, approximately 40% of the world's population, mostly those people living in the world's poorest countries, is at risk of malaria. Malaria causes more than 300 million acute illnesses and at least one million deaths annually. Of deaths due to malaria 90% occur in sub-Saharan Africa mostly among young children. Malaria, together with HIV and AIDS and TB, is one of the major public health challenges undermining development in the poorest countries in the world.

Mediation: In this context, strategically acting in ways that intercede between local agents and translocal bodies on behalf of local agents for things they cannot do, or can do only with great difficulty themselves.

Migration: The movement of people across a specified boundary for the purpose of establishing a new or semipermanent residence.

National faith-based health networks (NFBHNs)*:* Country-level providers of health services, or networks of health service providers (e.g. Christian Health Associations) . (USAID 2007)

Opportunistic infection: Infection that takes advantage of the body's lowered resistance due to the destruction of the immune system by HIV. They may be infections such as toxoplasmosis encephalitis, or cancers such as Kaposi's sarcoma.

Palliative care: Medical care that helps to alleviate symptoms of chronic illnesses without offering a cure.

Palliative care offers therapies to comfort and support patients with terminal illnesses.

Pandemic: Denoting a disease affecting or attacking the population of an extensive region, country or continent; extensively epidemic.

Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA): the primary research toolset developed by ARHAP to assess the contribution of religion and religious entities to health and wellbeing in Africa. It is based on a commitment to participatory inquiry, as well as to the framework of assets and agency.

Participatory The nature of both the process and content of the research. The *process* is inclusive and engaging of ordinary people, so that while the broad direction of the discussion is introduced, the *content* is driven by the participants themselves.

Assets, network and agency The three focus areas of the research is on what religious entities and capacities exist (assets), how these entities relate to one another (networks), and how people make use of the assets (agency).

People living with HIV or AIDS (PLWHA): It is preferable to use 'people living with HIV/AIDS (PLWHA)', since this reflects the fact that a HIV-positive person can continue to live well and productively for many years. It is a term of empowerment emphasizing living with HIV and AIDS rather than dying from AIDS. It is preferable to avoid certain terms: AIDS patient should only be used in a medical context (most of the time, a person with AIDS is not in the role of patient); the term AIDS victim or AIDS sufferer implies that the individual in question is powerless, with no control over his/her life. Referring to PLWHA as innocent victims (which is often used to describe HIV-positive children or people who have acquired HIV medically) wrongly implies that people infected in other ways are somehow deserving of punishment.

Policy: Broad statement of goals, objectives and means that creates the framework for activity. Often takes the form of explicit written documents, but may also be implicit or unwritten. (Buse et al. 2005)

Prevalence rate: The number of cases of a disease existing in a given population at a specific point or period of time.

Prevalence: A measure of how common or widespread a disease or infection is in the community or population group at a given period of time. This measure includes existing and new cases.

Preventive measures: Measures aimed at stopping the spread of HIV from person to person.

Primary Health Care is understood as a strategy for organising health systems to promote health. It encompasses essential health care made universally available to individuals and families by a means acceptable to them and at a cost that the society can afford, as well as intersectoral action for health. It is the nucleus of a country's health system and contributes to national socio-economic development. It is founded on recognition of the need for political action to address the social determinants of health inequity, taking account of the particular configuration of power relations within any society.

Public health: The science and art of promoting health, preventing disease and prolonging life through just and organized efforts of society.

Qualitative research methodologies: Approaches and tools used to provide a depth of insight into the meaning of beliefs, perceptions, attitudes and practices within the contexts in which they appear.

Religion: A wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organizations that range from fluid to codified, popular to formal, centralized to decentralized, communal to institutional. In Africa, this includes particularly African traditional religions, Islam, Christianity and generally a wide variety of other identifiable religious formations.

Religious coordinating body (RCB): Intermediary organisations responsible for supervising and coordinating religious activities of congregations; RCB may also supervise and support the health work of congregations. Examples: a diocese or National Evangelical Fellowship.

Religious entity (RE): This term seeks to capture the broad range of tangible RHAs, incorporating religious facilities, organisations as well as practitioners, both bio-medical and traditional. This encompassing term is necessary in order to be able to speak to the more traditional religious entities such as faith-based organisations, as well as those more amorphous entities such as individual traditional healers.

Religious health asset (RHA) is an asset located in or held by a religious entity that can be leveraged for the purposes of development or health of the public. The notion of RHAs captures the basic idea that assets carry value and may be leveraged for greater value. If they are not used, then they remain at rest, but always available for use through some agentive act. We are also using the term broadly to encompass any religion or faith.

Safe(r) sex: Term currently used when describing sexual activities most likely to reduce the risk of transmission.

Sexually Transmitted Infections (STIs): infections diseases transmitted through sexual activity such as Chlamydia,

gonorrhoea genital warts, ulcers and syphilis. Some signs of infection are if the urethra ever burns or itches, particularly when urinating, or if there is a greenish, yellowish, foamy, bloody, or foul-smelling discharge from the urethra. Using condoms can prevent transmission of STIs including chlamydia and gonorrhoea, which if not treated can have serious health consequences. Untreated STIs increase the likelihood of HIV transmission during sexual activity.

Sub-Saharan Africa: The geographic region of Africa south of the Sahara Desert

Tangible religious health assets *(See also intangible religious health assets):* The more visible and most studied religious health assets, including facilities, personnel, and activities, sometimes resembling those of secular entities. Interwoven with this tangible level, however, are the "intangible" religious health assets described above.

Traditional healer: This is a complex typology and is differently constituted in different contexts in Africa. However, for the purposes of this report, we indicate here three types of indigenous health providers, or traditional healers, in Lesotho and Zambia which are constituted by (i) Diviners, (ii) Herbalists and (iii) Zionist/Apostolic healers. Some herbalists distinguish themselves as working solely with herbal remedies. Diviners practice on the basis of engagement with ancestral and spirit forces, and other diviners are also Zionist/Apostolic priests. The three "types" must be understood as operating on a complex continuum.

Traditional medicine: Indigenous treatment regimes which manifest themselves in three principal forms: (i) home or folk remedies, (ii) herbalist medicine, and (iii) diviner treatment regimes, or a combination of the three.

Vertical programmes: Targeted disease-specific programmes, e.g. ART, delivered through the health system. Such programmes can weaken the health system, are often separately funded, hence better resourced, and draw expertise and other resources away from the primary health care and essential health system functions.

Voluntary counselling and testing (VCT): the process of undergoing a HIV test. It is confidential and includes pre-test counselling, testing after you agree to be tested and post-test counselling no matter whether the result is positive or negative.

World AIDS Day: held each year on 1 December and is a day of international, national and local support for the fight against HIV/AIDS and solidarity with people living with HIV/AIDS.

APPENDIX 3: The African Religious Health Assets Program (ARHAP)

A. History of ARHAP

The African Religious Health Assets Programme (ARHAP) an international research collaboration, was formed in December 2002 in order to address the general paucity of studies on faith based organizations working in health, in the face of growing public health crises in many parts of the world. Africa became the focus because it offers the potential for contributing a great deal of learning globally, given major public health challenges, a complex mix of religious traditions in varying contexts, and a wide variety of actors in the field of health.

Since its launch, ARHAP has worked at refining its focus and conceptual frameworks, and extending its dialogue with religious and public health agencies, practitioners and academics, particularly in Africa. In the process, ARHAP has become visible to players in the field of public health internationally, and a series of case studies have been undertaken in southern Africa.
The major ARHAP partners are: the University of Cape Town (UCT), University of KwaZulu Natal (UKZN), the University of the Witwatersrand (WITS), Le Bonheur Methodist Health Care, Memphis and Emory University - but there are firm connections to other key individuals and organisations.

B. ARHAP vision and objectives

ARHAP's overall objectives are as follows:

- To assess existing baseline information sources and conduct an inventory ("mapping") of religious health institutions and networks in Africa.
- To articulate conceptual frameworks, analytical tools, and measures that will adequately define and capture religious health assets from African perspectives, across geographic regions and different religions, in order to align and enhance the work of religious health leaders and public policy decision-makers in their collaborative efforts.
- To develop a network that will include nodes of scholars and religious as well as public health leaders in sub-Saharan Africa; plus scholars from outside Africa, religious leaders and representatives of key funding, development and policy-making organizations.
- To train future leaders of both public health and religious institutions in religious health asset assessment skills (capacity building).
- To provide evidence to influence health policy and health resource allocation decisions made by governments, religious leadership, inter-governmental agencies and development agencies.
- To disseminate and communicate results and learnings widely and regularly.

A guiding research question for ARHAP is: *In the context of major health crises (linked to environmental and social conditions), given the widespread engagement of religious entities (REs) in health activities, what criteria, categories and related assessment tools will engender a richer, more dynamic and more productive view on religious health assets (RHAs), their contribution to health, and their alignment (or lack of it) with public health systems*?

We are interested in focusing on what these religious health assets are, how they work, and what potential exists for strengthening them without undermining the very things they offer or destroying them through inappropriate interventions or engagements.

We begin with a positive view of faith based initiatives in health in the first instance, hence our description of them in terms of religious health *assets*,[4] which we understand much more broadly than the more traditional focus on facilities such as hospitals and clinics. At the same time, a naïve view of the role of religion would undermine our grasp of the necessary social realities; hence we recognize the need to balance the positive with a clear grasp of the limits and possible negative impact of religious traditions or faith based practices in particular contexts.

See www.arhap.uct.ac.za for further information.

[4] ARHAP bases its work on the assets-based approach as advocated by Kretzmann and McKnight. See Kretzmann McKnight 1993

APPENDIX 4.1: Questionnaire for Christian entities[5]

Thank you for agreeing to complete this questionnaire prior to attending the workshop on *(date).*

This brief survey questionnaire is being sent to all key informants from the National FBO and Church bodies, prior to the Participatory Inquiry workshop.

- Please complete it to the best of your ability. There are no right and wrong answers.
- You are most welcome to use MSWord to complete it, and to cut and paste from other documents where this will assist you. There is no fixed layout or page limit.
- Should you not want to answer any question, this will be respected.
- To help speed up the process, we have inserted some information that we hold about your organisation. You are most welcome to change/delete it.
- You are most welcome to contact the research manager Jill Olivier <jill.olivier@uct.ac.za> if you have any further queries.

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1. Please could you provide us with the full and correct name of the organisations, together with contact details such as telephone numbers, fax numbers, email addresses, web pages,
2. Please could you inform us of your significant institutional affiliations and connections. To whom are you responsible? What would you consider to be the key relationships?
3. Can you provide us with a short history of your organisation or church in (*country*). It would be good to know about key dates and key personalities. If you can direct us to information that already exists this will be appreciated.
4. Can you provide us with your most up to date mission statement, as well as declared aims, objectives, and/or goals?
5. Are you in a position to provide us with a map of the country with an identification of key places of where your organisation/church works?
6. We would like to know something about the size of your HIV and AIDS programme in terms of:
    a. How many people work for you, and in what capacity?
    b. How the programme is structured: what are the different projects, who is responsible to whom?
    c. How much of the country to you manage to serve?
    d. The number of beneficiaries your programme reaches.
7. A key goal of responding to HIV and AIDS is to promote "Universal Access to Prevention, Treatment, Care and Support". We would like to know something about which aspects of your work touches on these elements.
    a. Prevention: Work being done to prevent new infections.
    b. Treatment: Medical work to treat people infected with HIV
    c. Care: Care of people who are sick, as well as infants and the elderly

[5] This generic questionnaire has been reformatted

   d. Support: Psycho-social services for people infected and affected by HIV
   e. Other: Any other work you might do in the promotion of Universal Access

8. We would like to know a little bit about your financial situation. *(We know that this information can be sensitive, so please inform us if you are comfortable with this being known by others –otherwise we will keep it confidential).*
   a. Can you inform us of the size of your annual budget, with some kind of breakdown for the various projects you serve.
   b. Can you inform us of you key donors, and the relative donations that they have given to you over the past three years.
9. We are keen to know about your relationship to the government and its various agencies.
   a. Is your organisations kept up to date with government policy on HIV and AIDS? How does this happen?
   b. Is your organisation in a formal relationship with any government department or agency that has to do with HIV and AIDS? Can you explain something about this?
   c. Have you ideas or hopes of strengthening these relationships? What ideas have you had?
10. We are keen to know about your relationship to other role-players and stakeholders
   a. With whom does your organisation have strong relationships to assist with its work on HIV and AIDS?
   b. Are there any organisations or bodies that you would like to be engaged with? Why?
11. We would be very keen to receive any other additional literature that you might have as this will also tell us about your organisation.
   a. We would love to have copies of your annual reports for the past three years
   b. We would love to have any publicity materials, brochures, newsletters, etc. that you have produced
12. Should this brief questionnaire have raised any further issues or concerns you have about collaboration around HIV and AIDS (be it between FBOs, interfaith, with government or funders), you are most welcome to jot down your thoughts here – and/or bring them with you to the workshop. We are seeking to gain from your experience and wisdom, based on your knowledge of the country-context.

We look forward to engaging with you on this matter soon.

APPENDIX 4.2: Questionnaire for collaborative stakeholders[6]

Thank you for agreeing to complete this questionnaire prior to attending the workshop on *(Date).*

This brief survey questionnaire is being sent to all key informants from the National FBO and Church bodies, prior to the Participatory Inquiry workshop.

- Please complete it to the best of your ability. There are no right and wrong answers.
- You are most welcome to use MSWord to complete it, and to cut and paste from other documents where this will assist you. There is no fixed layout or page limit.
- Should you not want to answer any question, this will be respected.
- To help speed up the process, we have inserted some information that we hold about your organisation. You are most welcome to change/delete it.
- You are most welcome to contact the research manager Jill Olivier jill.olivier@uct.ac.za if you have any further queries.

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1. Please could you provide us with the full and correct name of the organisations, together with contact details such as telephone numbers, fax numbers, email addresses, web pages,

2. Please could you inform us of your significant institutional affiliations and connections. To whom are you responsible? What would you consider to be the key relationships?

3. Can you provide us with a short history of your organisation in (country). It would be good to know about key dates and key personalities. If you can direct us to information that already exists this will be appreciated.

4. Can you provide us with your most up to date mission statement, as well as declared aims, objectives, and/or goals?

5. Do you have a home country, and which is this? What other countries are you involved with?

6. Are you in a position to provide us with a map of (country) with an identification of key places of where your organisation/church works?

7. We would like to know a little bit about your financial situation. *(We know that this information can be sensitive, so please inform us if you are comfortable with this being known by others –otherwise we will keep it confidential).*

[6] This generic questionnaire has been reformatted

a. Can you inform us of the size of your annual budget, with some kind of breakdown for the various projects you serve?

b. Can you inform us of where you receive your finances from, and the relative donations that they have given to you over the past three years?

8. We are keen to know about your relationship to the government and its various agencies.
    a. Is your organisations kept up to date with government policy on HIV and AIDS? How does this happen?
    b. Is your organisation in a formal relationship with any government department or agency that has to do with HIV and AIDS? Can you explain something about this?

9. We are keen to know about your relationship to other role-players and stakeholders
    a. With whom does your organisation have strong relationships to assist with its work on HIV and AIDS?
    b. Do you work with religious organisations. Can you name these for us?

10. We would be very keen to receive any other additional literature that you might have as this will also tell us about your organisation.
    a. We would love to have copies of your annual reports for the past three years.
    b. We would love to have any publicity materials, brochures, newsletters, etc. that you have produced.

11. Should this brief questionnaire have raised any further issues or concerns you have about collaboration around HIV and AIDS (be it between FBOs, interfaith, with government or funders), you are most welcome to jot down your thoughts here – and/or bring them with you to the workshop. We are seeking to gain from your experience and wisdom, based on your knowledge of the country-context.

We look forward to engaging with you on this matter soon.

APPENDIX 4.3: Covering letter and consent form

Collaborating with Religious Entities in the Context of HIV and AIDS: Malawi, DRC and Kenya

Dear participant

Owing to your role in a key organization, we would like to invite you to participate to the research project, "Collaborating with Religious Entities in the Context of HIV and AIDS: Malawi, DRC and Kenya".

This project is a specific study for UNAIDS through the Christian charity organization, Tearfund. We are working toward the alignment of the activities of Christian responses to HIV and AIDS with those of governments and international donors towards what the WHO has called "Universal Access to Prevention, Treatment, Care and Support" in the face of HIV and AIDS.

Research background:

There is a prevailing lack of understanding from donors and governments about religious organisations; who they are, how they operate at a country level and what their comparative advantages are in the response to HIV and AIDS. Tearfund and UNAIDS are co-sponsoring this study on the role of religious entities as an effective partner to UNAIDS, governments and donors.

The **primary goal** is to ensure significant long term contributions will be made to National AIDS Plans through effective collaboration between government (including donors) and religious entities towards 'Universal Access'.

The **primary purpose** is to strengthen collaboration, increase mutual respect and understanding between religious entities, government and donors in three countries.

The research findings will be made available at the International AIDS conference in Mexico in August this year, and will form the basis for a second phase of work which will focus on strengthening the relationships between the Christian Entities, Government and Donors.

Your participation will therefore greatly enhance the knowledge that goes into this report, and will contribute to making a practical difference for those infected and affected by HIV and AIDS.

There are two key ways in which we would like you to contribute to the research.

1. To complete a questionnaire on various aspects to do with your organization.
2. To participate in a one-day research workshop that will enable us to find out more about your organization, and other organizations and their work.

The Principle Investigators for this research are: Professor Steve de Gruchy and Dr Beverley Haddad, School of Religion and Theology, University of KwaZulu-Natal, Pvt Bag X01, Scottsville, 3201, South Africa. Telephone: +27 33 260 5540; Fax +27 33 260 5858 <degruchys@ukzn.ac.za>; <haddad@ukzn.ac.za>

The Research Manager is: Ms Jill Olivier, ARHAP, Department of Religious Studies, University of Cape Town. Telephone +27 21 650 3458, jill.olivier@uct.ac.za

If you are willing to participate in this research, will you please sign the consent form overleaf. With grateful thanks, The Research Team.

ARHAP: CONSENT FORM

I agree to participate in the research project, "Collaborating with Religious Entities in the Context of HIV and AIDS: Malawi, DRC and Kenya" in these two ways:

1. I agree to answer the questionnaire that I have been sent, knowing that I may choose not to answer any question, and that I can withdraw from the process at any time.

_____ _____

Name Signature Date

2. I agree to participate in the research workshop held at _____ on _____.

I understand that my comments and answers will be combined with those of others in the workshop and will be used to help ARHAP, Tearfund and UNAIDS to strengthen collaboration, increase mutual respect and understanding between Christian entities, government and donors in three countries and to gain a deeper understanding of the relationship between health and religion in Africa.

I grant permission for my photograph or image to be captured during the workshop, and to be used in reports and documents reporting the findings.

All information will be anonymous, and will be kept in protective storage during and after the research.

I understand that I may withdraw from this process at any time.

_____ _____ _____

Name Signature Date

APPENDIX 5.1: Invitees and participants - Kenya Christian religious entities

Organisation		Individual	Attended	Questionnaire response
Adventist Development & Relief Agency	ADRA	Mr Barrack Bosire: BCS	Yes	Yes
Anglican Church of Kenya, Directorate of Social Services	DOSS	Mr. Joseph Nyaga Wangai: Health and HIV/AIDS Coordinator	Yes	Yes
Catholic Relief Services	CRS	Mr Timon Mainga: HIV/AIDS unit manager	Yes	No
Christian community services of Mt Kenya East	CCSMKE	Rev Ben Kanina	Yes	Yes
Christian Health Association of Kenya	CHAK	Mr Peter Ngure: HIV/AIDS Coordinator	Yes	No
Kenya Episcopal Conference	KEC	Dr Margaret Ogola:	Yes	Yes
Kenya Inter-Religious AIDS Consortium	KIRAC	Bishop Stephen Muketha: Chairman	Yes	No
Lifeskill promoters	LISP	Ms Emma Wachira: Director	Yes	Yes
Presbyterian Church of East Africa	PCEA	Rev Simon Githiora Njuguna: Youth Director	Yes	No
St Johns Community Center	SJCC	Mr Peter Njuguna: Project Manager	Yes	Yes
Young Women's Christian Association	YWCA	Ms Grace H. A. Okello: Programmes and Training Director	Yes	No
Catholic University			No	-
Churches United Against HIV and AIDS in Southern and Eastern Africa			No	-
Coptic Church Hospital and Hope Centers			No	-
I Choose Life - Africa			No	-
Medical Assistance Program, International	MAP		No	-
Mission for Essential Drugs and Supplies	MEDS		No	-
National Council of Churches of Kenya	NCCK		No	-
Rhema Rehabilitation Centre - Redeemed Gospel Church			No	-
Salvation Army	SA		No	-

APPENDIX 5.2: Invitees and participants - Kenya collaborative stakeholders

Organisation		Individual	Attended	Questionnaire response
All Africa Conference of Churches	AACC	Mr Peter Gichira Solomon: Research and Development Officer	Yes	No
Council of Anglican Provinces in Africa	CAPA	Mr Emmanuel Olatunji: Programme Coordinator	Yes	No
Church World Service, East Africa	CWS	Ms Mary Obiero: Program Coordinator	Yes	Yes
Ecumenical Pharmaceutical Network	EPN	Mr Jonathan Mwiindi: HIV and AIDS Manager	Yes	No
Inter-religious Council of Kenya	IRCK	Dr Francis Kuria: Programs Director	Yes	Yes
Kenya AIDS NGO's Consortium	KANCO	Ms Jane Mwangi: Programme Director	Yes	Yes
National AIDS Control Council (Office of the President)	NACC	Ms Harriet Kongin: Head of Stakeholder Coordination	Yes	Yes
Norwegian Church Aid East Africa	NCA	Ms Wasye' Musyoni:	Yes	Yes
Organization of Africa Instituted Churches	OAIC	Rev Nicta Lubaale: General Secretary	Yes	No
Sikh Supreme Council		Mr Joginder Marjara: Chairman	Yes	No
TICH, Great Lakes University oF Kisumu	TICH	Sr Masheti Wangoyi	Yes	No
UNAIDS Kenya	UNAIDS	Ms Sari Seppanen-Verrall	Yes	No
World Conference of Religions for Peace	WCRP	Ms Zebib Kavuma: Program Coordinator for HIV and AIDS in Africa	Yes	Yes
Catholic Organization for Relief & Development Aid	CORDAID		No	
FIDA International	FIDA		No	
Hindu Council of Kenya			No	
National AIDS Control Program	NASCOP		No	
Tearfund			No	
World Council of Churches, Ecumenical HIV and AIDS Initiative in Africa	WCC EHAIA		No	

APPENDIX 5.3: Invitees and participants: Malawi Christian religious entities

Organisation		Individual	Attended	Questionnaire response
Church of Central Africa Presbyterian - LISAP	LISAP, CCAP	Landson Thindwa: IEC Officer	Yes	Yes
CCBC (Baptist) - KOSI	CCBC	Lessie Mankhanamba: Finance and Admin	Yes	No
Christian Health Association of Malawi	CHAM	Francis Gondwe: Executive Director	Yes	Yes
Evangelical Association of Malawi	EAM	Howard Kasiye: Project Manager	Yes	No
	EAM	Bryer Mlowoka: Head of Programs	Yes	-
Episcopal Conference of Malawi	ECM	Dr Max Meis: Health Advocate	Yes	Yes
Evangelical Lutheran Church in Malawi	ELCM	Dean A Msuku: Dean and HIV/AIDS Coordinator	Yes	Yes
MANERELA+ (and BICC)	Manerela+	Ephraim Disi Mbewe: General Director	Yes	No
Malawi Adventist Church HIV/AIDS program - SDA	MASHAP	Dennis Matekenya: National Director	Yes	Yes
Partners in Hope	PiH	Lestor Chikoya: Pastoral Care Director	Yes	Yes
Private Schools Association of Malawi	PRISAM	Wilson Asibu: Programs Manager	Yes	Yes
Salvation Army	SA	Captain Dyson Chifudzeni: Development and Project Services	Yes	Yes
Scripture Union of Malawi	SUM	Rodrick Banda: General Secretary	Yes	Yes
World Relief, Malawi	WRM	Gibson Nkanaunena: Director of Programs	Yes	Yes
World Vision, Malawi	WVM	Paul Nkhata: International Church Partnerships Coordinator	Yes	Yes
Association of Christian Educators	ACEM		No	-
Anglican Diocese of Malawi CCPA			No	-
Christian AID			No	-
Malawi Council of Churches: Public Affairs Committee	MCC-PAC		No	-
Medical Assistance Program, International	MAP		No	-

APPENDIX 5.4: Invitees and participants - Malawi collaborative stakeholders

Organisation		Individual	Attended	Questionnaire response
Department of Religious Affairs, University of Malawi, Chancellor College, Dept of TRS		Prof J C Chakanza: Professor	Yes	yes
Malawi Interfaith AIDS Association	MIAA	Robert G Ngaiyaye: Executive Director	Yes	Yes
Muslim Association of Malawi	MAM	Saiti Burhan D Jambo: Executive Director	Yes	yes
	MAM	Dr Imuran Shareef Mahomed : Secretary General	Yes	-
National AIDS Commission of Malawi	NAC	Maria Mukwala: CMO	Yes	No
Norwegian Church Aid	NCA	Esther M Masika: Senior Programme Manager	Yes	yes
Quadria Muslim Association of Malawi	QMAM	Manuel Mbendela: HIV/AIDS Program Coordinator	Yes	yes
	QMAM	Sheik Abdulwahab Ali Thelele Mwale: National Dawah Coordinator	Yes	-
UNAIDS Malawi Office	UNAIDS	Emebet Admassu: Partnership Advisor	Yes	no
DanChurchAid	DCA		No	
Department for International Development (DFID)	DFID		No	
Ministry of Culture	MoC		No	
Ministry of Health	MoH		No	
Tearfund			No	-
The Global Fund To fight Aids, TB and Malaria Malawi Office			No	
UNFPA Malawi Office	UNFPA		No	
USG Malawi Office	USG		No	
WCC	WCC		No	
WHO Malawi Office	WHO		No	

*8 added by other advisors and removed by UNAIDS Malawi

APPENDIX 5.5: Invitees and participants - DRC Christian religious entities

Organisation		Individual	Attended	Questionnaire response
Action Presbyterian Contre SIDA	APCS	Pastor Albert Kabwe: Coordinateur APCS	Yes	Yes
African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS	Anerela+	Rev Philippe Ndembe: Coordinateur Régional en Afrique Francophone	Yes	No
APCS	APCS	Kashada Lengulula: Coordinateur Provincial	yes	Yes
BDOM Kinshasa (ECC: Eglise du Christ au Congo)	BDOM	Dr Benedicte Claus: Medecin-Directeur	Yes	No
	BDOM	Dr Zola: Medecin Superviseur Point Focal SIDA	Yes	-
Congolese Network of Religious Leaders Living with or Personally Affected by HIV & AIDS	CONERELA+	Abbé François Nseka: Coordinateur National	Yes	No
EHAIA/WCC: Conseil Œcuménique des Eglises	EHAIA	Hendrew: Lusey*	Yes	-
Kimbanguiste (Kibanguist Medical Department)	KMD	Dr Divengi Nzanbi: Coordinateur National	Yes	Yes
Projet SIDA CEK		Pasteur Thomas Matonga Mvwamba: Coordinateur Communautaire	Yes	Yes
Salvation Army	SA	Dr Nku Imbie David: Medecin Directeur	Yes	No
SANRU-IMA	SANRU-IMA	Dr John Okende: HIV Officer	Yes	No
Vorsi-Congo	VORSI	Dr Kamathe Sekera: Directeur National Vorsi-Congo	Yes	Yes
Alliance Biblique			No	-
Archidiocese of Kinshasa			No	-
CARITAS			No	-
Interfaith (CIC)			No	-
MERU			No	-
World Vision			No	-

* Mr Hendrew Lusey acted as facilitator and translator, but also provided his insights

APPENDIX 5.6: Invitees and participants – DRC collaborative stakeholders

Organisation		Individual	Attended	Questionnaire
Catholic Relief Service	CRS	Dr Bajah Raphael: Directeur Programme SIDA AMITTE	Yes	Yes
Christian Aid, RDC (DRC)	CA	Jean Ilunga Mukulu: HIV Programme Officer	Yes	Yes
COMICO: Muslim Community	COMICO	Muamba Kadiayi: Charge des Programmes SIDA RIPD	Yes	No
Catholic Organization for Relief & Development Aid	CORDAID	Arjanne Rietsema: Chef de Mission	Yes	Yes
Family Health International	FHI	Dr Jocelynne Kibungu: Chargee de SLE	Yes	No
Memisa-Belgique	MEMISA	Dr Anicet Mazaya: Coordinateur Medecal	Yes	No
ONUSIDA - UNAIDS	UNAIDS	Chirume Mendo	yes	Yes
National AIDS Control Programme	PNLS	Dr Ekofo Felly	Yes	No
Programme National Multisectoriel de lutte contre le SIDA	PNMLS		Yes*	No
World Conference of Religious for Peace	WCRP	Rev. Armand Kinyamba Linge	Yes	Yes
FNUAP (UNFPA)	UNFPA		No	-
Global Funds	GF		No	-
GTZ	GTZ		No	-
IMA World Health	IMA		No	-
Médecins Sans Frontières	MSF		No	-
Ministère de la Santé	MoH		No	-
Population Service International	PSI		No	-
Société Nationale d'Assurances			No	-
Tearfund			No	-
UNICEF	UNICEF		No	-
USAID	USAID		No	-
World Bank	WB		No	-

*Late arrival

APPENDIX 6.1: Key REs working in health in Kenya

These are key REs mentioned in secondary literature who are involved in health work. Emboldened are those who this research confirmed are involved specifically in HIV and AIDS.[7]

Name of organisation	Abr.	Type.
Action by Churches Together	ACT	Internat
Adventist Development & Relief Agency	**ADRA**	**Internat**
African Evangelical Presbyterian Churches	AEPC	CRE: CHAK
Africa Inland Church (Health Ministries)	**AIC**	**CRE: CHAK**
African Christian Churches and School	ACC&S	CRE: CHAK
African Divine Church	AADC	CRE: CHAK
African Evangelical Enterprises	AEE	CRE: CHAK
African Gospel Church	AGC	CRE: CHAK
African Independent Churches of Africa	AICA	CRE
African Inland Church	**AIC**	**CRE**
African Jesuit AIDS Network	**AJAN**	**Internat**
African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS	**Anerela+**	**Internat**
African Independent Pentecostal Church of Africa	AIPCA	CRE: CHAK
All Africa Conference of Churches	**AACC**	**Internat**
Anglican Church of Kenya (Directorate of social services-DOSS)	**ACK DOSS**	**CRE: CHAK**
Apostles of Jesus AIDS Ministries	AJAM	CRE
Association of Evangelicals in Africa	AEA	Internat
BALL	BALL	CRE: CHAK
Baptist AIDS Response Agency, Kenya	BARA	Internat
Baptist Church	BAPT	CRE: CHAK
Baptist Faith Ministries	BFM	CRE: CHAK
Believers Faith Centre Fellowship Inc	BFCF	CRE: CHAK
Caritas Internationalis	Caritas	Internat
Catholic Agency for Overseas Development	CAFOD	Internat
Catholic Medical Missions Board	**CMMB**	**Internat**
Catholic Organization for Relief & Development Aid	**CORDAID KE**	**Internat**
Catholic Relief Services (Kenya)	**CRS**	**Internat**
Catholic University of Eastern Africa		**CRE**
Centre for Urban Mission		CRE
Children of God Relief Institute		**CRE**
Christian AID	**CA**	**Internat**
Christian Children's Fund		CRE
Christian community services of Mt Kenya East - ACK	**CCSMKE**	**CRE**
Christian Connections for International Health	**CCIH**	**Internat**
Christian Health Association of Kenya	**CHAK**	**NFBHN**
Christian Missionary Fellowship (Kenya)	CMF	CRE: CHAK
Christian Missionary Fellowship International		Internat
Christian Organisations Research Advisory Trust	CORAT	CRE
Church Mission Society	CMS	Internat
Church of God	COG	CRE: CHAK
Church World Service (East Africa)	**CWS**	**Internat**

[7] Note, the Aga Khan health network would have been included in this list, but authors were informed that the Aga Khan feel strongly that they are not a 'religious entity' or 'FBO'. See AKDS <http://www.agakhanhospitals.org/nairobi/about.asp>

Churches United Against HIV and AIDS in Southern and Eastern Africa	**CUAHA**	**Internat**
City Harvest Church		CRE
Coptic Church Hospital and Hope Centers		**CRE**
Coptic Orthodox		CRE: CHAK
Council of Anglican Provinces in Africa	**CAPA**	**Internat**
DanChurchAid	DCA	Internat
Deliverance Church		CRE: CHAK
East African Pentecostal Churches	EAPC	CRE: CHAK
Eastern Deanery AIDS Relief Program		CRE
Ecumenical Pharmaceutical Network	**EPN**	**Internat**
Evangelical Alliance of Kenya	**EAA**	**CRE**
Evangelical Lutheran Church of Kenya	ELCK	CRE: CHAK
Fellowship of Christian Unions (Kenya)	**FOCUS**	**CRE**
Foursquare Gospel Church		CRE: CHAK
Free Pentecostal Churches of Kenya	FPFK	CRE: CHAK
Friends Yearly Meeting of Friends (Quakers)		CRE: CHAK
Full Gospel Churches of Kenya	FGCK	CRE: CHAK
German Institute for Medical Mission	**DIFAEM**	**Internat**
GPC		CRE: CHAK
Hindu Council of Kenya		RE
Holy Mission		CRE: CHAK
I Choose Life - Africa		**CRE**
IMA World Health	**IMAWH**	**Internat**
Indigenous Tabernacle of Kenya	**ITK**	**RE**
Inter-Church Organisation for Development	ICCO	Internat
Inter-Diocesan Christian Community Services	IDCCS	CRE
Inter-religious Council of Kenya	**IRCK**	**RE**
Int'l Gospel Mission		CRE: CHAK
IPC	IPC	CRE: CHAK
Islamic Relief Worldwide		Internat
Jesus Is Alive Ministries		CRE
KAG	KAG	CRE: CHAK
Kenya Anglican Youth Program	KAYO	CRE
Kenya Assemblies of God		CRE
Kenya Council of Imams and Scholars		RE
Kenya Episcopal Conference (Catholic Secretariat, Commission for Health)	**KEC**	**CRE, NFBHN**
Kenya Evangelical Lutheran Church (Kenya Lutheran HIV/AIDS Co-ordinating Committee)	KETAM	CRE
Kenya Interreligious AIDS Consortium	**KIRAC**	**RE**
King Jesus Faith Ministries		CRE: CHAK
Lavington United Church		CRE: CHAK
Lifeskill promoters	**LISP**	**CRE**
LightHouse For Christ Mission	LCM	CRE: CHAK
Lutheran World Federation	LWF	Internat
Maranatha Christian Fellowship		CRE: CHAK
Maranatha Mission		CRE: CHAK
Medical Assistance Program, International	**MAP**	**Internat**
Medical Missionaries of Mary		CRE

Medicus Mundi International	MMI	Internat
Methodist Church in Kenya	MCK	CRE: CHAK
Mildmay International		**Internat**
Mission for Essential Drugs and Supplies	**MEDS**	**CRE**
Mombasa Pentecostal Church	MPC	CRE: CHAK
Muslim Health Association	**SOBKEM**	**RE**
Muslim Sisters Network		RE
Nairobi Chapel		CRE: CHAK
National Council of Churches of Kenya	**NCCK**	**CRE: CHAK**
National Muslim Council of Kenya		**RE**
Ngong Pent. Church		CRE: CHAK
NICA		CRE: CHAK
Nomiya Church of Kenya		CRE: CHAK
Norwegian Church Aid (East Africa)	**NCA**	**Internat**
Organisation of African Instituted Churches (Kenya)	**OAIC**	**Internat**
Orthodox Church		CRE: CHAK
Pan African Christian Women Alliance (Kenya)	PACWA	Internat
Pentecostal Assemblies of God	PAG	CRE: CHAK
Pentecostal Fellowship of Africa	PEFA	CRE: CHAK
Presbyterian Church of East Africa	**PCEA**	**CRE: CHAK**
Reedemed Gospel Church	RGC	CRE: CHAK
Reformed Churches of Kenya	RCEA	CRE: CHAK
Rhema Rehabilitation Centre - Redeemed Gospel Church	**RRC**	**CRE**
Salesian Missions		Internat
Salvation Army (Kenya)	**SA**	**CRE: CHAK**
Samaritan's Purse		**Internat**
Scripture Union (Kenya)	**SUK**	**Internat**
Seventh Day Adventist	SDA	CRE: CHAK
SHM		CRE: CHAK
Sikh Supreme Council		**RE**
SLMIS		CRE: CHAK
SOC		CRE: CHAK
St Johns Community Center	**SJCC**	**CRE**
Supreme Council of Kenya Muslims		RE
Tearfund		**Internat**
TICH Great Lakes University of Kisumu		**CRE: CHAK**
TORSO S.A.		CRE: CHAK
UMC		CRE: CHAK
Upper Room Ministry (PREM-HIV project)		CRE
World Conference of Religions for Peace	**WCRP**	**Internat**
World Council of Churches: Ecumenical HIV and AIDS Initiative in Africa	WCC EHAIA	Internat
World Gospel Ministries	WGM	CRE
World Gospel Mission	WGM	CRE: CHAK
World Relief (Kenya)	**HLFK**	**Internat**
World Revival Union Church	WRUC	CRE: CHAK
World Vision (Kenya)	**WV**	**Internat**
Young Women's Christian Association (Kenya)	**YWCA**	**Internat**

APPENDIX 6.2: Key REs working in health in Malawi

These are key REs mentioned in secondary literature who are involved in health work. Emboldened are those who this research confirmed are involved in specifically in HIV and AIDS.

Name of organisation	Abr.	Type.
Action by Churches Together	ACT	Internat
Adventist Development and Relief Agency	**ADRA**	**Internat**
African Evangelistic Enterprise Ministries	AEEM	CRE
African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS	**Anerela+**	**Internat**
Anglican Diocese of Lake Malawi		CRE
Anglican Diocese of Malawi (CPCA)		CRE
Anglican Diocese of Southern Malawi		CRE
Assemblies of GOD AIDS Response Programme		CRE
Association of Christian Educators	ACEM	CRE
Baptist Convention in Malawi		CRE
Caritas Internationalis		Internat
Catholic Agency for Overseas Development		Internat
Catholic Development Commission in Malawi	CADECOM	CRE
Catholic Health Commission	**CHC**	**CRE**
Catholic Relief Services (Malawi)	**CRS**	**Internat**
Christian AID	CA	Internat
Christian Health Association of Malawi	**CHAM**	**NFBHN**
Christian Orphans Outreach Ministries		CRE
Christian Reformed World Church	**CRWC**	**CRE**
Christian Service Committee		CRE
Christiens Sans Frontier		Internat
Church of Central Africa Presbyterian, Blantyre Synod	**CCAP**	**CRE**
Church of Central Africa Presbyterian, Synod of Livingstonia	**CCAP**	**CRE**
Churches Action in Relief and Development	CARD	CRE
DanChurchAid	DCA	Internat
Ecumenical Counselling Centre	**ECC**	**CRE**
Ecumenical Pharmaceutical Network		Internat
Emmanual Healthcare (Malawi)	EMMS	Internat
Episcopal Conference of Malawi	**ECM**	**CRE**
Evangelical Association of Malawi	**EAM**	**CRE**
Evangelical Baptist Church		CRE
Evangelical Lutheran Church in Malawi	**ELCM**	**CRE**
Evangelical Lutheran Development Program	ELDP	CRE
Evangelical Lutheran Development Service (from ELCM)	**ELDS**	**CRE**
German Institute for Medical Mission		Internat
Herbalist Association of Malawi		RE
International Traditional Medicines Council of Malawi		**RE**
Islamic Relief Worldwide		Internat
KOSI (from CCBC)	**KOSI**	**CRE**
Livingstonia Synod AIDS Programme (CCAP project)	**LISAP**	**CRE**
Lutheran Development Program (LWF)	ELDP	Internat
Lutheran World Federation	LWF	Internat

Malawi Adventist Church HIV/AIDS program	**MASHAP**	**CRE**
Malawi Council of Churches: Public Affairs Committee	**MCC-PAC**	**CRE**
Malawi Interfaith AIDS Association	**MIAA**	**RE**
Malawian **Network of Religious Leaders Living with or Personally Affected by HIV & AIDS**	MANERELA+	CRE
Medical Assistance Program International	MAP	Internat
Muslim Association of Malawi	MAM	RE
Norwegian Church Aid	**NCA**	**Internat**
Partners in Hope	**PIH**	**Internat**
Presbytarian Church (USA)	PC	Internat
Presbyterian Church of Central Africa	PCCA	CRE
Quadria Muslim Association of Malawi	**QMAM**	**RE**
Salvation Army (Malawi)	**SA**	**Internat**
Scripture Union (Malawi)	**SU**	**Internat**
Student Christian Organisation of Malawi	**SCOM**	**CRE**
Tearfund		Internat
Word of God Ministries International		**Internat**
World Assembly of Muslim Youth		**Internat**
World Conference of Religions for Peace		Internat
World Council of Churches – Ecumenical HIV and AIDS Initiative	**WCC EHAIA**	**Internat**
World Hope International	WHI	Internat
World Relief (Malawi)	**WRM**	**Internat**
World Vision (Malawi)	**WVM**	**Internat**
Young Women Christian's Association (Malawi)	**YWCA**	**Internat**
Zam Zam Foundation		CRE

APPENDIX 6.3: Key REs working in health in the DRC

These are key REs mentioned in secondary literature who are involved in health work. Emboldened are those who this research confirmed are involved in specifically in HIV and AIDS.

Name of organisation	Abr.	Type.
Action by Churches Together	ACT	Internat
Action Presbyterian Contre SIDA	APCS	CRE
African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS		Internat
AIDS Care Education and Training	**ACET**	**Internat**
Alliance Biblique		CRE
African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS	**ANERELA+**	**Internat**
Archidiocese of Kinshasa		**CRE**
CARITAS	CARITAS	Internat
Caritas Internationalis		Internat
Catholic Agency for Overseas Development	**CAFOD**	**Internat**
Catholic Church - *L'Eglise Catholique en République Démocratique du Congo [RDC]*		**CRE**
Catholic Organization for Relief & Development Aid	CORDAID	Internat
Catholic Relief Service	**CRS**	**Internat**
Christian AID	**CA**	**Internat**
Church Mission Society	CMS	Internat
Church of Christ in Congo - *Eglise du Christ au Congo*	**ECC-BDOM**	**NFBHN**
Church of Jesus Christ on Earth		**CRE**
COMICO		RE
Communauté Anglicane au Congo	CAC	CRE-ECC
Communauté Assemblée de Dieu à l'Est du Congo	CADAF	CRE-ECC
Communauté Assemblée des Frères Evangéliques au Congo	CAFECO	CRE-ECC
Communauté Association des Eglises Evangéliques de la Lulonga	CADELU	CRE-ECC
Communauté Baptiste au Kivu	CBK	CRE-ECC
Communauté Baptiste Autonome Entre Wamba-Bakali	CBAWB	CRE-ECC
Communauté Baptiste du Bas-Uélé	CBCN	CRE-ECC
Communauté Baptiste du Congo Ouest	CBCO	CRE-ECC
Communauté Baptiste du Fleuve Congo	CBFC	CRE-ECC
Communauté Baptiste du Sud-Kwango	CBSK	CRE-ECC
Communauté Centrale du Christ en Afrique	CCCA	CRE-ECC
Communauté Chrétienne de Pentecôte au Congo		CRE-ECC
Communauté Chrétienne Evangélique au Congo	CCEC	CRE-ECC
Communauté de Douze Apôtres au Congo	CDAC	CRE-ECC
Communauté de Jésus-Christ au Congo	CJCC	CRE-ECC
Communauté des Assemblées de Dieu au Congo	CADC	CRE-ECC
Communauté des Assemblées de Dieu au Congo	CADC	CRE-ECC
Communauté des Assemblées des Frères au Katanga	CAFKAT	CRE-ECC
Communauté des Assemblées des Frères en Christ au Congo	CAFCC	CRE-ECC
Communauté des Disciples du Christ au Congo	CDCC	CRE-ECC
Communauté des Eglises Baptistes du Congo-Est	CBCE	CRE-ECC
Communauté des Eglises Baptistes Unies	CEBU	CRE-ECC
Communauté des Eglises Chrétiennes en Afrique	CECA	CRE-ECC
Communauté des Eglises Chrétiennes Indépendantes Evangéliques	CEBIE	CRE-ECC

Communauté des Eglises de Grâce au Congo	GEGC	CRE-ECC
Communauté des Eglises de Pentecôte en Afrique Centrale	C.E.P.A.C	CRE-ECC
Communauté des Eglises des Frères Mennonites au Congo	4ème CEFMC	CRE-ECC
Communauté des Fidèles Protestants	CFP	CRE-ECC
Communauté des Frères en Christ Garenganze	CFCG	CRE-ECC
Communauté du Saint-Esprit en Afrique	CSEA	CRE-ECC
Communauté Episcopale Baptiste Africaine	CEBA	CRE-ECC
Communauté Evangélique Africaine	CEA	CRE-ECC
Communauté Evangélique au Centre de l'Afrique	CECA	CRE-ECC
Communauté Evangélique au Congo	CEC	CRE-ECC
Communauté Evangélique Berreenne au Congo	CEBC	CRE-ECC
Communauté Evangélique Congolaise	CECO	CRE-ECC
Communauté Evangélique de l'Alliance au Congo	CEAC	CRE-ECC
Communauté Evangélique de Pentecôte au Katanga	CEPK	CRE-ECC
Communauté Evangélique du Christ au Cœur de l'Afrique	CECCA	CRE-ECC
Communauté Evangélique du Christ eu Ubangi	CECU	CRE-ECC
Communauté Evangélique du Kasaï-Occidental	CEK-BOOKE	CRE-ECC
Communauté Evangélique du Kwango	CEK	CRE-ECC
Communauté Evangélique en Ubangi Mongala	CEUM	CRE-ECC
Communauté Evangélique Luthérienne du Congo Ouest	CELCO	CRE-ECC
Communauté Evangélique Mennonite	CEM	CRE-ECC
Communauté Libre de Maniema-Kivu	CLMK	CRE-ECC
Communauté Libre Méthodiste au Congo	CLMC	CRE-ECC
Communauté Mennonite au Congo	CMCO	CRE-ECC
Communauté Méthodiste au Sud-Congo	CMSC	CRE-ECC
Communauté Méthodiste Unie au Congo Central	CMCC	CRE-ECC
Communauté Méthodiste Unie au Nord-Katanga	CMUNK	CRE-ECC
Communauté Nations du Christ en Afrique	CNCA	CRE-ECC
Communauté Pentecôtiste au Congo	CPCO	CRE-ECC
Communauté Presbytérienne au Congo	CPC	CRE-ECC
Communauté Presbytérienne au Kasaï-Occidental	CPKO	CRE-ECC
Communauté Presbytérienne au Kasaï-Oriental	CPKO	CRE-ECC
Communauté Presbytérienne de Kinshasa	CPK	CRE-ECC
Communauté Protestante au Katanga	CPK	CRE-ECC
Communauté Réformée du Congo		CRE-ECC
Communauté Réformée Presbytérienne	CRP	CRE-ECC
Communauté Région Sankuru	CRS	CRE-ECC
Communauté Union des Eglises Baptistes au Congo	CUEBC	CRE-ECC
Communuatés des Eglises Libres de Pentecôte en Afrique	CELPA	CRE-ECC
CONERELA+		**CRE**
Conférence Episcopale Nationale du Congo	**CENCO**	**CRE**
Congo Islamic Relief Organisation		RE
DanChurchAid		Internat
Ecumenical Office for Support to Development	BOAD	CRE
Evangelical Lutheran Church of Congo - *Eglise Evangelique Lutherienne du Congo*	**ELCC**	**CRE**
IMA World Health	**IMAWH**	**Internat**
Kimbanguiste (Kibanguist Medical Department)		**CRE**

le comité interconfessionnel	**CIC**	**RE**
Lutheran World Federation	LWF	Internat
Medical Assistance Program International	**MAP**	**Internat**
Memisa-Belgique (CORDAID)		Internat
MERU		Intgernat
National Council of Faithbased Alliance		RE
Projet SIDA CEK		**CRE**
Province de l'Eglise Anglicane du Congo'		**CRE**
Salvation Army - a*rmée du salut service medical*		**Internat**
Sikatenda's God Church		**CRE**
Tearfund		**Internat**
United Methodist Committee on Relief		Internat
Vorsi-Congo		**CRE**
World Conference Of Religious For Peace - conseil inter religieux de RDC	**WCRP**	**Internat**
World Council of Churches - *Conseil Œcuménique des Eglises*	**WCC EHAIA**	**Internat**
World Relief	**WR**	**Internat**
World Vision	**WV**	**Internat**