African Religious Health Assets Programme

ARHAP Literature Review:

Working in a bounded field of unknowing

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This document is a companion to *ARHAP Bibliography: Working in a Bounded Field of Unknowing.* This report, the companion bibliography and most of the literature mentioned are available from the ARHAP-UCT Resource Centre:
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This document represents a first step towards gathering the literature relevant to this area of enquiry. Research is ongoing and we welcome all comments and additions to this growing body of knowledge.

Note on Process: Some of the material on public health literature in general (see Chapters 2 and 3) was drawn from an earlier compilation by Lauren Graham from the University of the Witwatersrand working for ARHAP. This was incorporated in this document because it expands the picture of the field, but is not considered to be a complete nor fully comprehensive view of this area, and could be expanded significantly. We have chosen to include it nevertheless so that readers are at least aware of the field and some of its key parameters, and may identify some of the relevant literature.

Preferred Reference: Olivier J, Cochrane JR and Schmid B. *ARHAP Literature Review: Working in a Bounded Field of Unknowing*, (Cape Town, African Religious Health Assets Programme, 2006)

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Acronyms

ABC	Abstinence, be faithful and use condoms
ACSA	Anglican Church of the Province of Southern Africa
ACORD	Agency for Co-operation and Research in Development
ACT	Anglican Council of Tanzania
AICs	African Initiated Churches; African Independent Churches
AIDS	Acquired immunodeficiency syndrome
ARHAP	African Religious Health Assets Programme
ARV	Antiretroviral therapy
CADRE	Centre for AIDS Development, Research and Evaluation
CAPSA	Church of the Province of Southern Africa
CCDB	Christian Commission for Development in Bangladesh
CCG	Christian Council of Ghana
CCIH	Christian Connections for International Health
CCP	Centre for Communication Programs, Johns Hopkins University
CDC	United States Centres for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CMMB	Catholic Medical Mission Board
CPSA	Church of the Province of South Africa (Anglican Church)
CSDH	Commission on Social Determinants of Health (WHO)
DIFAEM	German Institute for Medical Mission
DFID	Department for International Development (UK)
EAA	Ecumenical Advocacy Alliance
FBO/I	Faith-based organisation or faith-based organization
FHI	Family Health International
GFATM	Global Fund to fight AIDS, TB and malaria
GHC	Global Health Council
GHW	Global Health Watch
HAI	Harvard AIDS Institute
HEARD	Health Economics and HIV/AIDS Research Division, UKZN
HAART	Highly active antiretroviral therapy
HIV	Human immunodeficiency virus
HST	Health Systems Trust
IFDC	Interfaith dialogue and cooperation
IHP	Interfaith Health Program
IMAU	Islamic Medical Association of Uganda
KABP	Knowledge, attitudes, beliefs and practices
KIT	Koninklijk Instituut voor de Tropen
NACA	Nigerian Interfaith Commission for HIV/AIDS
NGO	Non-governmental organisation
OVC	Orphans and vulnerable children
PHC	Primary health care
PLWHA	People living with HIV and AIDS
RE	Religious entity
RHA	Religious health asset
SACBC	South African Catholics Bishops Conference

SACC	South African Council of Churches
SRH	Sexual and Reproductive Health
SSA	Sub-Saharan Africa
STI	Sexually transmitted infection
TRIPS	Agreement on Trade Related Aspects of Intellectual Property Rights
UCT	University of Cape Town
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WCC	World Council of Churches
WCRP	World Conference of Religions for Peace
WHO	World Health Organisation
ZINGO	Zambia Interfaith Networking Group on HIV/AIDS

Chapter 1 Introduction and Overview

Abstract:
This ARHAP literature review focuses on the under-studied intersection between religion and public health, with a particular emphasis on literature addressing sub-Saharan Africa in the last ten years, and a further focus on literature addressing HIV/AIDS. By assessing a wide-ranging array of literature, the review seeks to establish a literary foundation for the theoretical work and conceptual concerns that motivate the interdisciplinary ARHAP group, which promises a better understanding of the way in which religion interacts with public health concerns and systems. It also raises questions for future study.

1.1 Rationale and process of study

For some, the terms 'religion', 'public health' and 'Africa' go together quite logically. Perhaps they are thinking of the long historical involvement of religions and missionaries in the establishment of hospitals and clinics, of initiatives that care for AIDS orphans, or of the way religions fundamentally seek to shape the behaviour of communities and individuals through food-related dictates or norms for sexual behaviour.

For others, though, these words do not fit comfortably at all. Under the influence of secularisation, biomedicine and public health, many people frequently regard religious interventions in health with narrow-eyed suspicion, using as their evidence the stigmatising effects of some religious positions on people living with HIV/AIDS, or the fact that religious health facilities may be a front for proselytization. Alternatively, religious organizations' involvement in public health is not visible to them at all, religion being seen as a subset of 'culture' and religious health infrastructures as a subset of non-governmental organizations (NGOs). This outlook is influenced by the long-standing dominance in social science of secularization models that are, in effect, 'religion-blind'.

However, in the current context of critical health challenges in many parts of the world, increasingly, groups and individuals are being pushed into the no-man's land between these two stances - standing with one foot in each camp, one might say - recognizing the potential of faith-based initiatives and organizations, while acknowledging their problematic aspects.

> *The role of African faith-based organisations in combating HIV and AIDS is widely recognised as having growing significance but, at the same time, one which is not fully exploited, given the influence and reach of FBOs in African societies. Their impact at the community and household levels and their well-developed on-the-ground networks make them uniquely positioned to influence values and behaviours and to mobilise communities - World Bank 2004.*

HIV/AIDS and other pandemic diseases such as malaria and tuberculosis are fundamental threats to human and economic development in sub-Saharan Africa. A potential outbreak of avian flu threatens everyone. This is complicated in many places by political and ethnic conflict, famine, chronic poverty, and other scourges. In this context, the religious health community in Africa, as elsewhere, is beginning to play a much more visible role in the effort to respond to such threats by creating the individual, communal, cultural, socio-economic and environmental conditions that enhance and maintain health. However, only in the

last few years have international health and development agencies begun to recognize the importance of religious health institutions and networks in combating HIV/AIDS and other epidemics.

There are various examples of this - for instance, at a World Health Organization sponsored non-governmental organization (NGO) meeting in 2000, Director General Gro Harlem Brundtland stated that now 'we must go beyond the traditional health sector - working with people in their homes, their work places, their schools, their community halls and their places of worship,' to confront diseases of poverty.[1] In their attempt to get ARV treatment to more people in developing countries, the WHO are also looking at the role that religious entities (REs)[2] can play in the rollout of ARVs, and are embarking on an unprecedented research direction that will analyse where REs are located and how they can aid in the healthcare of AIDS patients.[3] GFATM and the World Bank are also examples of agencies that, in recent years, have taken the decision to channel funds for health programs to REs because this is seen as a reliable and efficient means to impact on health crises.[4] UNICEF has also started to look at REs as sites of support for child-headed households as well as for the care of people living with HIV and AIDS. Other studies, largely published since 2003, indicate that African faith communities have begun to increase such efforts rapidly over the past five years - largely in response to the HIV/AIDS crisis,[5] but in some cases also because of collapsing or compromised health systems, sometimes following on misplaced structural adjustment programmes that were introduced in many countries in the 1990s.[6]

> *But there is an untold story about HIV and AIDS in Africa. Largely unrecognised, a huge and growing network of groups is toiling on the front line, tending the sick, caring for orphans, wrestling to halt the spread of infection. This network receives barely a mention in international and national strategies to tackle the pandemic, even though its volunteers' work is worth billions of pounds a year.*
>
> *This network is Africa's churches. Almost uniquely, their members are reaching the communities and people whom governments and NGOs cannot easily reach. International funding agencies and governments do not understand the nature of faith in local communities, nor do they appreciate how churches are working at village level - Tearfund 2006*

Adding impetus to this renewed focus on religion is the realisation that, globally, religion is making a comeback into public life. The secularisation thesis has been shown to be flawed, and under the influence of epidemics such as HIV/AIDS, diseases are now being more readily seen and studied as epidemics of society - in which factors such as religious worldviews and motivations challenge our understanding just as much as the biomedical quandary does. Biomedicine cannot be expected to have all the answers, nor the capacity to cope with the many diseases of society and the frequently confounding 'human factor' in the treatment of disease. In practice, this gives academic researchers a new mandate to move beyond the secular-focused and departmentally-divided training of modern academics and to begin more actively to pursue a complex understanding of health and society - notably through the sometimes uncomfortable lens of religion.

With this increased attention and urgency to religion comes the confounding realization that little is actually known about religious organizations or initiatives working in health. Some studies are emerging, and there is much anecdotal evidence that such bodies are present and busy intervening in health - but little is known about how they do their business, just what infrastructure they do or could

[1] In Martin 1999
[2] See Section 1.2 for explanation of the logic behind these definitions.
[3] See WHO 2004, ARHAP 2006
[4] Taylor 2005a, 2005b & 2006
[5] See Section 4.1
[6] ARHAP 2006

command, and what effects are particular to REs as opposed to developmental NGOs. Furthermore, in basic terms, the general invisibility of REs to the public health infrastructure must mean that efforts are not being properly coordinated, that differing local and public health systems are not in alignment, and that resources are thus being misdirected.

It is in this uncomfortable place that the African Religious Health Assets Programme (ARHAP) and this literature review have been positioned. To stand between professional (and often secular and biomedical) public health perspectives and that of 'the religious' - is to do research in what the ARHAP group has fondly begun to call, 'a bounded field of unknowing', a term that signals the great deal that still has to be understood if even recent work is beginning to fill in the picture.[7]

Half the work in education and health in sub-Saharan Africa is done by the church…but they don't talk to each other, and they don't talk to us - World Bank President James Wolfensohn in Kitchen 2002

This literature review, therefore, aims not only to delineate comparative academic literature, but also to act as a resource for a multidisciplinary group and the many professionals being similarly driven into this relative intellectual wilderness - to begin to draw together disparate interests, to share information, and to begin to clarify a position in a new area of understanding.

Background to ARHAP and theoretical framework

The African Religious Health Assets Programme (ARHAP) emerged in 2002 as a multidisciplinary and multinational collaboration of academics and professionals, including public health practitioners, theologians, medical practitioners, sociologists, demographers and anthropologists. These individuals brought with them many differing perspectives on how health and religion interact (a variety that is reflected in the diverse nature of this literature review). However, from these different perspectives, a group was formed in the common realisation that very little research had been done in the area of public health and religion generally - as opposed to individual experiences of health and spirituality - and even less from an African experience or perspective.

Despite evidence that religion plays an increasingly important role in health in Africa, there has been little focus on the interface between religious organizations and public health. ARHAP founders decided that active research was needed in order to identify to what degree religion was having an impact on health, and what the nature of this effect would be. The results of the research could then be used to support religious health interventions and increase the understanding of religion's role in health in order for better policy-making at a national and regional level.

ARHAP's theoretical approach - which structures this literature review - rests on three shared understandings: that the secularisation thesis is in crucial aspects invalid; that humans have the capacity to exercise their own agency in dealing with their health; and that an assets-based approach is most appropriate for research in this field.

[7] See Thomas et al 2006

❒ The failure of the secularisation thesis

The primary assumption of the research undertaken by ARHAP is that religion, in its own right, is important to the health of individuals and communities. This basic assumption sits in direct contrast to the secularisation thesis that has ruled the social sciences, and academia in general, for some time.

The secularisation thesis suggests, among other things, that as societies develop and modernise they will tend to follow the pattern that developed in Europe during the 20th century where religion has been increasingly relegated to the back seat and seemed to loose its influence in public life. The idea here, that religion will disappear or wither away as the superstition and ignorance that it supposedly represents is eroded by rational thought, is heavily rooted in Enlightenment thinking, by its very nature a backlash against the dominance of the church and theology during the period preceding the Enlightenment.

In this context it seems strange to reassert religion as a topical research area. However, the evidence increasingly shows that the basis upon which the secularisation thesis rests - that 'development' equals secularisation - is flawed, and that the religious is still very much intertwined with the social.[8] Religion is therefore not necessarily privatized by modernization (this is true in some cases but not in others and is contextually determined), nor has it disappeared as a force (some European countries have seen its wither, but not others), and indeed, it continues to play a role in the sphere of the public, whether positively (as in South Africa in the religious struggle against Apartheid), or negatively (again, South Africa where Apartheid was defended on the basis of a religious position offers a good example). Even a commentator such as Peter Berger, one of the key earlier proponents of secularization theory, concedes that religion is on the increase, and more importantly is a force to be reckoned with in the public context, as in the contemporary USA.[9]

More centrally for ARHAP, religion is vibrant in Africa. Christianity in the South and Islam in the North and West are the major mainstream religions in Africa and most Africans would label themselves as one or the other. The Commission for Africa notes that particularly where the state is perceived as unable to deliver, 'religious networks appear to be gaining a new attractiveness. Contrary to apparent assumptions in the 20th century that religion was in inevitable decline worldwide, people in Africa are converting in large numbers to Christianity and Islam.'[10] Not only would they call themselves religious, but the majority of Africans are practicing Christians or Muslims. The other major religion in Africa is traditional and ancestral worship in its various forms. For many, these religions are practiced together and the role of traditional religion should not be underestimated.[11]

For a local example, Garner points out that a large majority of South Africans are affiliated to Christian Churches and that this affiliation is not purely 'nominal', with research confirming that about half of South Africans attend worship once a week or more, 'making it one of the most "churchy" countries in the world'[12]. What this means is that for a majority of Africans, their interpretations of life and health would be powerfully religious.[13] Luckoff et al similarly observe that religion and spirituality are 'among the most important factors that structure human experience, beliefs, values, behaviour, and

[8] See Benn 2002, Cassanova 1994, Cochrane 2003, Derrida and Vattimo 1998, Habermas 2002
[9] See Berger (ed) 1999
[10] Commission for Africa 2005
[11] These issues will be thoroughly discussed within this review. See, for example, Sections 4.5
[12] Garner 2000b
[13] See Benn 2002, Cochrane 1999, Du Toit 2002

illness patterns'.[14] The secularisation thesis is increasingly difficult to uphold in face of the visible presence of religion in public life today, and its obvious effects in health.

❒ Agency

The ARHAP model of research builds on the assumption that even in the context of dramatic health challenges such as HIV and AIDS, human individuals and communities have assets and the capacity to exert agency through them. The leveraging of assets implies agency, without which they simply 'rest', that is, have no effect or impact. This rests on the concept of 'agency' that is at the heart of the thinking of Nobel Prize winning economist Amartya Sen for whom, 'greater freedom enhances the ability of people to help themselves and also to influence the world, and these matters are central to the process of development.'[15] He affirms the agency aspect of the individual, groups and organizations, and his work supports what he calls an agent-oriented view. Companion to this is the work of Martha Nussbaum on human capabilities.[16]

ARHAP follows this approach in exploring how health assets held by REs develop and express agency on their own and further contribute to the agency of the community in engaging health issues. It is clear that it is simply wrong to make the assumption that poor people are 'not able to do'. Poor people are always engaged in strategies and struggles for survival, adaptation and freedom. Agency rests within individuals, and in communities. What is still unclear is how agency is formed around faith or through faith-forming entities and religious organizations.

❒ Religious health assets: Tangible and intangible

Having noted the importance of the notions of assets and agency, we may add to this another related framework of relevance to ARHAP's approach, namely, the assets-based-development approach popularised by Kretzmann and McKnight.[17] This takes as its starting point the concern that people and their communities should not be viewed in the first instance in terms of deficits that hamper their development, and that needs analysis is thus not the best first step in determining appropriate development interventions. Instead, the view is on the assets that people have and that they leverage (even to survive), which may be further mobilised or strengthened for development, thereby empowering communities by beginning from what they know and do and building on that.

While acknowledging that religion can be and certainly has been used adversely, ARHAP believes that one under-theorized but key source of health assets lies in religion, for which it has coined the term 'religious health assets' (RHAs). Cochrane explains the power of a focus on RHAs:

> First, it captures the basic idea that assets carry value and may be leveraged to create greater value. *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. 'Assets' suggest a stronger agency in the local context, and prompt us to identify what is already there to work with, rather than beginning with lack or need - concepts that emphasize outside agency, even undermine local agency…External resources are obviously important, but policy, usually driven 'from above,' and therefore inherently oriented toward prioritising external resources, might be better served

[14] Luckoff et al 1992
[15] Sen 1999; see also Sen 1992 & 2000
[16] See for example Nussbaum 2000; Nussbaum & Glover 1995; Nussbaum & Sen 1993
[17] Kretzmann & McKnight 1993 & 2002

> by an approach that mobilizes existing internal *assets, strengths and capabilities*. This works simultaneously against ingrained habits of dependency and disabling gift giving or patronage, derived largely from generations of colonialism that have been hard to break. Constraints must also be taken seriously, but not as determining.[18]

Religion may operate as an asset in a variety of ways. For example, religious convictions and worldviews have directly and tangibly impacted on health through the work of missionaries who came to Africa, setting up mission hospitals, many of which are still relied upon today, and in more rural parts of Africa are often the only healthcare facilities available.[19] These 'religious health assets' - and other similar ones such as clinics, hospices or dispensaries - may be termed direct and tangible assets.

However, religion also has more intangible and indirect effects on health that, better understood and leveraged, might offer great potential for impacting health in Africa, whether through volunteerism and education, or behaviour change and the building of social capital, through seemingly mundane experiences such as singing in a choir regularly, or through the ways in which religious involvement engenders hope or resilience. Following on such notions, ARHAP works on the assumption that what often makes RHAs different from other health associations, institutions or structures lies in what is not visible - the volitional, motivational and mobilizing capacities that are rooted in vital affective and symbolic dimensions of religious faith, belief and behaviour.

If this framework suggests that religion impacts on health in countless ways that have not been considered adequately before, it also points to the need to develop new theory and appropriate, reliable tools capable of making visible or measuring such religious health assets in ways that are relevant to practitioners and policy makers.

This theoretical framework also speaks to the reasoning behind the inclusion of many documents in the following review that might otherwise appear odd. ARHAP is an interdisciplinary research project that not only seeks to align two disparate fields of research (religion and public health), but also seeks to search for 'invisible' and 'intangible' assets. A transdisciplinary approach is unavoidable, therefore, and it is in the nature of the interface between religion and health, reflecting a complex human reality, that new research routes are required to tease out the most crucial, vital parameters for understanding that interface with sufficient complexity and coherence. This literature review reflects this intention.

❒ Opposing literature

Two basic positions stand against taking religion seriously as an asset for health. The first, as noted, derives from the secularisation thesis, which is now generally understood as severely flawed in key respects. Thus, while religion under the sway of the notion that it is either in decline (to disappear) or at best a matter of the realm of the private and personal moved out of the focus of social scientists, the empirical reality speaks strongly against such ideas, at least without major qualification or modification. So, for example, the belief that religion is derivative (of an economic, political or other social reality) at most, hence illusory or unhelpful and of no relevance to the question of public health or heath care generally, continues to appear in the literature. This is an increasingly difficult position to take in the context of ARHAP's work, in view of just the visible assets and effects of religious organizations in Africa and beyond.

[18] Cochrane 2003
[19] See Section 3.5

The second position against a positive accounting of religion lies precisely in the many negative impacts or outcomes that have been identified with religion as part of the rise of social science and of the Enlightenment more generally. Indeed, as many have said in one way or another, the critique of religion may be regarded as the beginning of critique per se, in the modern sense. Thus Benn, for example, acknowledges that missionaries all too frequently had a negative impact on communities they approached in Africa, in that they denied people the practice of their traditional beliefs, in the process generating confusion or undermining what was positive.[20] This often meant what we would today describe as human rights infringements. More recent examples of the 'danger' of religion in much literature focus on the unhelpful role that some religious beliefs have played in the context of HIV/AIDS, for example, when the Roman Catholic Church is criticised for its negative stance on condom-use, or when religious organisations are challenged on their stigmatisation of people living with HIV or their avoidance of the topic of sexuality.

ARHAP acknowledges these deep ambiguities of religious authority, experience and thought. While committed to an 'assets-based' approach, it is clear that we cannot view religious organizations and individuals through rose-coloured lenses. Indeed, it would be a mistake to shy away from such critique or from considering some of the negative impacts of religion on public health as deterrents, for the same reason that it is unhelpful to ignore the positive: Both enable a more socially intelligent, humanly adequate response to the real complexities of health and ill-health. As the following literature review demonstrates, we are committed to the investigation of religion and public health as a complex paradigm, and one in which grasping that complexity more fully could become an asset in itself.

Scope and parameters of the literature review

Considering the above discussion, this literature review clearly covers a sprawling body of knowledge. In order to limit it to a more manageable body of work, further parameters were set for this initial review, namely: Literature with a focus on sub-Saharan Africa over the last ten years (1995-2005), with a further inclusion of a few key documents that emerged pre-publication in 2006.

❒ **Primary purpose of the review**

The primary purpose of this literature review is to delineate the scope and scale of the thinking that guides ARHAP in seeking to understand the interface between religion and health in Africa. A second intent is to highlight the most important gaps that need to be filled. A third is to do so with a view to making an impact on public health policies and appropriately empowering and aligning religious entities with public health systems (local, national or regional).

Accordingly, while this literature review focus predominantly on health and religion in sub-Saharan Africa (SSA), it does occasionally include other seminal literature that is likely to impact on the research needed, even when such does not precisely pay attention to SSA.[21] Furthermore, certain documents have been included in order to balance what otherwise might appear as a rather unbalanced collection. For example, as a result of the area and period of this review, HIV/AIDS and Christian responses to the pandemic inexorably become its focus. While Christianity is certainly the dominant religion in much of this geographic area, and HIV/AIDS the epidemic with the brightest spotlight, this emphasis of the literature might inadvertently leave the reader with the impression that these are the

[20] Benn 2003
[21] This is the case most clearly in Section 3, which deals with the theoretical component of public health

'only' areas of interest. In order to circumvent this impact, certain materials on initiatives and religious responses beyond SSA borders have occasionally been included.

In the same way, while one parameter limits the focus to literature published or written in the last ten years (1995-2005), occasionally important documents have been included that fall beyond this indicator. This is particularly the case in the section on 'Blending African religion, health and culture'[22] - where some materials on African culture are older, but made relevant by the relative lack of more current information.

❒ **Focus on (sub-Saharan) Africa in the last ten years**

The focus of this initial literature review for ARHAP is on sub-Saharan Africa (SSA), dealing mainly with English-language material. It includes material that has emerged from, or is about Africa. ARHAP itself consists of a multi-national group of scholars (and others) with international interests, and ultimately its work has a global intention, but for obvious reasons, an African focus provides its starting point for concerted research. Two further literature reviews are in process, one focussing on Northern America, and the other on Islamic countries in Africa, particularly French and Arab literature in the latter case.

An initial focus for the review on SSA parallels the urgent practical challenge as health systems in many countries buckle under the weight of an increasing disease burden. But, in SSA, religious groups also have a solid history of being involved in healthcare and therefore are already established as key players in certain healthcare strategies, as may be seen, for example, in the many national Christian health associations in southern and eastern Africa that oversee a significant number of facilities (hospitals and clinics).

Furthermore, as has been outlined above, Africa is a particularly religious continent and religion therefore impacts on the private and public lives of the majority of people living in Africa in multiple ways. Africa is also a complex setting of differing cultures and religions, and this often confounds externally generated research based on any homogenous understanding of culture, religion and health. This not only makes it a fascinating region in which to pursue research on RHAs, but such work potentially may be expected to have important results for understanding RHAs in other regions of the world.

Finally, studies about Africa have traditionally been Occidental in nature, and frequently alienating of the African. One outcome we hope for from this review is that it will encourage African intellectuals to study Africa along these lines, and ARHAP is committed to helping develop the capacity for this to be possible.

❒ **Review process**

The primary focus of this review is on academically recognised material - found mainly in peer-reviewed journals and in publications by established authors in the various fields. However, it quickly became apparent that in order to do justice to the region and the topic, it was necessary to consider 'grey' literature as well, that is, works by non-academic professionals, new unpublished academics, and the multitude of 'reports' and papers being published by REs and health agencies themselves. In this regard, each reference was individually weighed in terms of its relevance, its interest, and the

[22] See Section 4.5

scarcity of other documentation of its type - as well as the normal assessment of quality of its author and publication.

The research process began with the consideration of current review articles in various areas of religion and public health in order to establish that a review of this nature had not already been done. Then, extensive electronic searches were carried out on various electronic academic databases, both national and international, to identify relevant research in journals and books. However, because of the nature of the material uncovered, it soon became apparent that a wide-ranging information gathering process would be required - for example, much 'grey' material is not documented on the standard electronic search engines. The research therefore spiralled from this starting point, gathering material from various religious, development, research and health organizations, and checking the references of these documents against those already held in the database established for the literature review.

In light of the sheer volume of literature available, and the broad nature of this review, it is likely that some significant studies have been missed, and that some have been given attention beyond their actual usefulness. The frequency with which relevant new materials become available - even as this report is concluded - is in itself an indication of a renewed interest in this field. It also demonstrates the need for this literature review, as a further impetus for a much larger project of information collection and dissemination.

The documents reviewed were organized into categories that developed as the material grew and 'themes' of interest were established. In Chapter 4, in particular, materials are frequently grouped into 'themed' categories - for example, the section on 'Orphans and vulnerable children' could be grouped together with the preceding section on 'Interventions through religious entities', but the quantity of material and the interest in this area demanded consideration in its own right. It is therefore necessary to emphasise that while the material has been categorised in ways we believe will make it more accessible, we do recognize that the categorization process itself is artificial and could certainly be done in different ways. Also, there are a handful of important documents that cross over such categories, and reflect the ways in which these fields and themes overlap, intersect and depend upon one another. Therefore, on occasion, such documents are repeated in both the literature and companion bibliography.

Literature review sections

The literature review has been laid out as follows. In Chapter 2, we present a cursory review of fields of inquiry that have already been established, and that are vital to the research area in which ARHAP operates. It covers areas that are already well reviewed elsewhere, and functions as a tool to further define where ARHAP's research interests fall. In this section we briefly point the reader to: religion as an explanatory variable (i.e. individual health outcomes and the psychological aspects of religion); congregational studies; religion and development; and social capital.

Chapter 3 focuses on the material specifically relevant to public health professionals and researchers. It identifies major themes of interest to public health in relation to religion in sub-Saharan Africa.

Chapter 4 then takes HIV/AIDS as the lens through which to gather the variety of material important in the consideration of religious interventions in the public health arena. This includes not only

interventions by REs such as FBOs or mission hospitals, but also issues of community care and behaviour change. The burgeoning crisis of the HIV/AIDS epidemic in sub-Saharan Africa, particularly in the last decade within which this review is based, means that the majority of published material relevant to this study is indeed focused on HIV/AIDS.[23] Moreover, HIV/AIDS itself is a multiplex disease that is commonly researched in relation to a broad spectrum of issues, from the over burdening of health facilities, to the interface with social development issues and other opportunistic diseases. Furthermore, as we will see, religious entities are diverse entities and are rarely focused on a single health intervention - often shifting in nature in response to demand.[24] It is therefore our understanding, that by assessing the literature on the responses of religious entities to HIV/AIDS, we will gain knowledge on a broader spectrum of involvement.

Finally, Chapter 5 briefly presents a few of the studies which are not focussed on HIV/AIDS, and draws the literature review to a conclusion by giving recommendations for further research.

1.2 Definitions of key terms

❒ Health

Health in the biomedical sense is frequently defined as the absence of disease. It is also focused on the individual subject or body. Ill-health is determined by the presence of a disease and a cause for it. Dealing with disease thus means identifying the specific cause (such as a virus or bacteria) and targeting the cause to re-establish health. Biomedical interventions therefore tend to be highly technical and instrumental, and narrowly focused. Biomedicine has had to expand the definition of health over time to accommodate chronic diseases such as arthritis, heart disease and diabetes. In such cases the cause often cannot be treated directly, and the healthcare approach shifts from curing to caring. This biomedical definition of health is often seen as the dominant definition. However, it comes with its own complications. In particular, though medical training tries to compensate for this, the subjective state or social context of the individual is ignored to a large extent in defining what makes for illness or health.

However, there is increasing attention to alternative or expanded definitions of health. Public health practitioners tend to define health more broadly than this biomedical approach. The early WHO definition referred to health as 'the state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.'[25] In this sense health becomes 'well-being' and encompasses aspects such as how well a person lives, their lifestyle and emotional state of mind. So a person without the means to eat well, or a person who is depressed, could both be seen as 'unhealthy' even if there is no biological reason for their lack of well-being.

On an even broader scale, the African perspective of health relates far more to the social than to the individual. In recent ARHAP research,[26] the trend has become to describe this conception of health by the Sesotho term 'bophelo' - when it was realized that Sesotho did not hold distinct signifiers for 'health' and 'religion'. Bophelo is a term that is used for health but more appropriately denotes full

[23] It is perhaps necessary to point out that in the same way that Christian-based material inadvertently dominates this review; the focus on HIV/AIDS is driven by the nature of the current material, rather than representative of the ARHAP group interest which readily acknowledges the wide variety and complexity of health crises in SSA.
[24] See Section 3.5 & 4.1
[25] WHO 1948
[26] See ARHAP 2006; Germond & Molapo 2006

human life or life in all its fullness. Therefore it includes good relationships with the family, community and the ancestors, the means to live well, as well as absence of disease. Disease is here also more broadly defined and includes being bewitched or being depressed, conflict with neighbours or family, and social determinants such as poverty or poor land.

This is a comprehensive understanding of health, a far richer description, one that encompasses the spiritual elements of health that the biomedical model tends to ignore, and one that is linguistically embedded in a non-Cartesian unity of subject and object, of religion and health. It is also common in African languages (Xhosa and Bemba, for example, having direct equivalents). It is also far more relevant for the research to be conducted within and with participation from African communities.

❒ The Church

There has been a great deal of debate surrounding the use of the term 'church' in religious studies. In the context of this literature review, while we have tried to limit the use of this term because of its ambiguous nature and its Christian genesis, when the term is brought forth by the literature we understand it to mean the overarching religious structure - of any religion - with no particular bias to Christian organizations. Otherwise, wherever possible, we use other analogous terms.

❒ Faith-based organizations (FBOs) and Religious Entities (REs)

There is increasing debate as to the meaning of the label 'faith-based organization'. In the literature reviewed, this term is used in a variety of ways, for example, to mean NGOs with religious support, churches and community organizations, faith-based programs or religious networks.[27] This broad usage does not lend itself to a better understanding of the full range of religious health assets acting at both local and national levels.

Through our research, we have also found that religious entities are not always easily classified as 'faith-based organisations' - for example, many of the activities that would count as contributing to health are not necessarily organized in any formal way, often arising from rather ad hoc interventions or personal initiatives that may remain so even though they have a public impact. Not infrequently such initiatives turn into a more organized kind of intervention at a later stage, usually acquiring then the features of a definable organization, and thereby becoming more 'visible'. The social reality of health includes both kinds of phenomena.

Therefore, for the purposes of this review, we utilise the term '*religious entity*' (RE) to capture the incredibly broad range of (tangible) RHAs, encompassing all religious groupings, be they directly religious organizations (such as congregations, churches, mosques, synagogues or prayer groups); organizations tied to religious groups (such as mission hospitals and clinics, or faith-based CBOs and NGOs); as well as more nebulous formations such as community networks and personal initiatives of a pastor or other mediator. This term also enables us to speak of individual entities such as traditional healers as religious entities.

ARHAP is currently working on further elaboration of this schema, and has developed sub-category definitions for such entities such as:

[27] Most reports mentioned in Section 4.1 make considerable effort to explain just what they mean by whatever terms they have chosen to represent religious entities and actions - however, there appears to be little common agreement on this matter.

- **faith-forming entities (FFE)**: meaning those bodies whose primary focus is worship or some analogous practice, out of which people arise who demonstrate strong and enduring religious commitments, passions and motivations to action.
- **community support groups (CSG)**: this term applies in particular to Lesotho where community support groups of a particular nature were identified. In communities where access to healthcare services and facilities is beyond the financial reach of ordinary Basotho there has been a dramatic upsurge of local community support groups. Self-initiated, deeply religious, though not formally linked to any religious structure, they are identified as an important health provider in these communities.[28]
- **faith-based organization or initiative (FBO/I):** Faith-based organizations or initiatives are those religious entities that have a more structured nature as well as religious support. This includes initiatives and organizations tied to religious groups (such as mission hospitals or faith-based CBOs and NGOs); as well as community networks.

❒ HIV/AIDS

For the purposes of this review, the term 'HIV/AIDS' will be used to indicate the complete range of stages of infection, sero-conversion and resulting opportunistic infections associated with this pandemic, as well as the cultural, behavioural, political and spiritual factors impacting on the course of the pandemic. While it is acknowledged that HIV and AIDS are different conditions, for the sake of convenience and to remain in line with current conventions the term 'HIV/AIDS' will be used instead of 'HIV and AIDS'. Furthermore, it is currently understood that there is not just one epidemic but multiple local and national epidemics with different characteristics and patterns. In addition, HIV/AIDS is also a 'pandemic' that spans localised and national borders. However, while the plural 'epidemics' or 'pandemic' would be more accurate, for the purposes of this study the more commonly used singular 'epidemic' has been maintained, but in the understanding that it represents multiple variations and experiences of being infected and affected by HIV/AIDS.

[28] ARHAP 2006

Chapter 2 Religion as a Variable

In this short chapter we will briefly mention some of the already well-established areas of study that are nevertheless vital to ARHAP's research focus. The primary point of this chapter is to alert the reader to references in the companion bibliography that are intended to give context to the ARHAP work on the interface between religion and health, work that builds on or complements these areas of research. The references are not exhaustive, for the topic areas are too large, but they offer the necessary framework for reflection on the interface.

2.1 Religion as an explanatory variable and psychological aspect

There is an extensive body of knowledge that locates religion as an explanatory variable in individual health outcomes. There is also extensive work being done on the impact of religion on individual mental health. The study of the relationship of spirituality or faith to health outcomes has been the focus of many studies and publications, but overwhelmingly focused on medical or personal level effects.[29] Medical practitioners and nursing journals in particular have not shied from investigating the individual responses of patients to religious interventions or involvement.

Along these lines, Koenig et al have written a comprehensive volume reviewing the relation of religion to psychology and health. They say that 'religion encompasses behavioural, attitudinal, public, and private activities, all of which potentially involve different antecedent factors and consequences for health outcomes. There is increasing research evidence that religious involvement is associated both cross-sectionally and prospectively with better physical health, better mental health, and longer survival.'[30] Their review covers issue of definition and measures of religion, religious coping, psychological well-being and social support, religious practices and health, religious effects on health outcomes, explaining religion-health links, negative effects of religion, and implications for health practice. Of course, there are also various studies that look more closely at the negative effects of faith and religious practice on health.[31]

This area of investigation, which looks at the effects of religiosity on individual health, is in fact what is most commonly understood when 'religion and health' are mentioned. However, this is not the focus of ARHAP or this literature review, which seeks to gather literature that speaks to the interaction between religion and 'public health' - that is, health at 'population scale', beyond the individual, in relation to the public or community.[32]

It is worth noting, however, that this division between public and individual expressions and reactions to religion is an artificial one. While this literature review leaves out items on how personal faith or spirituality impacts on the health of individuals, it is nevertheless clear that there is overlap between the individual and the community or group. For example, behaviour change programs are seen to be in the realm of public health, but rely on individual constructions of religion. It is therefore occasionally necessary to delve into the rich literature on individual health and well-being in order to more properly

[29] Idler 2003
[30] Koenig et al 2001; See also Peltzer & Koenig 2004
[31] See Benn 2001
[32] See Section 3.1

inform public health research and interventions.[33] Furthermore, this might be an area in which future research could gain much insight in order to compensate for the inadvertently overwhelming focus on HIV/AIDS in this literature review - as research in this area has competently focused on other important health issues such as aging, alcoholism and mental health.

2.2 Congregational studies

The more recent field of 'congregational studies' can be primarily seen in the work emerging from the United States with the significant landmark being the publication of *American Congregations* in 1994.[34] This field is a subset of the sociology of religion in which the study of congregations rests in a wider community context, and has emerged with a stable body of methodologies and analytical frameworks seeking to capture the complex dynamic of the religious phenomenon in social space. Much of the study of congregations focuses on their role in providing social or health benefit to the community and the implications for political policy. The exploration of public scale health effects of religious participation was noticed early, but has only recently been a focus of policy level discussion.[35] This area has clear links with ARHAP research interests.

2.3 Religion, development and public health

This following section is a rather uncomfortable attempt to distinguish between 'development' and 'public health' in relation to faith-based interventions and responses. The field of 'development' or 'development sociology' is immensely broad and intersects and overlaps with 'public health' in many places. Clearly, when we are talking about the capacity of religious entities,[36] or of people of faith being challenged to change the world,[37] we are looking at a broad, transversal set of phenomena that cut across issues of concern to development, and public health, practitioners and theorists. The distinction we make here between development and public health primarily serves to alert the reader to the areas and materials of development studies that need to supplement our review of public health material. Given a broad definition of health, which includes environmental conditions and social determinants, this link is unavoidable.

Religion can be force for good or bad in African development, but it can't be ignored - Commission for Africa 2005

DFID reports that there is a high degree of motivation within the separate faith traditions towards addressing poverty which is potentially available to support the Development Agenda - in Bonney and Hussain 2004

There are, for example, various religious entities involved in interventions relating to poverty or unemployment. The Unit for Religion and Development Research (URDR) suggests that churches have the potential to impact poverty in communities as social service providers and promoting change and transformation.[38] Just as in the public health sector, there is renewed interest from various development agencies for the religious sector to become more closely aligned with the development agenda.[39] Religions have long been involved in social transformation and development, but have rarely been recognized in this role by development policy makers. However, while poverty and unemployment clearly impact on health,

[33] See Section 4.9
[34] Wind & Lewis (eds) 1994
[35] See Kiser & Michael 1999
[36] See Section 4.1
[37] See Section 4.6
[38] Erasmus 2005a & 2005b; Erasmus & Mans 2005
[39] See DFID 2006; Marshall 2001 & 2005

we have not included many of these studies in this review, though they clearly are development issues that are seen to impact 'indirectly' on health.[40]

Another collection of material that we have not addressed here in any great length, is that of humanitarian assistance - a role in which many small and large-scale REs are visibly involved. Again, a distinction has to be made between 'public health' and 'emergency aid' - although there is clear overlap.

Finally, an interesting theme of discussion that is largely carried out in the 'development' sector is that of 'dependency' and 'charitable choice'. While we will not go into this in any great detail, such discussions are relevant to how we view any assistance to and funding of REs in the public health sector.[41]

> *The April 2005 conference in Oslo, on roles of religious NGOs in development work, was testimony to a growing appreciation of the many links and areas of common concern between seemingly separate and contending worlds. We live in dangerous times, with dangerous roads ahead, and such roads are best traveled together by those whose direction and path are essentially the same…This demands urgent new thinking and action by different partners as it casts quite new light on ancient approaches, assumptions and roles - Marshall 2005*

The main conclusion here is that REs often operate in a murky interdisciplinary and inter-sectoral manner.[42] The HIV/AIDS epidemic is also a multiplex disease that is as much a disease of development as it is one of public health or biomedicine. It behoves us to remain open to a wide range of influences that might assist in our research trajectory.

2.4 Social capital

Moving naturally from the discussion on development, we might briefly consider the concept of 'social capital', a hot topic in the development sector that has crossed over into public health as well.[43] Social capital has been described as the glue that holds people together in groups and societies through shared experiences, ideas, ideals, beliefs and practices.[44] According to Coleman, social capital is built from the ties that exist between people, making it possible for those involved to take certain actions and to be able to get things done that they would not have been able to do on their own.[45] Coleman continues by identifying specific forms of social capital to illustrate how it differentiates from physical capital (as an economic concept, which is measurable and tangible) and from human capital (which refers to skills and knowledge).[46] There is a mass of research covering different aspects of social capital - such as that which describes different types of bonds, open or closed networks, and social holes.[47] This all has fascinating implications for ARHAP,

> *Since the middle of the 1990s the concept of social capital has provoked rapidly growing interest. Social theorists, policy makers and those NGOs working on the edge of theory and practice became fascinated with social capital. International organisations like the World Bank, UNDP and the OECD upgraded social capital to the 'missing link' in understanding (under) development - Schuurman 2003*

[40] Of course, this distinction becomes problematic as we begin to look at the more intangible responses and interventions into health - such as 'trust' and 'hope' in Section 4.9. This type of ambiguity and cross-over is to be found frequently when working in these boundary and interdisciplinary zones.
[41] See An-Na'im 2003; Cnaan & Boddie 2002; Sider 2005
[42] See Section 4.1
[43] For a review of social capital literature see Sobel 2002
[44] See Serageldin & Groontaert 2000
[45] Coleman 1990
[46] Coleman 1990
[47] See Burt 2001

especially in terms of researching the effect of REs within local communities. Thus, for example, Cochrane notes:

> A good example of the health benefits of closed religious networks in the South African context, may be found among the Zionist African initiated churches (AICs)…Because of their internal discipline and strong emphasis on nurturing virtues prized by employers, they create significant advantages for their members, including caring for them when they are ill, providing for informal credit cooperation which can be used to buy 'muti' or medicines or support hospitalisation, and promoting 'clean living' in respect of alcoholism, domestic abuse, promiscuity, and crime (and its associated violence) - all factors that enhance or sustain health.[48]

While social capital is a concept that clearly interests ARHAP, related as it is to an assets-based approach, we will not be reviewing this area any further in this document except for mentioning it briefly in relation to caring communities.[49,50]

[48] Cochrane 2003
[49] See Section 4.8
[50] Interesting material should soon start emerging from the 'Spiritual Capital Research Program' begun in 2003 - see Iannaccone & Klick 2003; Woodberry 2003. See also Iannaccone 1990 for investigations into 'religious capital'.

Chapter 3 The Field of Public Health

This section seeks to lay out the current thinking in public health relevant to this review. It is intended to offer some theoretical clarification on how we understand public health, which then underpins the investigation into religious health interventions that follows in Chapter 4. The aim is here not to review all the vast literature of the public health field, but rather to provide a few key texts from the field in general, and those that deal with religion in Africa in particular.

3.1 The focus on public health[51]

Since the end of the eighteenth century the biomedical model of explaining illness and disease has dominated western thinking about health and has influenced health systems and policies the world over. Until recently, this paradigm has been left relatively unchallenged. As Foucault states, it has become the 'dark, but firm web of our experience'.[52]

Social thinking about health began, according to Armstrong, with an 'almost total acceptance of the biomedical model.'[53] This model was reinforced by subject matter such as how to best influence patient behaviour. Armstrong explains that in its second phase, social thinking about health then began to establish itself as a field outside of the model, yet still failed to significantly challenge the model. It is only later in its third and fourth phase where social thinking begins to actively challenge the biomedical model - engaging with issues such as the power of doctors, the view of the passive patient, or more broadly the emergence of biomedicine into a culturally and historically specific location. These kinds of issues paved the way for more diverse thinking about health and illness - and in particular had a great impact on our understanding of behaviour change and subsequent developments in this area.

Much of the practical impetus towards a conception of public health as we know it began with John Snow and others who were alarmed by the impact of early industrial capitalism upon the health of children, women and workers. In particular, it was driven by a realisation that clean water, water-borne sewerage, eradication of child labour, a reduction of air and waste pollution were critical to a healthy populace, and that many biomedical conditions arose and would simply continue unless these causes of ill-health were dealt with. As such it takes health from an individual perspective to a public perspective.

Though nation-states and international agencies have adopted aspects of this realization, and though many people have since thought about broader causes of disease such as social, psychological and environmental factors, and about how best to address these issues through policy, nevertheless, the individual, biomedically-based model, powerful in its impact within its own limits, remains determining of much health policy and expenditure. A tendency in many parts of the world to reduce the role of the state in society across the board under the so-called neo-liberal paradigm has exacerbated this tendency, and weakened public health systems. Essentially, ARHAP's work is part of a counter-tendency, one driven once again by practical imperatives as systems fail and illnesses and diseases outstrip capacities for response, with high costs to many people, particularly those who cannot afford private care and services. This points to a constant tension in the public health field

[51] Unless otherwise stated, this section is informed by general public health reading, see Porter 1999, Rosen 1993
[52] Armstrong 2000
[53] Armstrong 2000

between understandings of neo-liberal individual responsibility for own health care, versus the concern with public responsibility for individual health, as well as setting the policy and funding context for addressing the causes of poor health.

The idea of the 'quality of life' is central to public health (that is, to economic and social assessment and also to public policy, social legislation, and community programs). However there is a great deal of debate about which indicators are the best measures of quality of life. Sen and Nussbaum edit a collection of essays in which the authors seek to rise to the challenge of finding appropriate measures that go beyond the commonly used, but crude, indicators of economic success, such as per capita income.[54] The adoption of the Millennium Development Goals has also been cause for interest in this area - as here health outcomes are included as indicators (for example, maternal and child health), but do not include quality of life indicators.[55]

3.2 Social determinants of health

This directs us, in the history of social thinking about health and illness, to the subject of social epidemiology or the social determination of health. Very broadly, social epidemiology or social determination is a field that looks outside of the patients to the conditions of their life that may influence their health or lack thereof. It moves away from looking at pathogens to looking at the environment, the lack of access to resources and the resultant socio-economic status, among many other factors, as the explanations for illness or disease - that is, structural upstream causes of health inequity.

This has led to a recognition of how social inequality impacts significantly on health, and within the development theory, to an interest in how health acts as a key indicator of the level of development within a country. Here, too, we find literature on the parallel field of the political economy of health.

> *The social determinants of health (SDH) can be understood as the social conditions in which people live and work, or in Tarlov's phrase 'the social characteristics within which living takes place'. SDH point to both specific features of the social context that affect health and to the pathways by which social conditions translate into health impacts. The SDH that merit attention are those that can potentially be altered by informed action…the concept of social determinants is directed to the 'factors which help people stay healthy, rather than the service that help people when they are ill' – CSDH 2005*

Bartley is one of the key researchers on the social determinants of health. He argues that interest in the field began with the recognition that certain race groups were more susceptible to particular diseases than others.[56] Many researchers have tried to establish that there are genetic differences between classes and races that determine health and there is currently realignment in the biomedical world to try to understand the genetic causes of illness.[57] However, Bartley sets out to establish categories such as race, ethnicity and gender as mediating factors of disease rather than direct causes. The real causes are not the race or gender of the individual but the social and political realities that effect the lives of individuals, and it is those that are ultimately determined by race, ethnicity or gender. Rather than attempting to establish biological causes to explain the differences, researchers should be looking at such elements as socio-economic status, the conditions under which the individual lives, education, social roles, and access to health resources, as some of the explanatory factors for disease.

[54] Nussbaum & Sen (eds) 1993
[55] See United Nations 2005
[56] Bartley 2004
[57] See Himsworth 1984

There has been a recent boom in the interest in this field, linked with the establishment of the Commission on Social Determinants of Health, based in the WHO.[58] However, for the purposes of this brief review, we will divide this area according to the five key theories or explanations of social determinants as set out by Bartley, which are useful in analysing this field of study.[59]

❒ Material explanations

A material explanation states that an individual's income determines their diet, the quality of their housing, and their working conditions - and these all impact on the health of that person. This is the area in which Wilkinson has done most of his work, adopting a critical view of the field of social determinants of health. For him the resultant theories that have been established over the years have only served to 'absolve the social structure of responsibility'.[60] In his view there has been far too much willingness in the field to assign blame for ill health on genetic factors, individual behavioural choices, or social mobility. He suggests that there still needs to be a recognition of the socio-economic factors that impact on health, and therefore, a need to redress the inequalities that result in ''excess' - or potentially preventable - mortality in society'.[61] In fact, for Wilkinson, 'the amount of inequality itself, in states, regions or nations, is associated with increased mortality and poorer health'.[62] Wilkinson, like Farmer,[63] therefore tends towards the more radical political economy approach.

Wilkinson, along with Bartley and Marmot, has also contributed to the key text, *Social determinants of health - The solid facts*.[64] This work is written with the assumption that there is no longer a need for disagreement about whether or not socio-economic status has an effect on health. For these authors, 'material disadvantage combines with the effects of insecurity, anxiety and lack of social integration to affect the health of those at progressively lower levels of socio-economic status'.[65] The book is based on internationally comparative data from the *World Development Report* and the WHO *Global Burden of Disease* Study and irons out some of the problems that Wilkinson was concerned about regarding comparability of data on social determinants in his earlier book.

Marmot is another key theorist in the field and writes with both Bartley and Wilkinson. In his work with Wilkinson,[66] he states that the field of social determinants has reached a stage at which there is enough evidence to prove that 'differences in health between population groups are due to characteristics of society, not to differences in health care'. He notes that the differences in health care are conversely due to the characteristics of that society, that people's health is correlative with the environment in which they live, that health is linked with socio-economic status across the spectrum (and is thus more complex than simply stating that poor people have poor health), that something can be done about what he terms the 'health gradient', and that social position determines health rather than the other way around.

Marmot is clearly concerned with the complexity of the field of social determinants and wants to move away from the simple thesis that poverty causes ill health. He also makes the case for a more

[58] CSDH 2005
[59] Bartley 2004
[60] Wilkinson 1996
[61] Wilkinson 1996
[62] Wilkinson 1996; See also Mechanic 2000
[63] Farmer 1990 & 2003
[64] Wilkinson & Marmot (eds) 2003
[65] Dixon 2000
[66] Marmot & Wilkinson (eds) 1999

nuanced analysis of the causes of inequality that lead to poor health.[67] 'It is not difficult to understand how poverty in the form of material deprivation - dirty water, poor nutrition - allied to lack of quality medical care can account for the tragically foreshortened lives of people in Sierra Leone. Such understanding is insufficient in two important ways. First, it fails to properly take into account that relief of such material deprivation is not simply a technical matter of providing clean water or better medical care. Access to these resources is socially determined. Second, and related, international policies have not been pursued as if they had people's basic needs in mind.'[68] For him, a better understanding of social determinants would allow public health professionals to have a more clearly defined path of action.

Mechanic agrees that there needs to be a more nuanced understanding of the pathways through which income, wealth, education, occupation, and other features of social rank influence health status and mortality.[69] He points to a new strand within the field of social determinant studies focused on the material or socio-economic factors of health. Marmot proposes that there is a distinct health gradient. This is one of the latest theories to come out of social determinants research. This theory states that it is not simply a case of poverty causing ill health. Rather at every level of the socio-economic gradient, health disparities exist. Therefore even at the top end of the scale, the differences in health of a middle manager and a top executive are distinctive. That is, 'increments of additional social advantage, even at the highest levels…appear to confer additional health advantage.'[70]

One area that is closely linked with socio-economic status in many respects is that of gender, a key area of research in the field of social determinants. A prominent researcher in the field dealing with gender is Krieger.[71] She points out that both sex and gender may have an effect on health, depending what the health problem is. For instance, women are more likely to be infected with HIV due to sex related factors (such as a larger surface area for exposure), and are also more likely to be exposed to the virus due to gender (with less power in a relationship, they are more likely to be forced to have sex). For Krieger, any studies around gender and epidemiology should take an empirical and case-by-case, rather than philosophical approach.

Moss also focuses on the field of gender and health.[72] For her, the relationship between socio-economic determinants of health and gender equity is critical. Researchers too often look at the micro-level issues that women face - at how the family, household and community impact on their health - but inadequately at the geopolitical context in which women find themselves. Moss suggests that it is essential to understand that the multivariate levels of social life all impact on a woman's health, and thus on her family's health. Research in this field therefore needs to look at the political forces that maintain her domination, the cultural and demographic landscape - factors that influence behaviour - as well as at the individual level where women face particular issues in the household. It is interesting that Moss points out the role of culture in influencing behaviour, but does not develop this point much.

[67] Marmot 2005
[68] Marmot 2005
[69] Mechanic 2000 & 2002
[70] Mechanic 2000
[71] Krieger 2003
[72] Moss 2002

Finally, Denton looks at two hypotheses around gendered health.[73] She analyses the behavioural determinants approach, which states that certain types of behaviour (smoking, drinking, and sedentary lifestyle) impact significantly on health, and that differences in behaviour between men and women explain gendered health. However, she challenges this hypothesis and through her research illustrates that social structural explanations of health were more important in explaining gendered health - and therefore structural inequality needs to be addressed.

In a later article, Denton discusses the two further hypotheses that aim to explain gender differences in health.[74] The first (differential exposure) suggests that due to structural inequalities, women are differentially exposed to diseases compared to men and are thus likely to suffer from different types of illnesses than men. The second hypothesis (differential vulnerability) suggests that the explanation for gender differences in health is directly related to how women and men react to diseases, that is, their vulnerability to them. Denton suggests that in fact there is interplay between the two explanations. Men and women are exposed to different diseases due to structural factors; however, they also react differently to them. Denton looks at how men and women react to life crises and work stressors to analyse differing reactions. It is interesting to note that despite working in the Divinity School, Denton never mentions the role of religion as a determinant in health.

Unfortunately, relatively little is written about the burden of disease on women as the carer and homemaker. While she may not be ill herself, inevitably the care of ill children, husbands and other relatives is borne by her. Furthermore, the feminisation of poverty is not given much attention, particularly as much of the literature regarding gender and health stems out of Europe and America. Despite recognition that female education can be a vitally important strategy in increasing health levels in poorer nations,[75] the link between gender and health in these nations is under-researched.

❒ Psychosocial explanations

The psychosocial approach states that 'status, control, social support at work or at home, balance between effort and reward influence health through their impact on body functions'.[76] This is a key area of research, and is a particular focus of the World Health Organisation's publication, *The solid facts*. The basic premise of this argument is that stress decreases the control an individual has over the circumstances of his/her life. 'Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life, have powerful effects on health'.[77] This risk increases the lower down the economic hierarchy an individual is in industrialized nations.

Employment is also linked with health outcomes. In general, it is better for your health to work than not to have a job.[78] However, certain work situations may negatively impact on health. Where individuals have little opportunity for decision-making and if they are not rewarded for their work, increase in cardiovascular risk results. Where social support exists in the workplace, this may be mediated. A great deal of valuable research has been done on social support and positive health outcomes already,[79] and there is some interesting work emerging on support provided by religious

[73] Denton & Walters 1999
[74] Denton et al 2004
[75] Mechanic 2002
[76] Bartley 2004
[77] Marmot & Wilkinson (eds) 2003
[78] Marmot & Wilkinson (eds) 2003
[79] See Berkman 1984 & 1985; Cohen & Syme 1985; House & Kahn 1985; Thoits 1995

social structures.[80] However, there appears to be little material with an African focus, or which recognises the religion and religious structures particular to an African context.

❒ Life course explanations

The life course approach states that a person's health is determined at a young age and that events and at birth and in childhood impact on health throughout the individual's life. So, for example, exposure to damp during childhood may in the long term result respiratory health problems, while early exposure to mercury can curtail the development of intelligence. Therefore, a person's access to adequate food in the early stages of their life will influence their immune system and general strength for the rest of their lives. But the argument goes beyond the nutritional aspect alone; children learn behaviour from their parents and are affected by their parent's health behaviour. Therefore education for parents around healthy lifestyles should be beneficial to children. Emotional support at a young age is also linked with positive health later in life and socialised behaviour.[81]

❒ Cultural behaviour approaches

The cultural behaviour approach tries to understand health behaviour through the differences in beliefs or norms between individuals and their communities that determine their health behaviour.[82] Thus, in some cultures drinking and smoking would be discouraged leading to less risk of heart and lung disease. In South Africa, cultural explanations of promiscuity that put people at risk of AIDS would fall into this category.[83]

In some ways, the roots of public health lie in the attempts by early religions to regulate behaviour in relation to health - from regulations on food and drinking to sexual behaviour. There is some literature here on culture (and within that, religion) as a factor that influences health - for example, material on femicide and female circumcision.[84] However, culture and religion are not easily measurable. The secularization thesis proposes that religion and by implication religious aspects of culture, have no effect on the public lives of people. In Africa and other developing nations, however, religion and culture remain important elements of public and private life, and as such, they have a major impact on health ranging from health seeking behaviour to support structures, lifestyle, socialisation and access to healthcare.

> *Using religion to improve health is an age-old practice. However, using religion and enlisting religious authorities in public health campaigns, as exemplified by tobacco control interventions and other activities undertaken by WHO's Eastern Mediterranean Regional Office, is a relatively recent phenomenon. Although all possible opportunities within society should be exploited to control tobacco use and promote health, religion-based interventions should not be exempted from the evidence-based scrutiny to which other interventions are subjected before being adopted - Jabbour and Houad 2004*

❒ Political economy explanations

Finally, the political economy explanation is perhaps the most radical. In this explanation, 'political processes and distribution of power affect provision of services, quality of physical environment and social relationships'.[85] Theorists working in this field may simply point out the disparities or may be more uncompromising by suggesting that this is an active decision by those in power and thus blame

[80] See Krause et al 1999; Nooney & Woodrum 2002
[81] See Blane 1999
[82] See Section 3.3 for further explanation and reference to this approach
[83] See Section 4.4 & 4.5 for more discussion on culture in relation to religion and HIV/AIDS - for example cultural-religious practices such as circumcision or FGM that affect health.
[84] See Sahl et al 2004
[85] Bartley 2004

can be laid at their door - as, for example, Farmer tends to do.[86] Given the prominence of this aspect in the religious-health arena, we will discuss it in more detail in Section 3.4 below.

Outside of seeing ethnicity and religion as factors, which may lead to exclusion from health care, very little attention is given to these determinants of political economy (relating to religion). The literature on social determinants is mainly focussed on socio-economic status and its effects on health. To a lesser extent race and gender are considered, although most often as simply mediating factors. The newly established WHO initiative - the *Commission on Social Determinants of Health* (CSDH) seeks to address the social factors leading to ill health and focus on health inequities. The determinants recognized here include unemployment, unsafe workplaces, urban slums, globalization and lack of access to health systems[87] - as of yet, there appears to be little focus (or interest) here in relation to religion.

3.3 Health behaviour

Marmot makes the case for socialization as a mechanism for explaining social inequalities in health.[88] However, rather than suggesting that unhealthy behaviour is a learned response, Marmot and Singh-Manoux suggest that socialization is the concept that can link previously mutually exclusive explanations for social determinants of health. They therefore suggest that social class, and the norms and values attached to it, teach us certain behaviours. Therefore, 'health related and psychosocial behaviours are never truly 'voluntary'; they are a product of, and embedded in, the structures of society'.[89] While this position may be criticized from the perspective of shifting blame once again to the individual and away from the powers that create the unequal structures, it does allow space for thinking about religion and health. Religion frequently plays an important role in socialization, which suggests that it too affects health behaviour in significant ways.[90]

Marmot does not refer specifically to religion in the socialization process, but his view clearly allows its incorporation into the set of phenomena that might be described as social determinants of health. Germond, for instance, demonstrates in an African context that religion has great power to influence behaviour.[91] It operates epistemologically at the level of informing tacit knowledge or 'common sense', thus profoundly shaping a wide spectrum of attitudes, choices and behaviour, not least, health behaviour. Garner also refers to the role that religion has in influencing behaviour.[92] His study illustrates that certain Christian denominations have stricter boundaries and teachings, as well as closer social connections and that it is in these congregations that behaviour is most powerfully influenced, and upward social mobility is evidenced. This is a key area for further research: How does religion affect health agency? One example can be a recent bulletin released by the WHO which considers the potential for religion-based tobacco control interventions, but concludes that not enough is known (under an 'evidence-based scrutiny') to be able to initiate such a project.[93]

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[86] Farmer 2003
[87] CSDH 2005
[88] Marmot 2005
[89] Marmot & Singh-Manoux 2005
[90] See Swatos (ed) 1998
[91] See Germond 2001, Germond & Molapo 2005
[92] Garner 2000
[93] Jabbour & Houad 2004

Gender is also linked to health behaviour. Annandale, amongst others, has looked at the hypothesis that 'women get sick and men die.'[94] This slogan, which characterizes a general theory emerging from studies on gender and health, suggests that there is a pattern of behaviour that is gender specific: Where women are more likely to visit a doctor and prevent or manage chronic illness, men are risk takers, increasing the chance of death, and also less likely to visit a doctor or effectively manage disease. While it is generally accepted that this has been the pattern, explanations of this vary and range from biological explanations to explanations of socialization.

Health-seeking behaviour is becoming an increasingly important issue - especially in the pluralistic context of sub-Saharan Africa where patients have multiple options from which to choose their appropriate health strategy. For example, it has been shown that patients often enact multiple health strategies simultaneously, depending on their understanding of 'what will work',[95] while a study by ARHAP on an integrated, comprehensive, faith-based HIV/AIDS programme in a rural part of South Africa completed in 2006 also address the issue of 'mixing' health seeking strategies (noting that mixing may be simultaneous, but is also often sequential.[96])

Another very interesting and linked area of research, and of particular relevance to HIV/AIDS, is that of sexuality. Various researchers have tried to analyse different understandings of male and female sexuality.[97] This is important as certain understandings of sexuality encourage different types of behaviour that impact on health. Thus for Riska, the Type A man is more likely to take risks, be sexually promiscuous and ignore symptoms of ill health.[98] The hardy man on the other hand is health conscious and will diet and exercise. Due to the fact that religion has a major impact on how we understand ourselves as male and female, both in terms of our gender expectations and in terms of sexuality, this is another key area for research at the interface between religions and public health. In the public spotlight of HIV/AIDS research, religious support for sexual abstinence is receiving increasing attention.[99]

3.4 Political economy

It is no coincidence that the idea to establish a world health organization emerged from the same process that identified the universal value of human rights. WHO's mandate is also universal. Our constitution… stat(es) that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.' - Dr Gro Harlem Brundtland, Director-General, World Health Organization 1998

We have pointed earlier to the issue, highlighted by Bartley and others, of the political economy explanation for the link between social inequality and health.[100] Writings in this area are often distinctly quantitative or demographic, as when economic conditions in a country are compared with life expectancy. More recent work focuses on the effects on health of discrimination according to ethnicity, or race, or religion.[101] This is one of the few areas in which religion is addressed as a determinant of health in existing literature.

[94] Annandale 1998
[95] See Section 4.5
[96] Thomas et al 2006
[97] See Campbell 2000; Riska 2002
[98] Riska 2002
[99] See Section 4.3, 4.4 & 4.5
[100] Bartley 2004
[101] See Acheson 1998; Bowen-Reid & Harrell 2002; Graham ed 2000; Krieger 1993; Walls & Williams 2004

Thinking about the political economy of health was popularised by Wilkinson, for whom it is inequality and not poverty alone that causes ill health.[102] Thus, even in rich nations, high levels of inequality lead to low levels of health and high mortality rates; and it accounts for cases in which poor communities have higher levels of health than would be expected because income or wealth or economic differentials generally are flatter, less unequal. Unfortunately, as Mechanic points out, this field is yet to yield any quantitative data that unequivocally ties inequality to ill health, which makes it difficult to base policy on this thesis. [103]

However, Mechanic also makes the case that we should all learn from policies in poorer countries that have managed to address many of their health problems, linked to poverty. For instance, Kerala, Cuba, Sri Lanka and Jamaica have managed to reduce infant mortality and other indicators of poor health significantly, and in many cases have better rates than their richer counterparts. For Mechanic, although this is not definitive, and cultural disparities must be accounted for, many lessons can be learned from these examples. He outlines the two major interventions as being the education of women and access to primary health care.[104]

Another researcher who looks at globalisation and social determinants is Spiegel.[105] While Mechanic looks at lessons that could be learned from nations around the world, Spiegel considers the process of globalisation as having both positive and negative effects on health. In his view, though globalisation has allowed for some interventions on health and the sharing of technology and training, overall, in its current neo-liberal form, its effects have been negative. The trade in unhealthy and processed foods (which are often cheaper) has increased the burden of disease on poorer nations, adding lifestyle-diseases to the communicable diseases already dominating in those nations. More importantly, trade agreements and liberalization policies are narrowing the leeway for governments to provide affordable health services. South Africa's court battle with the World Trade Organization over generic drug licenses and patents protecting rich pharmaceutical companies is a successful case in point, but unfortunately, not the norm.[106]

The other worrying global factor influencing health in nations worldwide is the move towards privatisation of services, including health services. For Spiegel, 'since most of these services are essential, meaning that there is a guaranteed market for them … it is easy to understand why private foreign investors are keen to open up this market to profit-making ventures'.[107]

Spiegel then looks at the case of one country that has, to a large extent, successfully avoided these negative effects of neo-liberal globalisation: 'Fidel Castro's blunt assessment of the International Monetary Fund's (IMF) influence on public policy is accordingly much more than a rhetorical broadside; it implies that one effect of globalisation has been to restrict options for building healthy public policies - an assertion that merits empirical examination.'[108] Spiegel uses the Cuban example to provide lessons about the impacts of globalisation and offer insight into how health inequalities can be addressed.

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[102] Wilkinson 1996
[103] Mechanic 2002
[104] Mechanic 2002
[105] Spiegel 2004 & Spiegel et al 2004
[106] Globalisation is also one of the themes of the *Commission on Social Determinants of Health* – see CSDH 2005
[107] Spiegel 2004
[108] Spiegel 2004

Farmer is certainly a key activist and academic in this field. He points out that 'inequalities have powerfully sculpted not only the distribution of infectious disease but the course of disease in those affected.'[109] For Farmer, diseases are inextricably linked to social inequalities and particularly to the resources to which people have access. As an academic, Farmer points to the need to have extended research into the effects of racism and sexism on health - but this needs to happen at a regional and global level as diseases spread across borders. As an activist, Farmer is outraged at the idea that resources essential for health, such as ARVs, are blocked from reaching the poorest people. He believes that this constitutes 'murder' in that certain organizations are knowingly depriving individuals of drugs that will save their lives. The same goes for diseases that are preventable and yet continue to plague the poorest nations. In his two books, *Infection and inequalities* and *Pathologies of power*,[110] he makes this point quite clearly. He also challenges governments to look at their own health policies and what they indicate about commitment to life and human rights. He contrasts the Cuban health system that provides universal health care and an HIV/AIDS program that has effectively dealt with the pandemic, to the American system that denies adequate healthcare to those who cannot afford it, even though most need it.

From ARHAP's point of view, this raises the question about what religion has done to fill the gaps that neoliberal policies have enforced on the healthcare systems of African nations. In what ways does the church promote or fight inequality? Where is the church's place in this global system and what voice does it have to influence policy? What role has the church played in mobilising access to treatment or supported HIV issues?

Today's global health crisis reflects widening inequalities within and between countries. As the rich get richer and the poor get poorer, advances in science and technology are securing better health and longer lives for a small fraction of the world's population. Meanwhile children die of diarrhoea for want of clean water, people with AIDS die for want of affordable medicines, and poor people in all regions are increasingly cut off from the political, social and economic tools they can use to create their own health and well-being.

The real scandal is that the world lacks neither funds nor expertise to solve most of these problems. Yet the predominance of conservative thinking and neoliberal economics has led the institutions that were established to promote social justice into imposing policies and practices that achieve just the opposite. They police an unjust global trade regime with a doctrinaire insistence on privatization of public services, and preside over the failure to curb disease by tackling the poverty that enables it to flourish – GHW 2005

This then leads us to material which places health as an issue of social justice.[111] While we will not review this broad area, it is worth considering the work such as that by the *Global Health Watch*,[112] which seeks to challenge accepted thinking. As we will see below, the area of social justice (in relation to religion and public health) is being greatly influenced by the HIV/AIDS epidemic.[113] Religious leaders and religious scholars are being challenged to consider issues of social justice in terms of health and health equity.[114]

[109] Farmer 1996
[110] Farmer 1998 & 2003
[111] See Boucher & Kelly eds 1998; Gruskin & Tarantol 2006; Krieger & Birn 1998; UNDP 2000
[112] GHW 2005
[113] See Section 4.6
[114] See Cochrane (forthcoming)

3.5 Health systems

It is impossible to generalise about health systems in sub-Saharan Africa. However, leading health agencies have called for the increased integration of religious entities within public health systems - especially as a result of HIV/AIDS.[115] In the following section we will pull out some of the more general points that are (mainly) held in common by the literature.[116]

❒ External agencies are increasingly looking towards REs

Despite some negative perceptions of their role and impact, religious entities (REs) are increasingly being seen by external agencies as the most viable institutions for responding to health crises as they have developed experience in addressing the multidimensional impact of epidemics such as AIDS, are seen to have access and infrastructure where other organizations do not, command extensive networks of people, and could effect behaviour change more effectively through the authority they hold with their members.

There are many reports of a renewed interest on the part of both multilateral and governmental agencies to increase the role of faith-based/religious organizations (REs) in mobilizing HIV prevention efforts, as well as in providing care and support services. This is most evident with the American President's Emergency Plan for AIDS Relief (PEPFAR) which acknowledges the concept of 'spiritual care' and whose funding entails particular directions in relation to faith and faith-activities.[117] The global public health policy community in general - for example, the Global Fund to Fight HIV/AIDS, TB and Malaria, UNAIDS and WHO - has 'discovered' religious organizations, entities and institutions and increasingly looks at them as allies in the delivery of health services and the accomplishment of global targets.[118]

Two significant proponents of working with FBOs are the World Bank and PEPFAR. The World Bank stresses that it seeks to be 'faith-blind'. The importance of FBOs must be in their results, rather than that they have a faith basis. Whilst PEPFAR is also results-focused, there is recognition that their faith basis is critical to many FBOs - Taylor 2006

Some worry that faith-based institutions will not be able to be objective about public health strategies such as prevention interventions and that public funds will be used to support religious agendas - Woldehanna et al 2005

Even in countries such as South Africa, where most church-owned health institutions have been nationalized, the public health agencies are increasingly expecting faith-based groups to play a major role in promoting health and caring for the sick.[119]

A further area in which faith-based organisations or religious entities are particularly receiving international encouragement is that of post-conflict situations - and the development and health programs that arise from this. However, there is little focus on SSA for this theme.[120]

[115] WHO 2004; Woldehanna et al 2005; UNICEF 2004; USAID 2004
[116] See also Section 4.1 - as much of this information has been gained from HIV/AIDS-related reports, but has not been repeated in this referencing and bibliography.
[117] PEPFAR 2004 & 2005
[118] See McFarland & Cochrane 2006
[119] Taylor 2006
[120] See Almquist 1997; Nolan 2005; Thomas 2004

❒ **There is also lingering resistance to the recognition of REs**

FBOs are increasingly being asked to back up and support previously functioning health care systems - Parry 2002

At the same time there is still resistance towards the participation of REs which lingers in some sectors. This could be as a result of various issues such as the prominence of a biomedical perspective, the difficulty of measuring the impact of religion, secularisation and the separation of church and state, the fear that REs may use public funds to proselytise their 'clients', competition for funding, and 'concern that ideological considerations are replacing sound empirical evidence of effectiveness in delivering health services.'[121]

❒ **Tangible RHAs are a visible part of SSA health systems**

We have a general understanding that religious entities hold tangible health assets - assets which can be seen and touched, and that buy goods from medical suppliers - such as hospitals, clinics, dispensaries, and organizations offering health-related services. This religious contribution to health systems is present and important - and statistics as listed below are convincing as to the scale of involvement of these health assets within the health infrastructure. We are also aware that they are sometimes the *only* functioning health service available in areas of political crisis, or post-conflict.[122] However, if one seeks to gain an understanding of exactly what healthcare infrastructure is managed or owned by REs, there is an array of confusing statistics and variable data that is difficult to reconcile. The following list of quotations from a variety of reports and articles is intended only to show the frequently contradictory nature of the wide range of information available.

- Religious organizations provide up to 40% of health provision in Ghana, Tanzania, Uganda, Zambia and Zimbabwe.[123]
- In Kenya, 34% of hospitals are owned by religious groups; in Zambia 53%. The Christian Health Association of Nigeria (CHAN) includes more than 300 health institutions and 3,000 outreach facilities. CHAN facilities serve at least 40% of the country's population - primarily those in rural areas or urban slums and those with the fewest resources…in many sub-Saharan countries it is estimated that between 30% and 70% of the *medical* infrastructure is in the hands of religious entities. However, no one has a remotely complete picture even of this resource, to say nothing of the broader range of *health promoting* religious assets.[124]
- Religious health institutions and networks comprise the second largest overall health complex in sub-Saharan Africa…in Africa religious bodies operated approximately 40% of health resources. This was before the major devastation of HIV/AIDS decimated many of the governmental systems beginning in the late 1990s.[125]
- Lesotho is divided into 18 health service areas, with approximately 50% of health services provided by the government and 50% by religious institutions. The Christian Health Association of Lesotho (CHAL), founded in 1974, coordinates closely with the government health system assuming primary operational responsibility for public health and health services in eight health service areas.[126]
- In 1999 the Ministry of Health in the Democratic Republic of the Congo (formerly Zaire) formally turned over responsibility for health care in 60 zones (of a total of 306) with a

[121] Woldehanna et al 2005; See also Breger et al 2001; Liebowitz 2002
[122] See above
[123] Robinson & White 1998
[124] Baird 1999; Hackney (unknown)
[125] Ausherman 1998
[126] Green et al 2002

population of 12,000,000 to a coalition of mostly faith-based non-governmental health organizations working in partnership with USAID.[127]

- The churches in many African countries administer 20-50% of health-care provisions. However, there has been only limited integration of REs into national health systems and large development programs.[128]
- Religious entities in many African countries provide between 30 and 50% of institutional health care. In Zimbabwe currently 68% of the total bed capacity of the country is managed by Christian hospitals under the supervision of the Zimbabwe Association of Church-related hospitals (ZACH). Insiders report that in the Democratic Republic of Congo (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.[129]
- Faith groups provide an average of 40% of the healthcare in African countries, particularly in rural areas where HIV infection rates are high.[130]
- Up to 50% of healthcare provision in Zambia is through church-owned hospitals.[131]

This hidden force is Africa's churches - and they are already the front line of care for millions of people. They receive little recognition, virtually no outside funding or partnerships, and so their potential remains largely untapped - Tearfund 2006

- Faith groups have historically played an essential role in providing services and relief to poor people. They often run the only schools and health clinics in rural communities and in sub-Saharan Africa. They have been estimated to provide 50% of health and education services. They are significant providers of services in fragile and weak states and provide a large share of the home-based care for people living with AIDS.[132]

A further area in which there is a serious lack of information is the ways in which these religious entities relate to medical systems - for example drug supply systems.[133]

While governments' difficulty has been addressed by many researchers, efficient management of missionary organizations and their large contribution in the health field are discussed in only a few papers…Existing literature has pointed out that missionary organizations' efficiency and their high service quality are due to a high dependence on foreign donors in addition to small scale activity - Kawasaki 2001

❒ **There is limited information on REs presence in health systems**

However, the same literature that points out that the religious health infrastructure is significant, also makes it quickly clear that there is still a serious lack of information. The full scope of the religious health system is unknown, and what information there is, remains disparate and often conflicting. ARHAP mapping in Lesotho and Zambia has revealed that while the larger, formally structured entities such as hospitals are (sometimes) visible on public health maps, the mass of smaller faith-based programs and initiatives are rarely visible to the public health system.[134] RE's informal involvement in health varies considerably from rural to urban contexts as well as by country, region and religion. There is huge variation between responses from larger organisations such as World

[127] Bear 2001; Ausherman 1998
[128] Asante 1998
[129] Benn 2003
[130] PACANet 2002
[131] Nussbaum (ed) 2005
[132] DFID 2006
[133] See Kawasaki 2001
[134] ARHAP 2006

Vision, and those of locally based support groups, for example doing HBC at a community level. This variation needs to be mapped and taken into account.[135]

Even the religious co-coordinating bodies are often oblivious to their own congregations' initiatives as these religious responses are often entirely locally-based and run initiatives.[136] Therefore, even the 'religious health system' is not aware of all of its own assets.

❒ Health care systems and REs are struggling under increasingly trying circumstances

Southern African health care systems are coming under increasing pressure from HIV/AIDS in particular, and a wider complex of health crises in general.[137]

Southern Africa is rapidly entering the AIDS phase. Hospital bed occupancy, with HIV/AIDS related illnesses, is between 50-85%. Rural Mission hospitals record an increasing burden as patients are discharged from urban health facilities to return to their homes in rural areas - Parry 2002

There is a great deal of evidence that, like the health care systems, religious entities are also struggling under increasingly trying circumstances - as many have to work under the constant strain of having to do more with less. In particular, they struggle with the combined effects of increasingly severe health problems, lack of access to technology and training, inadequate communications, dependence on not-always-reliable foreign assistance, and the constant outflow of medical, academic and religious professionals. Many REs are also threatened by the environment in which they work - for example a lack of staffing due to the effects of HIV/AIDS - and others face difficulties due to the political environment, which threatens their sustainability.[138]

❒ Need for information on funding channels and processes

Funding is an issue that is only rarely addressed in the literature published on religious organizations - and yet is an issue at the core of the religion-health interface. For example, public health initiatives are increasingly seeing religious organizations as desirable channels of funding - assuming that the capacity is there to absorb health funding at these levels, and that it would be spent wisely and efficiently. REs, in turn, consistently report a lack of funding as the reason for their lack of increased capacity. Yet there is alarmingly little (public) literature on the financial situation of religious organizations.[139,140]

79% of churches and Christian NGOs responding to HIV and AIDS in Namibia said they receive no outside funding - Munene 2003

FBOs are providing a huge share of the services in response to the HIV and AIDS pandemic…Yet despite substantial efforts and good will by all, churches and other faith-based organisations have not yet been consistently successful in accessing resources for their response to HIV and AIDS from international funding agencies. To help assess the current situation, a survey was undertaken among FBOs - DIFAEM 2005

There are also conflicting reports as to what degree REs are able to access funding (again, this conflict can in part be explained by the huge variation of entities customarily incorporated under the term 'faith-based organisation'). However, in general, it would appear that *some* REs receive funds from a variety of public and private sources (national and international), but not enough is known about the scale of funding or about the processes of accessing these funds.

[135] ARHAP 2006
[136] Liebowitz 2002
[137] See Bateman 2003; Benatar 2004
[138] Again, see Section 4.1 for more in relation to HIV/AIDS
[139] Taylor 2005a & 2005b; Munene 2003
[140] While this review was in production, Tearfund produced two documents that begin to engage with the approaches of international donors to the faith-based arena. See Taylor 2006; Tearfund 2006

Nevertheless, anecdotal evidence suggests that many REs are created, run (and sustained) despite a financial shortfall - because of religious commitments. Current evidence for this is minimal, but it is worth investigating

Parry has also noted that there is grossly inequitable resource allocation, and that while REs are encouraged, and expected, to expand their services to meet the growing needs of a multi-dimensional HIV/AIDS crisis, donors seldom provide core funding. 'REs are finding it increasingly difficult to run these expanded programmes looking only to their traditional sources of funds. Many do not receive external support, having to raise their own support locally in resource-constrained settings. Yet they are providing parallel services to government and more.'[141] There is clearly a need for further analysis and alignment between health systems, health funding and health providers.

❒ **Traditional African health systems**

Another broad issue is that of traditional African health systems. While we will consider traditional healers in more detail later, it is worth pointing out here that in SSA, traditional health systems exist in their own right, often carrying more authority with the individuals who utilise them than the biomedical system does for 'Western' health-seekers. As we have noted, these various health systems do not exist in isolation from each other, but are often part of a pluralistic mix of health seeking strategies.[142]

What the literature does reveal is that there is an increasing recognition of the role of the traditional health system, and further attempts are being made to pull traditional practitioners into the public system - for example in South Africa with new Traditional Health policies and regulation of traditional healers.[143] Traditional healers continue to provide their services - built on a tradition where healing and well-being is not separate from religion - to vast sections of the African population alongside, and increasingly in collaboration with, western health institutions and Christian congregations.[144] However, it would appear that in many SSA contexts, different health systems (religious, public health, or traditional) operate alongside each other without integration, sharing of information or joint planning. This must result in duplication of services in some areas and lack of facilities in others.

In regards to the potential for ARHAP, clearly there is a need for quantitative research to be undertaken in order to evaluate the religious health-care infrastructure, as well as to measure such aspects as funding. There is also a need for the exploration of the articulation of faith-based health activities with public health systems in specific national or multi-national contexts that are able to take into account alternative health options. Finally, it would appear important to increase our understanding of both how individuals move between different health systems, and how these systems work in relation to each other.

3.6 Health policy

Health policy is the topic that draws all these considerations together - for if religious institutions are not visible or recognized by the right people, are not properly understood and evaluated, then they

[141] Parry 2002
[142] See Section 4.6
[143] DOH 2003; See also Abdool Karim et al 1994; Richter 2003
[144] See Section 4.9 for more on 'trust' in relation to both religious and public health perceptions.

ultimately will not be recognized through health policy - and no manner of 'increased interest' will draw them fully in to equal partnership in the public health system or mobilize the resources on the scale that is necessary to deal better with the health crises we face. There are, however, some considerations about health policy that are particular to the SSA context.

Much health policy in the world is governed by the modern conception of the nation-state. Within this framework, governance largely proceeds through bureaucracies best suited to dealing with organizations or groups in terms of their public presence.[145] Religion, however, is not always construed in terms of visible institutions, let alone representative ones. There are often no clear representative structures or visible institutions given over specifically to religion as if it were an independent social reality or sector. This directly affects how policies play out in real contexts, and may explain why they often fail. Policies that are not appropriately rooted in local realities, commonly give rise to apathy, passivity or resistance at local level (and perhaps beyond).[146] One dimension of much 'local reality' in Africa is the holistic worldview that includes religion and does not separate it out from life or energy producing forces, that is, from health.[147]

A second relevant aspect of the policy environment in southern Africa concerns the construction of the nation-state itself.[148] For reasons that are rooted in social history, much health policy in the region, especially when it is directed externally in some way or another by outside agencies, assumes a split between state and religion that is much less radical than may be in practice.[149] The modernist model, with its heavy inclination to a form of secularism that treats religion as derivative, secondary or private, is at work here.[150]

A third dimension that pervades much social science and public health thinking and privileges the nation-state as the definitive territorial and demographic entity has to do with the migratory or mobile character of populations.[151] This is a particular feature of our time, perhaps a decisive one in some contexts.[152] Part of this is the transnational character of human relations, hence of their communities, hence also of their religious traditions and of their health-seeking behaviour.[153] Migration is another relevant factor that potentially affects many of the issues under discussion. Consider, for example, that migratory practices affect not only health policies, but health systems are also often left unstable or disrupted by migratory health practices. The role of religion in forming networks or social capital among migrants, or in affecting health remains a largely unexplored area.

However, those formulating health policy need substantive information with which to work so as to be able to factor in the variety and 'instability' of the SSA environment - as well as the religious health infrastructure that is embedded within this environment. It is clear from the above depiction of some of the current public health literature, that 'the religious' is not properly recognized in the public health sector or accompanying theory. There is a clear research role for ARHAP to play if religious health assets are to be properly understood and appropriately utilized in the public health arena.

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[145] Scott 1999
[146] Froestad 2002
[147] Smidt 2003
[148] Habermas 2001
[149] Cochrane 2000
[150] Casanova 1994
[151] Kearney 1999; Schiller et al 1999; Vertovec & Cohen 1999
[152] Bauman 1998
[153] Brettell 2000; Cochrane 2003

Chapter 4 Faith-based Interventions and Responses to HIV/AIDS

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. In the following section, we will consider a variety of information sources in order to begin to learn what documentation is available to assist us in understanding religious interventions into health, through the lens of the HIV/AIDS epidemic.[154]

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 - Birdsall 2005

This review seeks to logically categorize what documentation there is on the religious response to HIV/AIDS and has therefore grouped literature into themes relevant to the ARHAP research at the interface between public health and religion, as well as in relation to topical HIV/AIDS issues. In addition, in seeking out 'the religious response' - this section, more so than any above, is heavily reliant on so-called 'grey' material, and therefore occasionally steps beyond the dictates of a standard academic literature review. In this way, we seek to do more than simply list literature 'competing' in our research area, but rather to give a more valid depiction of what information there is and how it can be utilized in this 'bounded field of unknowing'.

Linking to the brief discussion above on religious health assets (RHAs),[155] this section seeks - in general terms - to move the focus of investigation from visible, tangible health assets such as health facilities and publicly visible interventions, to the more intangible assets such as faith and hope. All of these aspects are equally important to the research focus of the ARHAP group and it should also be made clear that there is a great deal of overlap between these categories. In fact, tangible assets must be assessed and understood in relation to the less visible, intangible elements, as this is what would add value to RHAs, to create 'best practices' and transformative and empowering initiatives.

4.1 Assessing, mapping and evaluating religious organizations

In the last few years, driven by the HIV/AIDS epidemic, there has been a sudden boom in the reporting of 'faith-based responses' to health crises, with an interesting array of both published and unpublished materials, nearly all of which can be accessed by anyone on the internet. In this section we seek to tease out some of the main points being made about the more tangible religious health assets such as organizations, clinics, hospitals and established HIV/AIDS programs.

We do this by focusing primarily on the literature that seeks to assess or report a more 'general' or 'broad-spectrum' response to HIV/AIDS, and by pulling out some of the key points that they hold in common (in the later sections, the review becomes more theme-specific, with a narrower focus,

[154] During the production period of this review, the ARHAP group completed a mapping study of RHAs in Zambia and Lesotho for the WHO. While we have included this report in the reference, we do not here engage fully with the results of the study as the results had not yet been released by the WHO at the time of printing. See ARHAP 2006.
[155] See Sections 1.1.1 & 1.2

though the more general reports frequently include information on some of these themes, e.g. stigma or sexuality). Documents of crucial importance are noted in both bibliographic sections. In general, the documents referred to in this first section provide a starting point for an overarching understanding of religious responses to HIV/AIDS. The following points summarize the findings of key studies:[156,157,158]

❒ **REs are significant players in response to HIV/AIDS in SSA**

While there has been little actual mapping and complete reporting of religious responses to HIV/AIDS, what information there is indicates that religious organizations are significant actors within the SSA HIV/AIDS response, although there is agreement that little is known about the community-level response, which is where REs are thought to be most active. For example, an audit of AIDS-related responses in three South African communities identified seven REs conducting AIDS activities in one community of 65,000 people.[159]

REs operate in parallel to governments providing virtually all the same major services as government but filling in the gaps where government fails to provide. Their outreach activities are to be found contributing to virtually every institution including medical, education, social welfare and justice and peace. Support for orphans and vulnerable children extends from community based initiatives to institutional care. They also offer care in correctional facilities, poverty alleviation schemes, agricultural projects, feeding programmes, homeless shelters and support for street children and are widely involved in development work. When government services fail, FBOs are increasingly being asked to back up and support previously functioning systems - Parry 2002

❒ **HIV/AIDs-focussed REs are proliferating**

Furthermore, despite the increased strain on operations and health systems,[160] it would appear that the faith-based response to HIV/AIDS is proliferating at an astounding rate. Specifically, many faith-based programs have been established in the last five years - for example in some parts of South Africa at a growth rate of 200% or more - and especially in the rural areas.[161]

❒ **REs provide a wide variety of HIV/AIDS-related services**

Religious responses to HIV/AIDS cross the entire spectrum of care. Clinical management and care, provision of ARVs, voluntary counselling and testing (VCT), education, prevention, counselling, palliative care, social support and behaviour change programs. However, it seems that the services that are provided the most are awareness, care and support, and HIV counselling and testing.

Most REs carry out a wide variety of functions, and most initiatives provide more than one service, which could be the reason they are not classified with other service-specific NGOs.

❒ **REs often provide a 'holistic' spectrum of service**

Many REs undertake a more 'holistic' perspective to health than is usually the case in either medically based treatments or preventive public health measures. Though the actual interventions may be partial or fragmentary, the understanding of health on which they are based usually embraces all of the elements of health included in the public health definitions - physical, mental, socio-economic and spiritual.

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[156] An attempt has been made to pull out information that is specific to religious entities - for example issues such as lack of technical capacity and lack of HIV/AIDS program knowledge is generally common to the development sector as a whole.
[157] Unless referenced to a specific document, these points are made commonly in general reports on the response of REs in Africa. See in particular: ARHAP 2006; Birdsall 2005; Birdsall & Parker 2005; Gennrich & Gill 2004; Green 2003; Foster 2003; Liebowitz 2002 & 2004; Parry 2002; Woldehanna et al 2005; Zingo 2005
[158] See Section 3.5 for information on health systems in relation to HIV/AIDS and funding issues.
[159] Birdsall & Kelly 2005
[160] See Section 3.5
[161] Birdsall 2005

This 'holistic' perspective is not only visible in the actual care, but also in the wide variety of services offered. In fact, Birdsall notes that the AIDS-related work of REs is often embedded within broader service portfolios, making it difficult to disentangle purely 'AIDS-related services' from the total range of services provided by REs. She notes that this may mean that their findings under-depict the actual scope of AIDS-related work being conducted by REs.[162]

In addition, REs are often fluid entities, adapting to the needs around them. For example, Parry notices that throughout Lesotho, REs have shifted from a long-term focus on HIV/AIDS, to a short-term response to the immediate crisis of food security.[163] This diversity and fluidity of REs makes it particularly important that 'policy-makers heed important differences among these institutions when devising ways to harness this potential.'[164]

❒ **Opportunistic diseases**

Because of the nature of HIV/AIDS, treatment of opportunistic infections is increasingly becoming part of the HIV/AIDS portfolio of REs.

❒ **A primary focus of REs is on orphans and vulnerable children**

Orphans and vulnerable children appear to be the 'client' group most served by REs as whole.[165]

The study investigated 686 faith-based organisations and found that some form of support for HIV/AIDS-related orphans was present in over 95% (539 of 563) of the REs surveyed for which results were available. Most of these served between 100 and 250 children each. In total, these programmes mobilise more than 7,000 volunteers who help maintain healthy conditions for more than 139,000 orphans and vulnerable children - Foster 2003

❒ **A majority of faith-based initiatives remain undocumented**

Even the most detailed reports openly recognise that most of the religious responses to HIV/AIDS and other health crises remains unrecognised and undocumented.

A central theme of this study among both country-level and international key informants is the neglect on the part of REs to document their work - Woldehanna et al 2005

There is a paucity of quality data available. The programs are there but documentation is a problem. Donor requirements for project proposals, monitoring, evaluation and reports can be extremely onerous and time consuming. REs are largely implementers: they are the 'doers'. Few are trained to meet the documentation requirements of major funding agents. If we are serious about collaborative partnerships, then here is an area for technical assistance. REs can be data collectors. With their unparalleled coverage and human resources, especially large numbers of committed volunteers, they could collect good data on HIV/AIDS and the social manifestations of the epidemic.[166]

A lack of documentation means that it is difficult to measure the cumulative impact of REs compared to the more visible project responses of development agencies.[167] This is due, at least in part, to this 'invisibility' factor with faith-based initiatives remaining outside the public health system.

[162] Birdsall 2005
[163] Parry 2002
[164] Agadjanian 2005
[165] See Section 4.2
[166] Parry 2002
[167] Although, of course, secular community-based NGOs often have just as large a documentation problem - however, this is particularly important considering the other constraints (mentioned above) which make it difficult for the public health system to include REs.

❒ **Many activities are proactively initiated by those who see a need**

Most of the these reports on REs responses to HIV/AIDS note that many REs' activities are initiated proactively by community members who 'see a need', which means that health responses often emerge well in advance of any systematic effort from outside to organize, train or resource them. Authors note that 'responses of congregations to HIV/AIDS are spontaneous and holistic, with resources available, even before they look for external sources of help'[168] - or that many REs have implemented Prevention of Mother-to-Child transmission programs (PMTCT) before governments have moved beyond pilot projects.[169]

❒ **Many REs rely on volunteers**

Many REs rely heavily on volunteers, who appear to carry out a full spectrum of different support and caring activities. This is alternatively regarded as both a huge asset of REs - to be able to access volunteers from the communities in which they are based - and as a threat to the ultimate sustainability of the program.[170]

Many excellent community based initiatives have been started by committed Christians who are trying to serve their communities. In the future, it will be important that churches identify, recognize and support these initiatives. This might demand a high degree of flexibility and willingness to accept innovation - Benn 2001

❒ **Many religious leaders play a prominent advocacy role**

Many mainstream religious leaders are prominent as health advocates in the public arena - frequently taking centre stage and utilising public media channels to project their messages. There are also an amazing amount of 'statements' of intent released by mainstream religious organizations on the topic of HIV/AIDS. The role of public speaker and advocate of health might be considered an intervention in its own right - although little has been documented or researched on the effects of public advocacy of religious leaders in the health arena.

Religious leaders are also increasingly being invited to multisectoral policy discussions and have social networks that extend beyond the communities they serve. But while we may know they are there and assume they are having some influence on the proceedings which they attend, little academic research has been undertaken as to the influence of religious leaders on the health-relating policies and consultations that they do attend or advocate for. That is, while there are news articles delineating who is at meetings, and sound bites from religious leaders, there is little academic material on religious leaders' influence on public health policy.[171]

REs are providing a huge share of the services in response to the HIV and AIDS pandemic. Faith-based organisations, rooted in local structures, have been and continue to be in an excellent position to mobilize communities to respond to the HIV and AIDS crisis…their long-term presence, broad networks of dedicated volunteers, and well-developed infrastructure are unmatched by any public or private organisation - DIFAEM 2005

REs are also increasingly developing their own HIV/AIDS policies and planning strategies.[172] Parry considers this to be evidence of an intensified response to HIV/AIDS, and a demonstration of commitment.[173]

[168] ZINGO 2002
[169] Parry 2002
[170] See Section 4.8
[171] See Section 4.5 - for material on traditional African healers and religious leaders who are certainly having and increased presence in public health discourses.
[172] See Church of Nigeria 2004; CPSA 2002a & 2002b; Judge & Schaay 2001
[173] Parry 2002

❒ **REs are seen to have unique aspects that can make them more effective**

There appears to be general agreement amongst these authors that REs have unique aspects to offer to the response to HIV/AIDS. The issues most commonly mentioned are such aspects as access to communities, dedicated volunteers, networks or educated leadership. However, few studies have taken these assumptions further. One unique study points out that the REs studied can hire qualified medical staff below the market wage, are more likely to provide pro-poor services and services with a public good element, and charge lower prices for services than for-profit facilities.[174] However, this type of detailed research is rare, and needs to be more fully tested if it is to be applicable to broader statements and policy decisions.[175]

Comments on the literature and further questions

From the main points above, it becomes clear that there is a great need for further research into the religious response to HIV/AIDS and other health crises - including at the level of the more visible or tangible RHAs. While a few documents stand apart,[176] in general the quality of the reports on religious responses are 'lacking' in some basic and significant ways that lessen their value to the public health perspective. The following general criticisms point to the scope for further research:

- ❒ The majority of these documents are not peer-reviewed, and are mainly self-reports published by the organization on its own initiatives.
- ❒ The most useful information can be found in studies that focus on smaller geographical areas[177] - rather than broad studies which seek to understand the global picture.
- ❒ Most of these reports observe that their research processes were rushed, and that information was based on qualitative assessment (mainly semi-structured interviews and self-reporting) rather than quantitative meta-analysis.
- ❒ There is a great need for careful mapping of faith-based initiatives - existing information is sketchy, usually linked to datasets of non-religious responses.
- ❒ Research is also needed to evaluate the impact of the new interest from outside agencies, and new governmental or other health funding on existing religious infrastructure, especially in the case of resource-poor REs.
- ❒ In-depth evaluation of faith-based initiatives is severely lacking - especially independent analysis that utilizes current social science evaluative techniques.
- ❒ Many faith-based studies appear to be behind current social science debates - especially in terms of topical HIV/AIDS discussions and techniques.
- ❒ This also means that faith-based research and reporting has a tendency to be reactive rather than proactive - that is, studies evaluating the religious response in comparison with the already established 'secular' studies.
- ❒ Many of these reports are snap-shots of what the current response is. Few evaluate the response in terms of its development over time, and this could be significant. For example, mainstream religious bodies appear to play a prominent 'strategic planning' role - which is important for organizational capacity. However, little is known how this role affects programs over time - whether this leadership role trickles down to community-based organizations.

[174] Reinikka & Svensson 2003
[175] See Section 4.9 for a further discussion of 'religious specific' intangible assets.
[176] In particular thinking of those referenced together at the start of this section. See footnote 119
[177] See Gennrich 2004

- There is a noticeable lack of evaluation reports tracking behaviour change interventions in a detailed way, utilizing such specialized techniques as those currently being put forward by psychologists (for example) evaluating programs.[178] Studies therefore lack in-depth analyses so as to be comparable with non-religious social interventions.
- Again, the issue of classification raises its head as even in standard lists of NGOs that do include REs, there is not enough detail to separate distinct types of faith-based initiatives - for example, to pick out an initiative that is developed and run by religious leaders but is classified as an NGO.[179] There is an urgent need to develop further categories and theories of classification of REs so that their nature and function can be more clearly understood. It is important, however, that any 'classification' process recognizes the 'holistic' or multiplex nature of many REs.
- There is an urgent need to source and research for information on faith-based initiatives that are not HIV/AIDS-related in order to get a more complete understanding of the effects of religious responses in the public health sector.
- Further, while literature on mainstream Christian responses to HIV/AIDS abound, little has been documented on other religions present in SSA, or 'non-mainline' Christian groups such as African Independent Churches (AICs).[180]
- In the same way, there is also very little published material on the response of traditional healers as religious leaders.[181]

All the above requires a new multi-levelled and multidisciplinary research focus, and will also require the development of specific tools to reliably measure religious entities in a way that takes into account their religious-specific nature.

4.2 Orphans and vulnerable children

Through the review of more general studies on the responses of religious organizations to HIV/AIDS and other health crises, it quickly becomes apparent that one sector on which they focus the most is the service of 'orphans and vulnerable children'. This is an area that has been extensively reviewed in relation to general community care.[182] Again, in the general literature, REs are most commonly represented as a subcategory of the overall NGO or community-based response. A few of the main points that arise from this body of literature are:[183]

- Religious organizations and communities are providing a significant percentage of care to orphans and vulnerable children in SSA.[184]
- Anecdotal evidence suggests that this could be an even greater role than is currently documented.
- REs (national and international), place a prominent advocacy role on the topic of orphans and vulnerable children - with a focus on the rights of children to proper care.[185]

There are more than a quarter of a million congregations in the AIDS belt of East and Southern Africa alone - more than enough to support the region's 12 million orphans. Kenya alone has 80,000 congregations: if each cared for 20 orphans, all the country's 1.6 million orphans would be supported - Foster in Tearfund 2006

[178] See Section 4.5
[179] HAI 2000
[180] These two points have been mentioned previously, and apply for all the sections of this review.
[181] See Section 4.6
[182] See Kelly et al 2001
[183] Significant studies for this section are Foster 2003c and UNICEF 2003b
[184] See Foster 2003c
[185] Young 2005

- As they are often community-based groups, REs are often better placed to provide care and support than external agencies - especially in the face of current efforts to keep orphans and children affected by HIV/AIDS within their communities.[186]
- REs are increasingly being seen as the most viable institutions at both local and national levels and have developed experience in addressing the multidimensional impact of AIDS and its particular impact on children.[187]

Comments on the literature and further questions

Again, we will consider some of the research considerations that arise from this literature:

- There is little information on the internal aspects of care such as fostering and adoption rather than organizational support - either from community members, or by outside individuals with religious motivations.
- Little is known as to the quality of care provided by religious organizations in comparison with NGOs.
- The intense focus on HIV/AIDS orphans might be detrimental to other vulnerable children in communities.

This area requires particular attention from researchers because it is such a prominent issue for religious organizations and communities - and especially those involved in HIV/AIDS programs. Not only could it give a clearer idea of what religious responses there are, but also an indication of more hermeneutical issues - such as why religious communities feel the need to respond in this sector so strongly, and how this interacts with other health efforts and messages. In addition this theme has great research potential in relation to investigations into issues such as funding from outside sources, networks external to religious bodies that could be unique to the religious sector, and the interface of African cultural and religious concerns regarding the child and the community.

4.3 Religion and stigma

The challenge of reducing stigma is an area where FBOs have spent considerable energy with some modest results – Liebowitz 2002

It has been suggested that the reason so many REs are drawn to initiatives supporting orphans and vulnerable children is because they are 'innocent victims' and because of their discomfort at dealing with the aspects of HIV/AIDS that relate to sexuality - and the stigma resulting from that discomfort. While this remains anecdotal information, stigma is certainly another theme that has received a great deal of published attention from a variety of sources. It is also an arena of great debate, with authors alternatively arguing that religions have a detrimental affect on health through stigmatising practices, or that they are suitably situated to combat stigma through compassion and open leadership.[188]

In the following section a few of the main points raised by the different literature have been arranged in three rough categories: 1) stigma as a religious response (looking at stigma arising out of religious

[186] See Foster 2003c
[187] UNICEF 2003b
[188] Just as this literature review was being completed, Parker & Birdsall (2005) released a new review on HIV/AIDS, stigma and religious entities, which is an effective summary of this area and a worthwhile read for anyone interested in following up on this theme in more detail. Following on the heels of that review, the HSRC (2006) study on stigma presently being released by the ACSA will also become a valuable resource for future enquiry in this area.

doctrines and practices), 2) stigma as a response to religion (looking at stigmatising practices against religious groups and interventions), and 3) religious responses against stigma.[189]

Stigma as a religious response

Of great concern to many people is the way certain religious beliefs and practices have enhanced the stigma felt by PLWHA, and discriminated against them in their places of worship.

In the era of HIV/AIDS, FBOs have been the recipients of many accusations: of being a 'sleeping giant'; of promoting stigmatizing and discriminating attitudes based on fear and prejudice; of pronouncing harsh moral judgments on those infected; of obstructing the efforts of the secular world in the area of prevention; and of reducing the issues of AIDS to simplistic moral pronouncements, that have not made Churches or Mosques places of refuge and solace, but places of exclusion to all those 'out there' who are but 'suffering the consequences of their own moral debauchery and sin - Parry 2002

- In many documents looking at aspects of the HIV/AIDS epidemic, stigma is the issue that warrants the only brief mention of religion - that is, this is the only aspect of religion important enough to mention, and again, religion is treated as a subset of culture - with particular stigmatising effects.
- It has been well documented that religious groups and leaders have often contributed to the stigmatisation of people living with HIV/AIDS (PLWHA) - frequently to very real and traumatic effects.
- Many religious leaders have publicly admitted this failure in their response to the epidemic,[190] and vowed to do better in the future and fight against stigma in the religious communities.
- This stigmatisation is often linked to religious or social taboos such as sexuality or death, and is enhanced by the difficulty some religions and religious leaders have in addressing matters of sexuality.[191]
- The discourse surrounding this stigmatisation often surrounds common myths such as viewing HIV/AIDS as a curse or a punishment by God.[192]
- In general, HIV/AIDS-related stigma has become a mechanism for sharpening the boundaries of the 'moral community' - which in the African setting tends to be couched in religious terms.[193]
- This effect can also lead to some people feeling 'immunized by their belief', when the disease is placed 'elsewhere' and therefore not seen as a personal threat due to their religious membership. This is becoming especially apparent in the emerging literature on Islamic responses to the HIV/AIDS epidemic.

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

Stigma as a response to religion

- However, in the more general sense, there is also a matter of stigmatisation against REs - for example by secular agencies or organizations who may bring negative perceptions or prejudice to any interaction between them. Adding this together with the other effects discussed above, such as secularisation, or the invisibility of REs to health systems, this becomes an important consideration as such stigma may hamper cooperation between religious and public health bodies.[194]

[189] See Tallis 2002
[190] WCC 2001
[191] See Section 4.4 for discussion on religion and sexuality, and Section 4.9 for discussion on death
[192] Green 2003; Hadjipateras 2004
[193] Ogden & Nyblade 2005
[194] Iwere et al 2000

- Furthermore, the weighting on stigma as an issue in the religious community can itself have the effect of stigmatising many communities as being uncaring and inhumane - a process that can perpetuate existing marginalisation.[195]

Religious responses against stigma

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. Indeed, many religious entities have put considerable energy into stigma-mitigation programs, often spread through religious education and ministry.[196] This position argues that:

Churches that maintain a highly moralistic position on HIV prevention may also seek to provide a generous and forgiving position on infection, helping patients to accept their condition with faith and hope – Futures Group 2005

- Religions (of all varieties) are well suited to combat stigma as they tend to hold tolerance and compassion as guiding principles, often based on the belief that they have a duty to support all suffering persons.[197]
- Many also point to the way religious leaders can mitigate the effects of stigma through demonstration of respectful caring for PLWHA.
- Religious leaders are also able to appropriate religious texts and cultural symbols in their struggle against stigma with powerful effect.
- Religious leaders are seen to be able to counteract the effects of stigma by openly speaking of the disease both in their communities and in their advocacy roles in the broader public arena.[198]
- Finally, a great deal of the debate over stigma appears in journal articles with a 'theological' interest. Theologians appear to have taken up this issue with a vengeance, and this can be seen as a response or intervention in itself. For example, Gennrich notes 'data on church leader's views also reveals an ideological resistance (based often in stereotypical views and simplistic theologies which associate HIV/AIDS with promiscuity), to accept the realities of HIV/AIDS in their own lives.'[199] If stigmatising attitudes come from 'simplistic theologies', then it is important that theologians and religiously situated academics continue to interface with this topic in that discourse - as an intervention with religious leaders and congregations as the targets.

Comments on the literature and further questions

So far we have sought to briefly highlight a few key points from a large body of material. However, even from a cursory look at some of these documents there are clear indications of places where further research would be needed.

- **Stigma needs to be researched in its complexity**

Stigma in the context of HIV/AIDS has become a hugely complex issue with a vast amount of literature growing out of it. The struggle against stigma is not only a religious issue, although it has become prominently linked to the public perception of religious reactions to HIV/AIDS. However, what current research on stigma has shown us is that any simplistic answer will not get at the root of

[195] Parker & Birdsall 2005
[196] EAA 2003; Liebowitz 2002
[197] Solomon 1996
[198] Parker & Birdsall 2005
[199] Gennrich 2004

stigma. To this end, research in stigma has become contextually-based in that stigma is built out of a complex weave of aspects, such as social, cultural, religious, racial, gendered, sexual or historical. In fact, much of the more recent literature on religion and stigma concludes that different responses to stigma are required in different contexts.[200]

Again, this means that complex research is needed in order to understand the effect and role of stigma in religious organizations. We have to move beyond simply telling anecdotal stories, such as the one about the pastor who refused to allow the PLWHA to drink from the communion cup, and begin to research the multiple layers of influence that create actions like that as well as their complex outcomes.

❒ **Further research is needed about religious-specific aspects**

Again, too little is known about the religious-specifics of stigma, and there is a need for detailed analysis and evaluation of religious responses against stigma. For example, what is the effect of utilizing the leper parable in relation to PLWHA? Is it helpful in creating compassion, or harmful in its relation to the social construction of another infectious disease? Little is known whether religious groups can circumvent stigma in other ways beyond leadership and theology. For example, Snyder et al point to the way HIV/AIDS volunteers feel the detrimental effects of stigma[201] - but what would the effects be of adding religion or a religious compassion into this consideration? Would volunteers in religious entities feel these effects in the same way? Would this affect their ability to function? Even though the body of knowledge on stigma is relatively large, there is still a great deal of research necessary in the context of religious entities and the relation of stigma to the health of people infected and affected by HIV/AIDS.

4.4 Sexuality, gender and behaviour change

The connection of religiosity to sexual practice is another area in which much has been written. It is also an area in which it is difficult to make a distinction between literature that is relevant to individual experience of sexuality and religion and that which is relevant to our focus on public health - as changing behaviour and issues of sexuality are essentially about the individual. In the following section we will briefly consider literature that engages with this interface between religion and sexuality, and the knowledge that drives attempts at behaviour change. We will then consider some of the key aspects of these interventions, and finally consider the issue of gender as distinct from sexuality.

Religious norms regarding human sexuality are surprisingly similar. Muslims, Jews, Christians and other religions largely adhere to the ideal of sexuality as having its rightful place in lifelong marriage - Benn 2002

[200] PolicyProject 2004; Parker & Birdsall 2005
[201] Snyder et al 1999

Religion, HIV/AIDS and behaviour change

There is a vast body of material on religion and sexuality as it has long been a main area of discussion and debate. However, in the last ten years in which this review is based, the focus has unremittingly turned to religion and sexuality in the context of HIV/AIDS, and in particular how religion influences sexual behaviour and an understandings of AIDS.[202]

❒ **Failure of KAB ushers in a complex view of sexuality**

In the behaviour change circles, a sweeping effect of the relentless HIV/AIDS epidemic has been that any simplistic model of KAB - knowledge-attitude-behaviour (change) - has been shown to be flawed. It is perhaps under the influence of the continued failure of such programs that more and more behaviour change research (and interventions) is seeks a more complex understanding of sexuality, thereby opening the door to the religious perspective. For example, Eaton et al speak of a growing body of evidence which points to the complexity of sexual behaviour, showing that HIV risk behaviour is influenced by factors at three levels: within the person, within the proximal context and within the distal context.[203] Through the emergence of more and more studies on religion and sexuality in relation to HIV/AIDS, it is clear that there is a growing recognition that religion works at all these levels - and not only within the person.

Even more clearly, there appears to be growing awareness that any research or intervention into sexuality that does not consider religion is severely limited - especially in Africa where, for example, HIV/AIDS-related risk assessment and behaviour choices are formed within an interpretative grid that draws on a religious moral framework.[204]

The potential of religion for behaviour change and intervention

Alongside this awareness that religion is present and needed in order to gain a full picture and design worthwhile interventions, is a growing set of reasons why religious interventions have a great deal of potential or advantage in dealing with the HIV/AIDS epidemic. These include various mechanisms religious groups have to influence behaviour, such as 'indoctrination'.[205] They are also said to have particularly good access and networks - with grassroots communities, to out-of-school young people, child-headed households and vulnerable children. They define norms, even impose them on a number of areas relevant to HIV/AIDS interventions, such as morality and reproductive rules.[206] They have leaders with authority who are readily believed, and they also have sustainability as their networks remain even when the external support for specific projects ends.[207]

Moving from potential to protection and prevention

However, there is a distinct difference between articles which profess that religion 'should' be a powerful force, and research which tries to prove or disprove (through scientific methods) that religion

[202] It is worth mentioning that in SSA, HIV/AIDS is predominantly seen and researched as a heterosexual disease, and the literature reflects this. This is not to say that homosexuality does not exist in Africa. However, a few documents on religion and homosexuality have been included in the companion bibliography in order to balance this perception - even though they do not speak directly to the issue of HIV/AIDS or other health crises.
[203] Eaton et al 2003
[204] Smith 2004
[205] Garner 2000
[206] See DFID 2006
[207] Garner 2000; Garvey 2003; Liebowitz 2002; Ruteikara et al 1996

is either a risk or a protective factor in the AIDS pandemic in SSA. While there is not the capacity here to review every document utilizing 'religiosity' as a value, it is interesting to consider the different ways these pieces of research have gone about it. Consider the following examples:

- In Transkei, South Africa, Buga et al set out to investigate the factors associated with adolescent sexual activity to facilitate the design of preventative programmes. They found that the top reason provided by sexually inexperienced girls for delaying intercourse was religious values (although the statistics were not greatly significant). However, despite this outcome, their conclusion does not mention religion at all and rather suggests a school-based strategy.[208,209]
- In Kwazulu Natal, Garner looked at sexual behaviour in three groups: Pentecostals, mainline Christians and people without adherence to a particular church. He found that Pentecostals had significantly lower rates of extra-marital relations while there was not much difference between mainline and non-Christian people. [210]
- In rural Senegal, Lagarde et al sought to describe the association between religion and factors related to sexually transmitted diseases (STD)/AIDS in a country where religious leaders were involved early in prevention. They measured religiosity by asking respondents how important religion was to them. They concluded that 'individuals who considered religion to be very important were not more likely to report intending to or actually having become faithful to protect themselves from AIDS. These findings stress the need to intensify the involvement of religious authorities in HIV/AIDS prevention at a local level'.[211]
- To get at relationships between religiosity and sexuality, Lefkowitz et al looked at some aspects of religiosity (group affiliation, attendance at religious services, attitudes, perceptions of negative sanctions, and adherence to sanctions) sexual behaviours (abstinence, age of onset, lifetime partners, condom use) attitudes (conservative attitudes, perceived vulnerability to HIV, and condom-related beliefs). They found associations between the measures of religiosity and sexuality, although the patterns differed by measures used. Religious behaviour was the strongest predictor of sexual behaviour. Many aspects of religiosity were associated with general sexual attitudes, which was not the case for perceived vulnerability to HIV and condom-related beliefs.[212]
- Investigating the interrelationship between religion and AIDS behaviour in Ghana, Takyi found that religious affiliation had a significant effect on knowledge of AIDS, but was not associated with changes in specific protective behaviour, particularly the use of condoms.[213]
- Wawer et al sought to determine the association between religion and HIV infection, and to assess the behaviours and characteristics that might explain differentials in HIV between religious denominations in rural Uganda. Lower rates of HIV infection among Pentecostals appeared to be associated with less alcohol consumption, sexual abstinence and fewer sexual partners, whereas the low HIV prevalence in Muslims appears to be associated with low reported alcohol consumption and male circumcision.[214]
- Trinitapoli and Regnerus found few differences in perceived risk according to religious affiliation. Men belonging to Pentecostal churches consistently reported lower levels of both HIV risk behaviour and perceived risk. Regular attendance at religious service was associated both with

[208] Buga et al 1996
[209] Van Rossem & Meekers, 2004 - similarly measured religious affiliation in their datasets on secondary abstinence but came to no conclusion about the importance of religious aspects
[210] Garner 1999
[211] Lagarde et al 2000
[212] Lefkowitz et al 2004
[213] Takyi 2003
[214] Wawer et al 1996

reduced odds of reporting extramarital partners and with lower levels of perceived risk of infection.[215]

- In Nigeria, Coplan et al sought to identify the determinants of self-reported STDs and self-identified methods to prevent STDs among Nigerian youth. They found that traditional (ATR) and Catholic religious affiliations were strong determinants of STD risk, as were perceived barriers to condom use.[216]

It is clear from these few examples that there are a variety of ways different researchers are attempting to measure how religiosity (in different formats) affects sexual behaviour and perceived risk of HIV/AIDS infection.

Religiosity both as an aid and an obstacle to health behaviour

The above examples also highlight the way in which the main issues in the religion-sexual-health arena are matters of debate and conjecture. The literature consistently argues back and forth - that religiosity prevents risky behaviour, and that it engenders risky behaviour; that abstinence works, and that the focus on abstinence is harmful; that religious leaders should talk about sex, and that they cannot; that preaching is a moralizing process that leads to stigma, and that it is education leading to healthy behaviour change. A veritable storm of controversy rages over the use of condoms, especially in Catholic and some Muslim contexts - which has been recently renewed in light of the PEPFAR funding associations. This is an argument into which people of all positions have entered - religious, political, social and medical.[217] Theologians are also a strong voice in this health matter. For example, many of the articles in Keenan et al raise this issue as a central ethical concern, debating whether it is permissible for a discordant married couple (where only one is HIV-positive) to use condoms.[218]

Unfortunately we do not have the scope within this review to portray these different areas of contestation to their fullest extent. However, to illustrate this point further we will expand on one of the most contradictory debates - that of abstinence as an effective response or intervention against HIV/AIDS.

Debating abstinence

One of the primary areas in which religious organizations are seen to be able to intervene is through the promotion of abstinence. However, there is huge debate as to whether (and how) abstinence programs work. In addition, there is a particular focus in the literature on the Ugandan experience, which apportioned part of its 'success' to its abstinence-based programs and partnerships with religious entities - and was then hailed as the HIV/AIDS behaviour centre of the world, although increasingly, this is being questioned.[219] We have pulled out some arguments that are representative of what is being said in the different forums discussing the issue of abstinence. This was done in order to

> *Religious taboos on sexual education have been harassing AIDS prevention throughout Latin America. The confrontation between the condom and abstinence or fidelity has snapped closed any possibility for negotiating joint strategies. It has polarized political stances that clash public opinion and counterattack official efforts for AIDS prevention - Ornelas et al 1992*

[215] Trinitapoli & Regnerus 2005
[216] Coplan et al 1998
[217] See Byamugisha 1998
[218] Keenan et al 2000
[219] See Barnett & Parkhurst 2005; Cohen & Tate 2005; Low-Beer & Stoneburner 2004; Singh et al 2002

demonstrate the range of factors impacting on or influencing a faith-based intervention through abstinence:

- Kalyowa and Kiwanuka argue that abstinence for AIDS control is a feasible option especially when the condom campaign is faced by many challenges like illiteracy, poverty, religious opposition, and distribution logistics. They argue that strong religious commitment, parental strictness, and effective AIDS education were believed to increase abstinence. They conclude that premarital sexual abstinence is a potential AIDS control option that should be promoted with full support of all AIDS intervention agencies in the communities.[220]
- Barnett and Parkhurst argue that abstinence-based prevention messages fail to engage with diversity and the social and economic contexts of sex. [221]
- They also argue that the ABC approach in Uganda was in fact promoting abstinence as one of a variety of options and there is no evidence of any causal link between any single message and the behaviour change observed.[222]
- Cohen and Tate argue that the scaling up of abstinence programs in Uganda deprive young people of life-saving information and provide little information for those most at risk.[223]
- There is a great deal of political considerations surrounding abstinence-based interventions because of the focus of some of the United States funding bodies on abstinence and fidelity.
- Singh et al point out that the debate between abstinence and condoms as the reasons for Uganda's success in combating HIV/AIDS has become highly politicised.[224]
- James considers the failure of abstinence-only interventions in preventing sexual transmission.[225]
- Kirby argues that until more research is done it is important to continue with 'abstinence-plus' programmes that encourage abstinence but also encourage use of condoms and contraceptives amongst youth if they do have sex.[226]

An interesting further point is that made by Ornelas et al - which notices that the confrontation between abstinence or fidelity has closed any possibility for negotiating joint strategies.[227] It is therefore worth considering that these arguments or debates can themselves be having an effect - for example, if condoms and abstinence are set at polar opposites the option of combined strategies becomes more unlikely.

Other interventions issues on the sexuality and religion interface

The above discussion has created a framework in which to understand the variety of positions and influences that can bear on a religious organization seeking to change behaviour by utilizing the religious-health paradigm. There are a few primary issues that the literature addresses:

- **Non-HIV/AIDS interventions**

It has been mentioned that religious organizations engage in a variety of interventions, often at the same time and seeking holistic forms of care. While the focus of this review has fallen on HIV/AIDS, and therefore (in this section) sexual-based behaviour change interventions, this is not to say that REs

[220] Kalyowa & Kiwanuka 1998
[221] Barnett & Parkhurst 2005
[222] Barnett & Parkhurst 2005
[223] Cohen & Tate 2005
[224] Singh et al 2002
[225] James 2004
[226] Kirby 2002
[227] Ornelas et al 1992

are not busy attempting to change other behaviours. These interventions, (for example, those focused on drug use), creating family ties or safer streets, can be seen to indirectly aid in the prevention of HIV/AIDS by creating stronger communities and networks.

❒ Intervention through (sex) education

While the section on pastoral care through education will deal extensively with the issue of education as a faith-based intervention in public health,[228] it is perhaps necessary to point out here that education remains one of the primary focuses and functions of faith-based initiatives. Education interventions include the provision of information on HIV/AIDS, sex and health, usually as part of a whole package of 'life-skills' based training and knowledge.[229]

❒ Health promotion

Another important way in which religious entities intervene is through what we have called 'health promotion' - although it is rarely classified as such directly. While many of the faith-based interventions could be classified as health promotion initiatives - such as preaching on health to a congregation, or a youth program - at this moment we are specifically thinking of the public role of some religions and religious leaders. That is, the advocacy role mentioned earlier, where religious leaders use the media to promote their messages of healthy behaviour, could be considered to be a health promotion strategy. However, while there are a few documents appearing that evaluate larger scale interventions (using the media), again there are few that directly consider this in relation to religious entities. This is an increasingly important field as more and more religious bodies become involved in mass-media health interventions.[230]

❒ Focus on 'faithfulness'

There is also a renewed interest in the 'be faithful' aspect of the ABC campaign, and there is an obvious focus on REs to become involved in this. However, the literature that does mention this new direction is not stemming from religious organizations. This appears to be another place in which REs and the literature surrounding them are reactively behind new trends that they could be leading.[231]

On the other hand is the literature problematising faithfulness. Authors point out that in Africa (and elsewhere) married women, who are faithful to their spouses, make up a high-risk group for contracting HIV. Being faithful may create a sense of being safe, especially where this is emphasised in preaching, yet it does not guarantee the fidelity of a partner, nor does it empower women to take a stand for what protects them.[232]

❒ Focus on 'the youth'

Another area in which REs appear prominently is in prevention interventions that are focused on the youth. There is a great deal of published material on HIV/AIDS related behaviour change programs with 'the youth' - but little specific to religious responses. For example, an annotated bibliography that summarizes research findings from studies specifically focused on youth and HIV/AIDS in sub-Saharan Africa since 1995, rather astoundingly has no articles relating to religion at all.[233]

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[228] See Section 4.7
[229] See Garvey 2003
[230] See Bature 2004 - for an example of a mass media campaign focused on abstinence.
[231] Patient & Orr 2004
[232] While it is certainly true to state that married women constitute a risk group, we have to point out that the danger is by no means restricted to married women or women per se. See Lurie 2000 for data on discordant couples.
[233] Woog 2003

❒ Theology of sexuality

In theology, Christian as well as Muslim, some tentative steps have been taken towards developing a new 'theology of sexuality'. This literature goes beyond the judgement and prohibition around sexual behaviour which have contributed significantly to HIV-related stigma, toward discovering the essence and gift of human sexuality and developing guidelines for sexual relationships that are relevant to our time.[234]

Through a gendered lens

For the purposes of this literature review, material on 'gender' has been included in this section on sexuality - although certainly gender-specialists might be offended at this. However, the burgeoning amount of literature on gendered responses to religion and HIV/AIDS frequently speaks of gender and sexuality in the same text. Gender is a crucially important issue in the growing understanding of HIV/AIDS in particular, and other health crises in general. It is also a topic that spans a variety of disciplinary boundaries and discussions. In this section, we have gathered the material into three topics most important to the focus of this review: 1) women disadvantaged and endangered by their gender 2) masculinities and HIV/AIDS, and 3) gender violence as a health crisis.

❒ Women disadvantaged by gender

A growing body of literature analyses the way in which gender differences endanger women, and many religious groups run programs that seek to intervene in gender issues -which would affect health indirectly. On the other hand, some work seeks to understand how gender issues in religious settings can be harmful to good health - for example, through patriarchal systems that bestow privilege on men whilst encouraging submissiveness in women, and therefore make women more vulnerable to HIV/STDs.[235]

Some studies also seek to correlate the relationship of gender to religiosity in order to assess the relationship to HIV/AIDS preventative behaviour. For example, Agadjanian looks at how gender differences in perceptions of HIV/AIDS and preventive behaviour are mediated by religious involvement. His analysis detects women's disadvantage on several measures of knowledge and prevention but also suggests that gender differences are less pronounced among members of 'mainline' churches. The study also highlights how gender differences are shaped in different religious environments, and he concludes that 'although the potential of faith-based institutions in combating the HIV/AIDS pandemic is undeniable, policy-makers need to heed important differences among these institutions when devising ways to harness this potential.'[236]

❒ Masculinities and HIV/AIDS

Of course, modern gender studies recognise that men can also be 'victims' of the social construction of gender. That is, masculinities can also lead to increased risk in relation to HIV/AIDS - for example by expectation of particular kinds of sexual behaviour, or from not feeling able to go into a local clinic. In fact, a recent surge of research looks at African masculinities in relation to gender, sexuality and HIV/AIDS.[237] However, there is little relating to the religion-masculinities-health spectrum, and this is certainly a place for further research. For example, Simpson explores masculinities in Zambia -

[234] Burggraeve 2000, Byamugisha 1998, Byamugisha 2000, Denis 2003, Germond & de Gruchy 1997, Germond 2004, John 1995, Kugle 2003
[235] Soloman 1996
[236] Agadjanian 2005
[237] See Barker & Ricardo 2005

using a cohort of men educated at a Zambian Catholic mission, but does not set religion in a prominent place in his analysis, which suggests that he does not feel religion is a significant factor in the development of masculinities.[238]

❒ **Gender violence as a health crisis**

Finally, there is an obvious and well-researched link between gender violence and HIV/AIDS.[239] Gender violence is a common cause for HIV infection in women and children; conversely violent reaction is a common response to discovering sero-positivity. We would therefore argue that any programs REs might establish to intervene against gender violence can actually be seen as a direct health intervention. Again, this is a situation where religious groups are running programs that relate to HIV/AIDS, but are not considered to be health interventions.[240] In addition, these programs might take forms that are not recognised outside the religious setting, such as the development of gendered readings or interpretations of the bible - which ultimately could have effects on health-seeking behaviour.[241]

Comments on the literature and further questions

Throughout this section of literature review on religion, sexuality and gender, we have consistently seen areas that are in need of further research or consideration. Some of these main points are:

- ❒ It is vital that each faith-based initiative be assessed in context, with its individual nuances - especially in teasing out specific constructs of religiosity and sexuality.
- ❒ A need also exists for more complex evaluations of faith-based behaviour change interventions. This would benefit from input from specialists such as psychologists who have the capacity to work with intricate and complex behavioural change models - rather than broad-spectrum self-report surveys, which are generally the norm.
- ❒ There is potential for researching REs using the theory and methodology of public health promotion - especially considering the increased partnership and advocacy role many religious leaders and groups are playing. For example, an idea could be for congregations to be treated as 'health promoting schools' which have developed a substantial amount of literature - where schools become centres for health-seeking behaviour.
- ❒ As REs step into the public spotlight more and more, and become engaged in public and national-level behaviour change programs, it is essential that they do so with well researched knowledge on the specific religious effects they might be having or might be seeking.
- ❒ It is basic that research on religious-based interventions, such as abstinence, begins to emerge from within religious communities and scholars - rather than reactively following outmoded behaviour change models which have been shown to be flawed in any case.
- ❒ The end of the secularisation thesis means that multi-discoursal, or multi-disciplinary outlooks will be urgently needed at the interface between religion and health. Pfeiffer's article. *Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: A clash of AIDS prevention messages*,[242] offers in its title just one indicator of the types of paradigms simultaneously at play. Pretending that 'the youth' receive one set of behaviour change messages at a time is naïve, and potentially dangerous.

[238] Simpson 2005
[239] See CADRE 2003
[240] See Theilen 2003
[241] See Erasmus & Hendricks 2005; Pillay 2004
[242] Pfeiffer 2004

- There is a lack of awareness about the intersections between disciplinary fields - especially relating to different behaviour change techniques and methods.
- The range and quantity of the debates surrounding religion and sexuality is not an indicator of saturation of the field. In fact, more than ever before, there is a need for nuanced, well-measured information that REs can utilize to better their intervention efforts.
- There remain a great many unanswered questions as on how to reliably measure religion or religiosity - and therefore an urgent need for the further development of tools specific to the religion-public health interface.
- There is little integration of mainstream religious interventions into sexuality with traditional African cultural practices. Behavioural change models have often been designed in 'developed' countries that do not always have to deal with plural cultures, religions and health-seeking behaviours as we do here in Africa. This is where the next focus of this literature review will go.

4.5 Blending African religion, health and culture

As the previous chapter suggested, Africa is a complex environment in which to do research. Religious life in sub-Saharan African is a mix of indigenous and externally sourced religious worldviews,[243] and religious worldviews interact in multicultural contexts and interactions.

A factor that has not received sufficient attention is culture and the philosophical framework or paradigms determining our understanding of diseases, their causes and appropriate methods for prevention. All people are influenced to some degree by at least three different paradigms: the scientific, the religious and the traditional one. All of them provide different interpretations of HIV/AIDS, its origin and the most appropriate methods to overcome it - Benn 2002

Plural religious affiliation in SSA

Much of the review up to this point has focused on reactions and interventions through mainstream religious organizations, for they are much better documented than the variety of smaller religious groups, or the huge number of fragmented, and hence less visible African Independent Churches (AICs). In fact, countries in southern Africa are predominantly Christian, at least nominally, with smaller groupings of Muslims, Hindus, Jews, Ba'hai, Buddhists and others.

In many resource-poor settings of Africa, a majority of people living with HIV/AIDS depend on and choose traditional healers for psychosocial counselling and health care. If the current pan-African prevention and care efforts spurred by the HIV pandemic do not actively engage African Traditional Medicine, they will effectively miss 80%, the vast majority of the African people who, according to the World Health Organization, rely on traditional medicine for their primary health care needs - Homsev et al 2004

But behind this bland statement lies a deeper complexity. Much of the Christianity visible in REs is imbued with African traditional religion,[244] most notably among the 'Zionist' churches that are possibly now the numerically dominant form of Christianity in southern Africa. Many of the so-called mainline churches judge these elements harshly; African members generally adhere to the traditional practice nonetheless, albeit secretly. African traditional religion (ATR) is also experiencing something of a renaissance.[245]

[243] Cochrane 1993; Cochrane 2000; Mugambi 2000
[244] Amanze 2002; Chitando 2002
[245] Oduyoye 1995; Amadiume 1997; Magesa 2000

Surrounding this religious diversity is an underlying multiculturalism as well as the usual cultural constructions of such classifications as race, nationality and gender. In addition, communities in Africa are highly mobile, often trans-national in character, and not very stable.[246] This clearly has implications for studies, such as those above, which seek to measure 'religiosity' as based on fixed congregations. This mobility is one major reason that current 'congregational studies' emerging from America must be (re)considered in the light of these context-specific characteristics. That is, 'congregations' based in some SSA areas might be unrecognisable to some congregational theorists, and therefore require unique methods and interventions.

Mistakenly citing Islam as a reason for the practice, the largely illiterate Beja community believes that girls' circumcision is a religious practice. Though the Holy Qur'ãn does not contain any call for FGM, many Muslims supporters of the sunna type of circumcision refer to few sayings by the Prophet Mohamed…As a result of the awareness-raising interventions and campaigns by ACORD, the Beja of Halaib have recently begun to distinguish between what is religious and what is a traditional/ cultural practice - Sahl et al 2004

Pluralistic health (seeking) behaviour and religious practice

We have referred already earlier to the body of literature that recognises that in Africa people engage in pluralistic health-seeking behaviour that might not conform to 'western scientific' or biomedical expectations. The point may be repeated in this context, that individuals may simultaneously engage with different health systems, or may choose different remedies depending on their perception of the disease and the treatment that is offered.[247] These health systems may be biomedical hospitals and clinics, traditional healers, or even faith healing.

A public health system or intervention (or a religious intervention for that matter) which does not take into account this pluralism is at the last ineffective, and at worst, potentially dangerous. For example, Bate points out that health interventions may be guided by frameworks of interpretation alien to the health-seeker or provider, and may even be seen as hostile and fail to 'translate' across these divides.[248] Therefore, health interventions (whether 'Western scientific', 'traditional indigenous' or 'religious') must be placed within a broader range of behaviours and practices that are holistically conceived.[249]

Religion, traditional medicine or 'African culture'?

Literature relevant to understanding, researching and intervening in these multiplex communities can be found across a broad spectrum of academic disciplines - from medical practitioners practices, to scholars of African traditional religion (ATR). It soon becomes clear that the boundaries between 'religion', 'traditional medicine' and 'African culture' are greatly blurred, both in the health-practices of individuals and communities, and in the literature.

❒ **Traditional healers or religious leaders?**

In the same way that the term faith-based organization is inadequate to describe the varieties of religious entities, the term 'traditional healer' is inadequate to convey the variety of traditional practitioners. For example, some individuals are herbalists and others are spiritually inspired health

[246] Brettell & Hollifield 2000
[247] See Jansen 2001; Gwele 2005
[248] Bate 1995
[249] Pato 1997

practitioners. What this points to is that in a pluralistic view, 'traditional healers' can cross over to be counted as 'religious leaders'. In fact, Jansen points out that there is a striking resemblance between the prophet of the spiritual churches and the traditional healer/diviner.[250]

❒ Faith-healing or traditional healing?

There is also an unclear distinction between faith-healing and traditional-healing, with some literature referring alternatively to either concept. In fact, while practices may differ, healing and health is of vital importance to most traditions. For example, Zionists and neo-Pentecostals often stress healing, in thought and in practice,[251] as does African traditional religion.[252]

❒ Witchcraft as an explanation

There is an interesting pocket of literature that addresses the issue of 'witchcraft' as an explanation for disease, and often in discusses this in relation to a traditional religious framework.[253]

❒ Increased attention on traditional healers in HIV/AIDS interventions

In the last five years there has been a definite increase in the recognition of African traditional medicine as a health system, and traditional healers as a 'professional' body. This has largely been as a result of the HIV/AIDS epidemic, and the need to access the many Africans who do not utilize the standard public health systems.[254] Traditional healers are increasingly being drawn into biomedical interventions, or at least into greater rapport with public health and biomedical health systems.[255] They are being called on to provide a wide spectrum of services, and involvement in many different levels of HIV/AIDS interventions. Traditional healers are also being drawn into other public health crises such as acting as TB treatment supervisors.[256]

> *Even when the technical intervention is effective in another cultural and religious context it is likely to fail, if not in the short term, then over the long haul. In this sense, good hermeneutic insight and the wisdom to use it have deep developmental implications, for the health sector as much as any other - Benn 2002*

❒ Interventions against harmful cultural-religious health traditions

There are a variety of 'cultural' practices that are also tied up in a cultural-religious bundle, and have been studied from both sides. Of particular concern are those practices which expose people to disease and HIV/AIDS infection, such as virgin/sexual cleansing, widow inheritance, certain forms of initiation or female genital circumcision (FGC). Parry notes that many AICs, syncretic and traditional religions, which command large followings, do not have a clear stand on these cultural practices, which are widely practiced.[257] Whether they have an official stand on them is less relevant than recognising that in the practice of these activities, 'religion' and 'culture' are closely bound.[258] An interesting example of a faith-based intervention is in a northern African intervention into FGM that utilised religious rationalisations and leaders to effect change.[259]

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[250] Jansen 2001
[251] Sebahire 1987
[252] See Kwenda 1999; Amanze 2002
[253] See Bjerke 1989; Douglas 1997; Forster 1998; Ingstad 1989
[254] See Homsey et al 2004
[255] See Chipfakacha 1997; CEDPA 2003; Green 1999; Green et al 1995; Wreford 2005
[256] Wilkinson et al 2000
[257] Parry 2002
[258] See Bruce 2003; Malungo 2001
[259] Msterson & Swanson 2000; Sahl et al 2004

Comments on the Literature and Further Questions:

Therefore, we can see that there is a great need for further research on plural health-seeking behaviour, and in general, on the way the blend of African religion and culture impacts on public health. A few further research pointers are:

- The AICs are operating on a huge scale with a fundamental interest in health and healing, but with very little being researched or documented.
- It is vital that research is done on the hermeneutic construction of religious worldviews and the different ways this impacts on health.
- There is little literature that simultaneously interfaces between frameworks of religion in the African context, public health and cultural practices.
- It may be necessary for such 'public health' research to also play an intermediary role between greatly disparate 'religious' groups.
- It is crucial that such research on African religion, health and culture emerges from within Africa.
- Understanding health in sub-Saharan Africa demands multiple approaches - which is true for the rest of the continent and globe as well

4.6 Challenges, calls for change and increased partnership

We began this literature review process with a clear idea of what categories of literature we were looking for, and how they would fit into a depiction of 'religious responses and interventions'. However, during the process of investigation, we slowly became aware of another issue appearing regularly throughout the literature, although not always as an intention of the author or as a 'keyword'. This is captured in our heading, 'challenges, calls for change and increased partnership', a strong theme in various bodies of literature. Driven by the HIV/AIDS epidemic and the developmental and health crises in general, social researchers, social commentators and religious scholars alike are speaking about being challenged to change society as we know it.

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 - Taylor 2006

HIV/AIDS as a challenge to the 'church'

The HIV/AIDS epidemic is seen from many angles as a challenge (and threat) to religious theologies and religious practice. The many titles using the word 'challenge' or 'opportunity' calls for further investigation as to how religious groups and communities are changed by HIV/AIDS.[260]

- **HIV/AIDS challenges the resources of the church**

The most straightforward suggestion is that HIV/AIDS is placing increasing strain on religious resources, often threatening their sustainability.[261] They are therefore also often being challenged to forge new networks - such as accessing new sources of funding, and new relationships with 'secular' organizations.

[260] See companion bibliography for a selection of such documents
[261] Ntsimane 2000

❒ HIV/AIDS challenges the church to engage and forge new partnerships

In many ways, REs are being challenged to become more active in 'secular' civil society. There appears to be increased calls from both sides for faith-based groups to become involved and to 'form partnerships' - especially in HIV/AIDS interventions.[262] In fact, Uganda's 'success' in combating HIV/AIDS is frequently attributed to the multisectoral approach that was taken, and the inclusion of the faith-based groups.[263] These calls for increased partnership may mean that REs and religious leaders have or will have a greater opportunity to effect change at the policy level.

However, such public-private partnerships in public health are generally tenuous, and it will continue to be a challenge to bring organizations with different values, interests and world-views together.[264] However, much of the literature speaks of the critical public health crises, and that this urgency should be enough to bring disparate bodies together in shared vision.

As discussed above, the move for partnership is not only from the side of religious entities, but also from powerful development and public health agencies.[265] This is not only a nominal challenge to form new relationships, but appears to be a doorway to the development of new ideas and perspectives. As Katherine Marshall of the World Bank says, 'the role of religious institutions, leaders, and programs in the development process is one of the more significant 'blind spots' in past development practice. These institutions, ideas, and perspectives have been too little understood, and their potential role in the complex kaleidoscope of development insufficiently explored. In many parts of the development business and in many religious programs and institutions, dialogue has resembled ships passing in the night'.[266]

❒ HIV/AIDS as a challenge to faith

On the grounds of edict or morality, religion cannot be a non-participant - Solomon 1996

Our faith calls us to challenge stigma and discrimination and to make the invisible visible! - EAA 2003

To fail to respond to an issue of such great magnitude as HIV/AIDS would be to imply that God, Jesus and Christianity are irrelevant to contemporary society - Nicolson 1995

Another theme that emerges, primarily from theological or religious scholars, is that HIV/AID is challenging faith and religion itself. For example, from an individual perspective, there are a variety of authors questioning how the church could have been responsible for the stigmatisation of PLWHA, and that this is a challenge to the fundamental religious undertakings of compassion and 'selfless love'.[267] In a variety of ways, the literature shows a faith community interrogating their response to HIV/AIDS, and what this means for their individual faith, and for the relevance of the church itself. Similar questions are raised in progressive Islamic texts exploring a 'theology of compassion' in the context of AIDS.[268]

❒ HIV/AIDS as a moral/ethical challenge and responsibility

Many authors are therefore utilising religious tools to challenge their own communities to respond to HIV/AIDS. They are challenging them to do so utilising their faith as the driving tool - it is their

[262] As mentioned above, however see Woldehanna et al 2005
[263] See Singh et al 2002; WCC 2001
[264] HCP 2002
[265] See Sections 2.3 and 3.5
[266] Marshall 2001
[267] See Masenya 2001; Messer 2000; Vitillio 1995
[268] Positive Muslims 2004

religious responsibility, moral duty, or ethical challenge to do so.[269] In this way, these organizations and individuals are intervening in health through theology. Their argument is backed up by a general drive to understand the HIV/AIDS epidemic as an ethical challenge.[270]

❒ HIV/AIDS as a challenge to theology

There are also increasing calls to make the theological response to HIV/AIDS relevant to the needs of the church. That is, the HIV/AIDS crisis makes it urgent that theological and academic exploration makes its way to the community-level responses. For example, PACSA, reporting on the churches response to HIV/AIDS in the Pietermaritzburg area said 'despite the wealth of theology and academic exploration around the issues, it is questionable how much churches' responses on the ground are actually grounded in a clear theological framework.'[271]

❒ Challenged to change the world as we know it

In addition to this urgency to respond to HIV/AIDS - there is a growing body of literature looking at the religious response to the structural or political economic reasons for disease.[272] Religious groups, advocates and leaders are increasingly challenging for real economic and structural change at a global level.[273] This is sometimes expressed in terms of a 'new Kairos' - which in the South African context, reflects back to previous times when religious groups have become heavily involved in social change.
As mentioned above,[274] the HIV/AIDS epidemic appears to have here given momentum to the view of health as a matter of social justice. Kelly, for example, a Jesuit priest and scholar from Zambia suggests a dynamic framework within which to look at the prevention and treatment of HIV by linking justice concerns such as poverty, gender disparities and power structures, stigma and discrimination, and global socioeconomic structures and practices.[275] Cochrane emphasizes that the connection between ill-health, power and justice is an essential area of concern for people of faith.[276]

> *There are several ways that advocacy can help. We can advocate for churches to work together, to convince the churches to desist from judgemental condemnation and spreading false information, and to request them to develop good practice in prevention, treatment and care…*
> *While churches have played a substantial role at community level, their participation at national level in speaking about HIV and AIDS has been rather limited - a limit that is self-imposed. National stakeholders…need to encourage the church to speak out as part of the national debate. They should advocate for the churches to become advocates! - Futures Group 2005*

This in turn is related to many calls for the church to become more fully involved in advocacy - that is, more directly involved in debates previously seen as the realm of government and public health policy makers. It appears that this is an area in which religious organisations do not always involve themselves, and in which there is considered to be a great deal of potential.[277] Inter-religious organisations often seem to take the lead in this area. For example, the Ecumenical Advocacy Alliance is looking into trade agreements on access to medicines - challenging REs (through the EAA) to become involved in campaigning for access to medicines, and involvement in the TRIPS agreements.[278]

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[269] See Bate 2003; EAA 2003; Nicolson 1995
[270] Niekerk & Kopelman eds 2006
[271] Gennrich & Gill 2004
[272] See Section 3.4
[273] See Dube 2002
[274] Section 3.4
[275] Kelly 2006
[276] See Cochrane 2006 & 2007 (forthcoming)
[277] See ARHAP 2006
[278] Blaylock 2006

Comments on the literature and further questions

From the few points above, it is clear that religious groups and individuals are responding to HIV/AIDS and other health crises in ways that are not captured by simply mapping the number of HIV/AIDS programs in existence.

- There is little known about the effect of these challenges and calls for change - whether they drive individuals to change their outlook, or behaviour - both in the religious setting and in their public lives.
- There is also a need for more in-depth enquiry into the role religious leaders are playing in the public health, civil society arena, and what (if any) effect they are having on policy formation.
- Formal research is needed to assess the developing public-private partnerships that relate to health.
- Again, there may be an intermediary role to be played between different discourses - despite there being an emphasis on shared challenge.

4.7 Pastoral care through education

Two of the most prominent responses of religious entities to HIV/AIDS and other health crises can be seen to be *education* and *care*. In this section we will consider the literature that gives some indication of how religious groups have responded to HIV/AIDS through education strategies, and in the next, on the aspect of 'care'.

Many of the references cited in the companion bibliography for this section are evidential rather than referential - that is, they are presented as evidence of the religious response through education - such as manuals, pamphlets and education booklets. The main point of argument in this section is that there is a vast body of this type of material - and therefore what has been included is only representative of a larger mass of information.

Education of congregations

It would not be an exaggeration to say that a 'mass' of material is aimed at educating congregations and faith-based groups on HIV/AIDS. Simple internet searches reveal an incredible amount of educative material such as guidebooks, pamphlets, flyers, posters, program information and course outlines. We suggest here that this body of material, and the dissemination practices that accompany these in their particular settings, in fact reflects a substantial 'intervention' of religious entities. Overall, it is usually the larger religious coordinating bodies that develop and publish these materials, although there are a surprising number of 'self-published' items. While there is huge variety within this response, it is possible to make a few general observations:

- **Characteristically religious slant on health information**

In the case of HIV/AIDS, a primary function of these manuals and programs is to educate specific religious audiences. That is, general information and best-practices are 're-presented' using religious language and anecdotes specific to the intended audience.[279] These cover anything from transmission information to notes on the particular issues of stigma and sexuality specific to the religious response

[279] For example, compare Gennrich 2004; PositiveMuslims 2004; Pick 2003

to HIV/AIDS. Many of these documents utilize theological explanations and act as an interpretative filter for educating religious communities on health matters

> *Carrying out some form of home care and visitation was another common activity of many FBOs…During such visits, those involved provide some or all of the following: care, moral/emotional/ spiritual support, food, and treatment. Most FBO leaders identify home care and visitation programs as the ones in which congregation members have taken the most interest and in which they have participated the most fully. In some cases congregation members initiated such programs and often are entirely responsible for carrying them out - Liebowitz 2004*

It is worth noting that much of this material is not just characteristically religious, but consciously religious - the point here is one of 'intentionality'. HIV/AIDS education material is often meant to be disseminated to as broad a readership as possible, and an information booklet from one sector can be just as easily utilized in another. The point of interest here is just how much of the religious material openly states that it is intended for a particular audience, often describing that intended audience in detail. The best interventions are those that are adapted to suit the audience they are intending to reach - and it would be interesting to consider if this religiously-filtered HIV/AIDS information has any greater or lesser effect than standard HIV/AIDS education material.

Further to this are the materials that depict 'popularly written' theologies. These materials are frequently developed out of groups meetings and programs, and reveal particular, situational interactions between religious understandings and health situations.[280]

However, another aspect of this train of thinking is that because these materials are developed, published and disseminated by faith-based groups for faith-based groups, they frequently remain outside the 'screen' of academic evaluation and review of such information. For example, *Fikelela*, the South African Anglican AIDS Project, has released the results of a research project aimed at establishing if church-going young people are adhering to the principle of 'no sex before marriage', or if there are other competing 'voices' and pressures that young people succumb to. This is intended as a report to inform the churches' intervention in youth sexuality programs. Of great interest is a short sentence tacked on to the end of the abstract of this report, where the authors say: 'this booklet is not designed as an academic paper; rather it is a tool for church leaders and those involved in ministry with young people.'[281] This links in with a general sense in much faith-based and development material in general - where they are focussed on 'just getting things done' rather than getting caught up in academic investigation and debate.[282]

Education of religious leaders and community health educators

Religious entities are not only focused on the health education of their communities and congregations - they are also focused on the health education of religious leaders as an intervention that would trickle down to the broader communities. This is seen in material that sets out to train community health educators,[283] as well as in literature discussing the integration of HIV/AIDS and public health information in theological school curriculums or religious-training programs.[284]

[280] See UWTG 1994
[281] Mash and Kareithi 2005
[282] See Section 4.1 or Parry 2002
[283] See Ruteikara et al 1996
[284] See Dube 2003

Comments on the literature and further questions:

- Being called 'guides' or 'manuals' does not detract from the fact that these materials and the processes linked with them are in fact a type of health intervention seeking to inform and change behaviour.
- There is an obvious need for the analysis of these materials. This is not to judge them from an academic standpoint, but rather to consider them as a resource of information on understanding how specific religious groups are interfacing with health issues. In addition, popular theological responses do not necessarily result in good health educative practices.
- It would be useful to draw this field of health-education-intervention in closer with the other bodies of research being done on health education through schools or other development interventions. There may be ways that religious entities are disseminating information that is either helpful or harmful in comparison with other initiatives.
- It would be interesting to assess the magnitude of the audiences that these materials reach. That is, they are being actively distributed to schools, religious congregations, bible study groups, and community organizations. It would be helpful to know the size and depth of such networks for health information dissemination.
- It would also be interesting to know what processes are linked to these materials in faith-based settings. For example, if a bible study group carefully works through a faith-based manual on HIV/AIDS each week, tied in with the 'ritualised' bible study session, how does this impact on the effect of the information?
- There is a great need for good hermeneutical research in order to understand how these materials are being read in each context.
- It is also clear that while there are a great number of materials 'out there' - there is little information or knowledge on just how often they are being used.
- Again, it is clear that there is need for an intermediary between 'religious' and 'academic' bodies. That is, while not wanting to stifle spontaneous religious initiatives, it is also possible that certain harmful practices are being initiated because of the ability to publish-act-intervene with no review process.

Churches have the most valuable item needed for an effective outreach, they have volunteers - Sr. Handler in Parry 2002

4.8 Intervention through community care

Alongside education, the other most visible response of faith-based groups in the literature is 'community care'. Returning to the first section on this discussion on religious responses and interventions in HIV/AIDS and other health crises[285] - when we looked at the assessing, mapping and evaluation of tangible assets - it was noted that there is little known about the extent of care or infrastructure that religious entities provide. It was also pointed out that even less is known about the 'religious-specific' aspects of this care. In this section of the review, we seek to continue from that point, and to consider the less tangible aspects of community care - not the physical facilities and visible programs, but rather the literature that points to more amorphous networks, community systems and supporting roles.[286]

[285] See Section 4.1

[286] Please note that a great deal of evidence for the general statements made in this section are taken from those primary reports on religious responses to HIV/AIDS. Please refer to Section 4.1 of the companion bibliography for these references.

Networks of care

Lament is a form of mourning. It is also more…Lamenting is both an individual and a communal act which signals that human relationships have gone awry - Ackermann 2000

Many sources comment on the fact that religious groups provide networks of care, or are 'caring communities'.[287] This is not a new aspect of religious intervention, but rather one built on historic systems that include caring for the sick and aged. In the context of HIV/AIDS, this translates into religious communities becoming involved in home-based care initiatives for those dying of AIDS and care for the orphans that are left behind. It also has come to mean that religious communities (must) create safe or 'sacred' spaces for PLWHA.[288] We will highlight a few of the main points that are raised by this collection of literature that is most relevant to the public health perspective.

❒ **Home-based care**

The HIV/AIDS epidemic has drawn increasing attention to home-based care as a vital aspect of health care - especially in areas of sub-Saharan Africa that do not have adequate healthcare or support facilities. However, although there is a burgeoning amount of literature on home-based care in general, there is little that directly evaluates the scale or nature of the religious community's impact in this area. This is also an extremely difficult area to quantify as, for example, a home-care or nursing program might only be called 'religious' if it is a large-scale initiative focused entirely on that aspect. However, if homecare is a task being quietly undertaken by community members at a local level, or religiously-motivated individuals are joining non-faith-based homecare organizations (such as the Hospice), then there is little way to tell whether or not these individuals are motivated by religious doctrines or challenges.[289] This then makes it virtually impossible to affect the policy makers decisions who are providing resources based on evidenced provision of care.

❒ **Volunteers**

Millions of Christians are involved as volunteers in churches throughout Africa working on behalf of those who are sick or orphans. Their labour is worth billions of pounds a year in UK terms - Foster in Tearfund 2006

Another issue which is consistently highlighted is the ability of faith-based initiatives to access and mobilise volunteers. This is clearly a valuable resource for funding-restricted areas and initiatives. However, although there is general agreement that there is this resource, little is know as to its actual extent. A recent Tearfund report resorted to 'matchbox maths' to estimate that there are over 5 million volunteers from Christian communities in Africa, resulting in accumulative work valued at 2.5 billion pounds per year.[290] Even less is known about the religious-specific aspects which drive or sustain volunteers in comparison with individuals who are not religiously-motivated.[291] Of interest, however, is the concept of volunteers in relation to social capital.[292] Onyx and Bullen point out that the importance of the volunteer was that 'they were found to be strongly connected in social networks and able to pass on those connections, or aid the connections between vulnerable groups and outside resources.'[293]

[287] See Section 2.2
[288] Gennrich & Gill 2004
[289] See Section 4.6
[290] Tearfund 2006
[291] See Reinikka & Svensson 2003
[292] See Section 2.4
[293] Onyx & Bullen 1998

❒ **Focus on the family**

Another general trend is for religious entities to focus on the 'family' - or at the least utilise language that frequently refers to family. In some cases this can be seen as a specific religious intervention. In the HIV/AIDS context there is a great deal of literature that assesses the impact of the epidemic on the family or the like.[294] Despite there being correlation, little has been written on how a religious family-focus could relate to health or HIV/AIDS interventions. However, if religious organizations can affect the conditions and norms of a community in ways that indirectly aid in the prevention of HIV, for example through forging stronger family- or community ties, then this should be considered an intervention into health.

Death, lament and care for the dying

Finally, there is another major aspect of community care that religious organizations provide, but which is perhaps not always considered a public health priority. This is intervention by interaction with the dying and those close to them. It has been recognised that in the HIV/AIDS crises, a substantial number of REs are offering support to family during illness, bereavement and funeral arrangements[295] Death and its processes appear to be intensely private matters, however, from reviewing the literature, we would argue that, in fact, it can be a 'public' health and community health matter, and one in which many religious entities are intervening and responding to the HIV/AIDS epidemic and its accompanying tragedy.

❒ **Religious organizations and individuals are heavily involved in palliative care**

There are many (tangible) religious entities that provide palliative care to individuals and communities. There are also many NGOs (such as hospices) which are not classified as REs, but who provide faith-based care, and whose staff are often motivated through faith-based processes (such as staff prayer meetings each morning).

❒ **Religions and public grief and lament**

In sub-Saharan Africa, we regularly hear of the effects of HIV/AIDS through anecdotal reports of funerals every weekend, and cemeteries filled to the bursting. Religions and REs play a crucial role in the intervention in public and private grief. For example, religions provide mourning or lamenting rituals in face of mass grief and tragedy. While this has been mostly treated as a theological or psychological matter - it can also be argued that it is relevant to public health. If a ritual provides comfort and understanding to a community, it might also have an effect on social networks and emotional and mental health. This might in turn affect health-seeking behaviour or choices.[296]

> *Palliative care simply means soothing care. This can involve treatment and control of symptoms related to HIV/AIDS but in the main refers to the emotional, psychosocial, spiritual and environmental support and care in respect of those infected and affected by HIV/AIDS - ZINGO 2002*

❒ **HIV/AIDS can be a 'social death'**

Furthermore, it has been frequently mentioned that as a result of the accompanying stigma, HIV/AIDS can be seen as a 'social death' long before a person actually dies.[297] Part of this stigma is built from social fear and resistance to death itself.[298] If a religion or religious entity can bring some degree of

[294] See Barolsky 2005; Bor & Du Plessis 1997
[295] ZINGO 2002
[296] See Baai 1991; Mdende 1997, Nieuwmeyer 2002
[297] See Alonzo 1995
[298] See EAA 2002

understanding that has the effect of destigmatising death - then this could be seen as an intervention against stigma.

Comments on the Literature and Further Questions:

This section begins to indicate religious health assets that are less tangible, or visible, but may be just as important to public health - if they can be identified and measured.

- ❒ Community care is an area in which religious groups and public health professionals should be able to find common ground.
- ❒ While effect has been noted - there is little literature that can compare the religious caring network with 'secular' systems - or knowledge of what percentage of 'secular' caring systems are made up of members of religious communities.
- ❒ There are basic religious roles and rituals which could be argued to be 'health interventions'. However a great deal of further research would be needed for this to be argued successfully.
- ❒ Exploring the similarities and differences between home-based care groups common in Africa and the parish nursing model found in developed countries, the respective roles they fulfil in different societies may yield helpful insights.

4.9 Spiritual Mechanisms

As we move from tangible to intangible aspects of the religious response to HIV/AIDS and other crises, we are increasingly having to make arguments based on a suggestive blending of different sources - rather than direct referencing from social studies. This final section seeks to collate the most intangible and nebulous aspects - namely the spiritual mechanisms that impact on health, the 'something extra' which religious organizations bring to the public health arena.

So far, we have seen in nearly every section of this review that there is a consistent need to understand the religious-specific aspects of the different interventions that impact on public health. The literature on the intangible aspects of religion prevents us from easily separating 'individual' from public experiences of religion and health - as most of these considerations are intensely private. However, we argue here that these aspects do in fact impact on public health, and should be considered in future research into the public-health-religious paradigm.

Measuring that religious 'something extra'

Some aspects of religious health assets can - and should - be examined appropriately by public health (economic) analysis. However, other aspects of these assets need another frame of analysis to measure, evaluate and build strategies for enhancing such qualities as compassion, mutual support, honesty, prayer, and moral authority. These converge with economic measures when we seek to understand the performance and tenacity of leaders, employees, volunteers and the community linkages that are the key to the durability and effectiveness of religious assets.

Obviously, these more 'intangible' aspects are mentioned much more frequently in the literature emerging from the side of religion. However, this is rarely done in a manner that translates into public health perspectives. For example, a religiously minded person reading a religious HIV/AIDS program

report might find it quite acceptable that a RE felt that its major impact was to bring hope to the community, and create meaning in life.[299] However, a public health professional will find it less palatable to incorporate the effects of faith healing and prayer into a report on the sustainability of a health intervention. There is therefore a desperate need for (social) scientifically valid methods to be utilised in tackling some of these more intangible religious assets. Nevertheless, the literature does raise three aspects that can be seen to translate across this divide: trust, hope and resilience.

❒ Trust

'Trust' is one area in which religious and public health discourses appear to come together. Of course, the concept is utilised differently in these two fields. In public health it is usually used in relation to the utilisation of health systems or networks, and there is a significant amount of research being done in this area in relation to trust in African health care.[300] Trust is actually becoming a very 'hot' topic in the social science field. In the October 2005 edition of the *Social Science and Medicine* Journal, the main topic of discussion was 'Building trust and value in health systems in low- and middle-income countries'. There is also increasing research into trust and sexual behaviour in relation to HIV/AIDS - that is, how people make sexual or protective choices based on their level of trust of their partner.[301] However, few of these research streams consider religion to be a factor worth investigating.[302]

On the other side of the divide, religious organizations and academics are reporting on the multiple ways trust is involved in the religious experience. For example, there are reports on how a compassionate response lessens stigma and increases trust to disclose, or of the increased effectiveness of faith-based interventions because of the level of trust they enjoy at the community level.[303] The point here is that while these two interests do not seem to intersect, they are a possible place at which intersections could be forged.

❒ Hope

There is also a great deal of literature on the aspect of 'hope' in relation to medical practice, and in particular nursing practices in relation to spirituality (of nurses and of patients).[304] However, on the public health level, little consideration is given to 'hope' - which is mentioned in nearly every 'religious' article on HIV/AIDS in the database that was collected for this review. Hope is in fact an aspect of crucial importance to both religious and public health perspectives. In relation to HIV/AIDS, for example, the despair which the epidemic might be in direct contrast to an individual's (or youth's) hopes for their future. This is a complex area in which hope might affect public opinion on HIV/AIDS, the sustainability of volunteers, behaviour choices, or risk assessment.[305] Religious traditions have a long philosophical relationship with hope, and could utilise this to engage at a public level. In addition, another of the 'unknown' factors is whether or not a religious (hopeful) perspective affects your health behaviour or choices.

❒ Resilience

Resilience is also a concept that might be able to cross the religion-public health divide. It too, is a concept that is gaining increasing attention in light of the HIV/AIDS epidemic - as people seek to

[299] See Benn 2002
[300] See Gilson 2005; Goudge & Gilson 2005; Thiede 2005; Tibanaebage & Mackintosh 2005
[301] Klein & Coombes 2005
[302] See Cochrane 2006
[303] Parry 2002
[304] Culliford 2002; Dubree & Vogelpohl 1980; Harrison 1997; Kylma et al 2001; Limandri & Boyle 1978; Paraklea 1991
[305] See Olivier 2005; Olivier 2006a & 2006b

increase resilience against the disease. Research on resilience can be seen both in relation to the individual,[306] community,[307] and organization.[308] Briefly, there are clear areas of synergy between religion and public health here, if it were to be properly researched. For example, resilience is increased if an individual (or organization for that matter) is part of a network of support, and we have seen how religious entities are seen to engender community networks. We have also suggested above that volunteers with a religious organization may have greater capacity - or resilience, and the same goes for religious leaders, who may have more resilience to work in difficult health sectors if they have a sense of spiritual support. Or religious entities may have greater resilience to run in the face of decreased funding because of a faith-aspect. Further investigation is warranted.

Spiritual mechanisms

Finally, we consider the actual spiritual mechanisms that accompany these religious aspects. While there has been a mountain of material written on the impact of prayer, meditation and faith healing on health, their relevance for public health interventions has not received attention, and it remains a question as to how one might show it.

It is worth mentioning however, that even apparently private spiritual mechanisms can have public faces. The Alcoholics Anonymous intervention has famously utilized religious aspects as part of their intervention, including prayer. Faith healing in Africa can be very public, in fact, public healing is a primary reason why people join African Independent Churches (AICs).[309] An ARHAP case study found that an ARV program being run by the Moravian church was made more successful because of a device where by the person on ARVS took their medicine scheduled according to the morning-prayer ritual of the Moravian church.[310]

Comments on the Literature and Further Questions:

We are clearly lacking in valid tools and methods to measure these more intangible aspects. Nevertheless, it can be argued that they could be playing a significant (and as yet undetected) role in public health interventions. Despite the fact that public health professes to approach health in a more holistic fashion than old-fashioned biomedicine, it is difficult to inform policy on anecdotal reports of hope, or a gut sense that religious motivation is an important factor in the sustainability of REs. It is therefore crucial that at least an attempt is made to 'quantify' these internal aspects such as hope, if they are to be taken seriously in the public health sector.

> *If the African state is to become more effective it needs to understand what it is about religion that builds loyalty, creates infrastructure, collects tithes and taxes, fosters a sense that it delivers material as well as spiritual benefits. Religion can, of course, be misused but it can also be a partner in development – Commission for Africa 2006.*

[306] Mallman 2003
[307] Cannell 2006
[308] James 2005
[309] See Jansen 2000
[310] Thomas et al 2006

Chapter 5 Conclusions and Recommendations

5.1 A note on responses and interventions to other health crises

As discussed above, this literature review inadvertently became focussed on HIV/AIDS. From the few references for this section in the companion bibliography which relate to other critical epidemics - such as TB or malaria - it is clear that there is a great deal of further research needed to dig out the interventions of religious entities in other public health matters, and still be able to retain the focus on sub-Saharan Africa.

5.2 Conclusions and Recommendations

In the introduction to this literature review, we positioned the African Religious Health Assets Programme (ARHAP) with a foot in each of the camps of religion and public health - in a bounded field of unknowing. We then moved our way through a wide variety of materials - some of which would be regarded with suspicion by public health professionals, and others that would be regarded in the same way by religious scholars and leaders.

Where then does this leave us? A primary conclusion is that there is substantial valuable information out there, but that it is often so dispersed, inconsistent or tucked in unrelated-seeming places that it is not easily gathered or formulated into distinct arguments or conclusions.

The other primary conclusion is that there is a huge amount of research that still needs doing, very often on vital aspects of public health interventions that are already being acted upon with little to no supporting evidence. We have seen that there is increased attention on religious entities and initiatives, calling on them to play even greater roles in public health. Under the influence of the HIV/AIDS epidemic and the other health crises which are threatening sub-Saharan Africa, there is such urgency for effective action that interventions are often, by force, being rushed into place. This literature review, therefore, not only leaves ARHAP with a clearer sense of where research is needed, but also with the realization that such research is urgent.

We have therefore gathered together the main research recommendations, looking to take the next step towards informed research and interventions:[311]

5.3 General research recommendations

- **Need to search further for material on religious initiatives beyond HIV/AIDS and mainstream Christianity**

It is clear that this literature review has a heavy focus on the response to HIV/AIDS, and that mainly from the perspective of mainstream religions. Further efforts are needed to source materials on other major health crises and other religions. This gap in the literature also points to an area that urgently requires further research.

[311] Please return to the sections on 'comments on the literature and further questions' for points more specific to each topic of discussion.

❒ **Need for mapping and quantitative research on religious health assets.**

While there is enough evidence to conclude that REs command greater health assets than was previously thought, in comparison with the NGO and public health sectors there is dangerously little known about what is in place and where. The scale and scope of these assets are not systematically known or understood by either religious communities/leaders or public health decision makers. Even when they are recognized, they are likely to be misunderstood, sometimes being overestimated and sometimes undervalued in terms of their contribution to health; no-one has a sense of their combined scale and contribution to public health. Therefore, mapping, quantitative and qualitative research are greatly needed.

❒ **Need for nuanced evaluation and analysis of religious interventions, and of religious health assets**

There is a fundamental need for in-depth and nuanced evaluation and monitoring of all varieties of religious interventions in health - from behaviour change programs to the assessment of education material. Some REs may be resistant to this outlook as they have become used to a certain degree of isolation from current academic and social knowledge. In addition, some religious health assets are more visible and easily measured than others, but this does not necessarily mean that they have more impact on health. There must therefore not be a bias towards those assets that are more easily assessed, than to those which are more difficult to analyse, but which may be just as influential in the health sector.

❒ **Need for proactive research and proactive action on the part of religious entities**

Religious entities are being challenged to become proactive in their actions against disease as well as in their intervention strategies. Proactive and innovative research will assist in developing unique prevention and care strategies that build on the strengths and internal features of religious organizations.

❒ **Need for research that recognises diversity, variety and pluralism**

It is vital that there is recognition of religious entities and communities as diverse entities, which cannot be assessed through any simplistic method of categorisation. Furthermore, further research is needed if we are to understand the pluralism of African communities, and the blend of African culture, religion and health-seeking behaviour. This includes recognition of individual complexity and contextual factors which influence health and health decision-making.

There is a gap not only in the evidence concerning the relationship of faith forming entities to diseases such as HIV/AIDS, but in the conceptual map in which such evidence might be understood that does justice to the full complexity of both the religious phenomenon and the disease phenomenon as both are experienced as social realities.

❒ **Need to begin the search for the 'religious-specific'**

What is largely missing from most studies that might inform this work is the dimension of religion that is 'internal' to faith based communities or organisations; an element that explains their motivations, commitments, attitudes, actions and relational or associational strengths on the basis of their own self-understandings and world-views. This dimension is harder to take into account in defining religious health assets, particularly in any way that makes for easy identification, replicability and generalisation - the requirements of a mapping process that would be useful to public health professionals or policy makers.

❒ **Need for a common discourse between religion and public health and multidisciplinary research**

The language of religious studies and the language of public health have few cognates and there are few who are bilingual. What is needed is an interdisciplinary language to develop tighter, empirical, comprehensive and systematic concepts of religious health assets and agency. There are also places of intersection that could be nurtured, such as a common interest in trust, or by focussing on a shared commitment to holistic health in general. There is therefore a real need for groups such as ARHAP to play an 'intermediary' role, facilitating dialogue between religious and public health bodies that often appear to be speaking in different languages.

❒ **Need 'transdisciplinary' research and the development of unique tools**

If interdisciplinary research is a group of differently placed researchers working on the same project, then 'transdisciplinary' research is the combined and simultaneous use of various methods and theory within a single study.[312] It is therefore transdisciplinary research that is needed to work in this space, constantly crossing the boundary between religion and public health. This requires that unique methods and tools be developed for this purpose - methods which can be regarded as valid by those in both religious and health research communities, and perhaps more importantly, by those in the religious and public policy community.

Working in the relationships between disciplines, fields of practice, institutional capacities and competencies…is not primarily an intellectual space, but a physical, existential space that is in between all those things we know. The space in which we are trying to do scholarship is filled with haunting ambiguities and confusions in which hope and horror are intermingled - Gunderson 2003

In conclusion, this broad literature review shows that ARHAP can offer an important strategy to bring together the assets of Africa, the interest of the global faith community, and the extensive, although fragmented, evidence base of 'what works' when religious people, communities, and institutions address the struggle for sustainable health on that continent with pragmatism and hope.

It may also show that African faith communities, out of the need to rely and build on the assets available to them, are approaching health issues with holistic strategies that are largely untried in more richly endowed Western communities. The results of research such as is recommended above would be relevant beyond the geographical space of sub-Saharan Africa. Nations around the world are struggling under the increasing pressures of disease and illness, and religion is a powerful force in many parts of the globe.

As epidemics such as HIV/AIDS move towards new areas, it is vital that we learn from what is happening here in order to help ourselves as well as other communities who could gain from this knowledge. The bounded field of unknowing appears to be more than just a valid place in which to do research. It is a vital contribution to the increasingly necessary alignment of health systems, resources and assets.

[312] Max-Neef 1991

African Religious Health Assets Programme

ARHAP Bibliography:

Working in a bounded field of unknowing

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October 2006

This document is a companion to *ARHAP Literature Review: Working in a Bounded Field of Unknowing*. This report, the companion literature review and most of the literature mentioned are available from the ARHAP-UCT Resource Centre: arhap@humanities.uct.ac.za

This document represents a first step towards gathering the literature relevant to this area of enquiry. Research is ongoing and we welcome all comments and additions to this growing body of knowledge.

Preferred Reference: Olivier J, Cochrane JR and Schmid B. *ARHAP Bibliography: Working in a Bounded Field of Unknowing*, (Cape Town, African Religious Health Assets Programme, 2006)

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Contents

Introduction

This bibliographic review is a companion document to a literature review of the same title. Please see the introductory chapter of the companion document for an in-depth explanation of the review process and procedure.

References correspond to the matching sections of the literature review, and it is for this reason that a few have been repeated in more than one section. However, these documents were only abstracted once in the area to which they are most vital. In addition, only the most relevant documents were abstracted, with author-written abstracts being given preference - otherwise abstracts were written for selected texts.

The emerging texts were organised thematically and it was through this process that the classification process for this document was derived. We accept that the areas of classification may not be perfect, and that in certain instances, texts do not fall neatly into the categories that are provided. However, it is our intention that in the future this review will be supplemented by the availability of an electronic database.

Finally, due to the broad nature of this review, a large quantity of information was being handled. However, we are aware that certain important documents may unfortunately have been excluded. We therefore hope that this review is only the starting point for a growing body of knowledge which can add to this exciting field.[1]

[1] Note on production: as there was a significant gap between completion and production of this review, several crucial documents emerged in the first half of 2006 beyond the research parameters of 1995-2005. For the interests of future research, these documents have been included in the bibliography in their appropriate sections but have not always been given the full attention they deserve in the review itself.

Chapter 1 Theoretical background and overview

ARHAP (2006)
Appreciating Assets: The Contribution of Religion to Universal Access in Africa, Cape Town, Report for the World Health Organization, (ARHAP) African Religious Health Assets Programme

ARHAP (2006)
Executive summary: Appreciating Assets
Journal of Theology for Southern Africa 126(November)

Benn C (2002)
The influence of cultural and religious frameworks on the future course of the HIV/AIDS pandemic
Journal of Theology for Southern Africa 113(July):3-18

Benn C (2003)
Why religious health assets matter
ARHAP: Assets and Agency Colloquium. Pietermaritzburg, South Africa, August 2003, (ARHAP) African Religious Health Assets Programme

Berger PL (ed) (1999)
The desecularization of the world: Resurgent religion and world politics
Washington DC, Ethics and Public Policy Centre

Casanova J (1994)
Public religions in the modern world
Chicago, University of Chicago Press

Cochrane JR (1999)
Circles of dignity: Community wisdom and theological reflection
Minneapolis: Fortress Press.

Cochrane JR (2003)
Religion in the health of migrant communities: Cultural assets or medical deficits?
International Conference on Health and Migration, Oxford University, Queens University, University of Cape Town (January 2003)

Commission for Africa (2005)
Our common interest: Report of the Commission for Africa
London, UK, Commission for Africa

De Gruchy S (2003)
Of agency, assets and appreciation: Theological themes for social development
Journal of Theology for Southern Africa 117: 20-39

De Gruchy S (2004)
A Christian engagement with the sustainable livelihoods framework
Society for Urban Mission, Pretoria, South Africa

Derrida J and Vattimo G (1998)
Religion: Cultural memory in the present
Cambridge, UK, Polity Press

Du Toit C (2002)
The place of values in the science-religion dialogue: Biology, human nature and the cultural environment
Journal of Theology of Southern Africa 113: 75-95

Erasmus JC and Hendricks HJ (2003)
Religious affiliation in South Africa early in the new millennium: Markinor's world value survey
Journal of Theology for Southern Africa 117:80-96

Erasmus JC, Hendriks HJ and Mans G (2004)
Religious research as kingpin in the fight against poverty and AIDS in South Africa
RRA Conference in VSA, October 2004

Garner RC (2000)
Religion as a source of social change in the new South Africa
Journal of Religion in Africa 30(3): 310-343

Garner RC (2000)
Safe sects? Dynamic religion and AIDS in South Africa
Journal of Modern African Studies 38(1): 41-69

Germond P and Molapo S (2006)
In search of bophelo in a time of AIDS: Seeking a co-herence of economies of health and economies of salvation
Journal of Theology for Southern Africa 126(November)

Gunderson GR (1998)
Aligning assets for community health improvement: Building on enduring strengths of faith groups and health sciences
The Medical Journal of Allina (Fall)

Gunderson GR and Kiser M (1997)
Strong partners: Realigning religious health assets for community health
Atlanta, The Carter Center

Habermas J (2002)
Religion and rationality: Essays on reason, God and modernity
Cambridge UK, Polity Press

Kitchen M (2002)
World must coordinate efforts, end waste, says Wolfensohn
UN Wire (October 24)

Kretzmann J and McKnight JL (1993)
Building communities from the inside out: a path toward finding and mobilizing a community's assets
Chicago, ACTA Publications

Kretzmann J and McKnight JL (2002)
Assets-based strategies for faith communities
Asset-Based Community Development Institute of Northwestern University

Luckoff D, Lu F and Turner R (1992)
Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems
Journal of Nervous and Mental Diseases 180 (11): 673-82

Martin R (1999)
The future of Christian hospitals in developing countries: The call for a new paradigm of ministry
APHA Meeting, (APHA) American Public Health Association

Nussbaum M (2000)
Women and human development: The capabilities approach
Cambridge, Cambridge University Press

Nussbaum M and Glover J (eds) (1995)
Women, culture and development: A study of human capabilities
Oxford, Clarendon Press

Sen A (1992)
Inequality re-examined
Oxford, Clarendon Press

Sen A (1999)
Development as freedom
New York, Anchor books

Sen A (2000)
Population and gender equity
The Nation 2000 July 24-31:16.

Taylor N (2005)
Many clouds, little rain? The Global Fund and local faith-based responses to HIV and AIDS
HIV/AIDS Briefing paper 4, Teddington, UK, Tearfund

Taylor N (2005)
The warriors and the faithful: The World Bank MAP and local faith-based initiatives in the fight against HIV and AIDS
HIV/AIDS Briefing Paper 5, Teddington, UK, Tearfund

Taylor N (2006)
Working together? Challenges and opportunities for international development agencies and the church in the response to AIDS in Africa
HIV and AIDS Briefing Paper 7, Teddington, UK, Tearfund

Tearfund (2006)
Faith untapped: Why churches can play a crucial role in tackling HIV and AIDS in Africa
Teddington, UK, Tearfund

Thomas L, Schmid B and Cochrane JR (2006)
Executive summary: Let us embrace
Journal of Theology for Southern Africa 126(November)

Thomas L, Schmid B, Gwele M, Ngubo R and Cochrane JR (2006)
Let us embrace: The role and significance of an integrated faith-based initiative for HIV and AIDS
Cape Town, (ARHAP) African Religious Health Assets Programme

Weber M (1958)
The Protestant ethic and the spirit of capitalism
New York, Scribner's Press

WHO (1948)
WHO Constitution
Geneva, (WHO) World Health Organization

WHO (2004)
Faith-based groups: Vital partners in the battle against AIDS
The '3 by 5' Target Newsletter, Geneva, (WHO) World Health Organization

World Bank (2004)
Concept note
HIV and AIDS workshop for faith-based organisations and national AIDS councils, Accra, Ghana

Chapter 2 Cursory review of established fields

In this short chapter we only briefly mentioned some of the already well-established areas that are nevertheless vital to ARHAP's research focus. The primary interest of this chapter would be these references that are intended to give context to the ARHAP work that in some ways builds on or complements these areas of research. These references are therefore not by any means comprehensive listings of these large topic areas.

2.1 Religion as an explanatory variable and psychological aspect

- *See Section 4.5 for some more references on religion as a psychological aspect in relation to African cultures and traditions*
- *See Section 4.9 for some more references on spiritual mechanisms relevant to public health*

Benn C (2001)
Does faith contribute to healing? Scientific evidence for a correlation between spirituality and health
In: Neglected dimensions in health and healing: Concepts and explorations in an ecumenical perspective, Tübingen, (DIFAEM) German Institute for Medical Mission. Study Document No 3: 49-58

> Is there a correlation between practiced faith and health? Usually there is a strict separation between these two terms. They are referred to very different academic faculties: theology and medicine. At most faith and healing will be related to charismatic movements and faith healers whose practices cannot be verified by scientific methods. However, recently there has been an increasing number of studies published in respected scientific journals using the tools of epidemiology to investigate the correlation between religion and health. There is a great potential for a multidimensional approach to health that needs to be rediscovered and applied. The insights presented in this article can contribute to the required interdisciplinary cooperation.

Chatters LM (2000)
Religion and health: Public health research and practice
Annual Review of Public Health 21: 335-367

> A review of published research from the 1990s on religious involvement, spirituality and health

Clements WM (ed) (1989)
Religion, aging and health: A global perspective compiled by the World Health Organization
New York, London, Haworth Press

Coleman CL (2003)
Spirituality and sexual orientation: Relationship to mental well-being and functional health status
Journal of Advanced Nursing 43(5): 457-464

Coruh B, Ayele H, Pugh M and Mulligan T (2005)
Does religious activity improve your health outcomes? A critical review of the recent literature
Explore (2)3:186-191

> By systematically reviewing the most recent literature, the authors sought to assess the role of religion in health outcomes.

Fowler JW (1993)
Alcoholics Anonymous and faith development
In: McCrady BS and Miller WR (eds), Research on Alcoholics Anonymous. New Brunswick, NJ, Rutgers, Center of Alcohol Studies: 113-135

Golner JH (1982)
Sabbath and mental health intervention: Some parallels
Journal of Religion and Health 21(Summer):132-144

Gorsuch RL (1993)
Assessing spiritual variables in Alcoholics Anonymous research
In: McCrady BS and Miller WR (eds), Research on Alcoholics Anonymous. New Brunswick, NJ, Rutgers, Center of

Alcohol Studies: 301-318
Harrison MO, Koenig HG, Hays JC, Eme-Akwari AG and Pargament KI (2001)
The epidemiology of religious coping: A review of recent literature
International Review of Psychiatry 13: 86-93

Idler EL (2003)
Religion and physical health: Historical perspectives and current NIH research
Integrating research on spirituality and health and well-being into service delivery: A research conference Washington, DC, International Center for Integration of Health and Spirituality

Koenig HG (1994)
Aging and God
New York, Haworth Press

Koenig HG (1997)
Is religion good for your health?
Binghampton NY, Haworth Press

Koenig HG (1999)
The healing power of faith: Science explores medicines last great frontier
New York, Simon and Schuster

Koenig HG (2001)
Religion, spirituality, and medicine: How are they related and what does it mean?
Mayo Clinic Proceedings 76(12):1189-1191

Koenig HGM, Michael E and Larson DB (2001)
Handbook of religion and health
Oxford, Oxford University Press

> What effect does religion have on physical and mental health? In answering this question, this book reviews and discusses research on the relationship between religion and a variety of mental and physical health outcomes, including depression and anxiety; heart disease, stroke, and cancer; and health related behaviours such as smoking and substance abuse. The authors examine the positive and negative effects of religion on health throughout the life span, from childhood to old age. Based on their findings, they build theoretical models illustrating the behavioural, psychological, social, and physiological pathways through which religion may influence health. The authors also review research on the impact of religious affiliation, belief, and practice on the use of health services and compliance with medical treatment. In conclusion, they discuss the clinical relevance of their findings and make recommendations for future research priorities.

Luckoff D, Lu F and Turner R (1992)
Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems
Journal of Nervous and Mental Diseases 180(11): 673-82

Pargament KI (1997)
The psychology of religion and coping: Theory, research, practice
New York, Guilford Press

Peltzer K and Koenig HG (2004)
Religion, psychology and health
Journal of Psychology in Africa 15(1): 53-64

> Religion encompasses behavioural, attitudinal, public and private activities, all of which potentially involve different antecedent factors and consequences for health outcomes. There is increasing research evidence that religious involvement is associated both cross-sectionally and prospectively with better physical health, better mental health and longer survival. This review covers definitions and measures of religion; religious coping, psychological well-being and social support; religious practices and health; religious effects on health outcomes; explaining religion-health links; negative effects of religion; implications for health practice; and a conclusion. The study of religion, psychology and health is a true frontier for psychology and one with high public interest, particularly for Africa.

Ross L (1995)
The spiritual dimension: Its importance to patients' health, well-being and quality of life and its implications for nursing practice
International Journal of Nursing Studies 32(5): 457-468

Schumaker JF (ed) (1992)
Religion and mental health
New York and Oxford, Oxford University Press

Siegel K and Schrimshaw EW (2002)
The perceived benefits of religious and spiritual coping among older adults living with HIV/AIDS
Journal for the Scientific Study of Religion 41(1): 91-102

Somlai AM (1996)
An empirical investigation of the relationship between spirituality, coping, and emotional distress in people living with HIV infection and AIDS
Journal of Pastoral Care 50: 181-191

Somlai AM, Heckman TG, Kelly JA, Mulry GW and Multhauf KE (1997)
The response of religious congregations to the spiritual needs of people living with HIV/AIDS
Journal of Pastoral Care 51 (4): 415-426

Tuck I, McCain NL and Elswick RK (2001)
Spirituality and psychosocial factors in persons living with HIV
Journal of Advanced Nursing 33(6): 776-783

Van Ness PH (1999)
Religion and public health
Journal of Religion and Health 38(1)

> The paper begins by acknowledging several ways in which religious beliefs and behaviour have had a negative impact on people's physical and mental health; fanatical violence, mortifying asceticism, and oppressive traditionalism (e.g., sexism) are mentioned. Three areas of positive influence are explored: 1) the role of religious practices in personal health; 2) the impact of social ministries on community health, and 3) the complementarity of religious ideas of salvation with medical conceptions of health in contemporary conceptions of human well-being. That religion mediates between the social and individual dimensions of well-being is a unifying theme of the paper.

Yarhouse MA and Anderson G (2002)
Persons with HIV/AIDS
Journal of Psychology and Christianity 21(4): 333-340

2.2 Congregational studies

Albrecht G (1995)
The character of our communities
Nashville, Abingdon Press

Ammerman NT (1997)
Congregation and community
New Brunswick, New Jersey, Rutgers University Press.

Ammerman NT (2001)
Doing good in American communities: Congregations and service organizations working together
Hartford Institute for Religion Research

Ammerman NT, Jackson CW, Carl SD and McKinney W (eds) (1998)
Studying congregations: A new handbook
Nashville, Abingdon Press

The authors suggest gathering and interpreting congregational information through four "frames" or "lenses": the ecological frame, the culture frame, the resources frame and the process frame. They maintain that studying congregations is a way of discovering and expanding a local church's practical theology. Congregational studies also elevate the importance of clergy and lay leadership in "helping to shape a congregation's unfolding story" for on-going ministry and mission.

Claman VN (1994)
Acting on your faith: Congregations making a difference: A guide to success in service and social action
Boston, Insights

Droege TA (1995)
Congregations as communities of health and healing
Interpretation 69(2):117-129

Dudley CS and Ammerman NT (2002)
Congregations in transition: A guide for analyzing, assessing, and adapting in changing communities
San Francisco, Jossey-Bass

Foster C (1996)
We are the church together: Cultural diversity in congregational life
Valley Forge, Pennsylvania, Trinity Press International

Gunderson GR (1997)
Deeply woven roots
Minneapolis, Fortress Press

Gunderson GR (1998)
Religious congregations as factors in health outcomes
Journal of the Medical Association of Georgia 87(4): 296-298

Gunderson GR (2000)
Social strengths of religious congregations
In: W DuBois and RD Wright (eds), Applying sociology: Making a better world, Allen and Bacon

Kiser M and Michael H (1999)
Engaging faith communities as partners in improving community health
Atlanta, GA, (CDC) United States Centers for Disease Control and Prevention, and The Carter Center

This report provides an overview of a 1997 forum on partnerships between United States health systems and faith communities. According to the authors, 'the faith sector…represents the values of the community' and it is essential to consider these values when seeking to change behaviours and social norms within a community.

Pattillo-McCoy M (1998)
Church culture as a strategy of action in the black community
American Sociological Review 63:767-784

Thumma SL (1998)
Methods for congregational study
Nashville, Abingdon Press

Wind JP and Lewis JW (eds) (1994)
American congregations
Chicago, University of Chicago Press

Wuthnow R (1998)
Loose connections: Joining together in America's fragmented communities
Cambridge, Harvard, Cambridge Mass, Harvard University Press

2.3 Religion, development and public health

An-Na'im A (2003)
The synergy and interdependence of human rights, religion, and secularism
In: Runzo J, Martin NM and Sharma A (eds), Human rights and responsibility in world religions: 27-49

Bonney R and Hussain A (2001)
Faith communities and the development agenda
Report prepared for the Department for International Development (DFID), Centre for the History of Religious and Political Pluralism, University of Leicester

> This report results out of a consultancy which aimed to report on the current awareness of development issues among different faith groups in the UK. Particular attention was to be paid to public awareness of the 2015 targets for poverty reduction in the third world and the capacity of faith communities to organize themselves as potential partners with DFID. A final strand of the consultancy was to assess, where possible, the effectiveness of existing partnerships between DFID and non-governmental organizations involved with public awareness and understanding of development issues.

Cnaan RA and Boddie SC (2002)
Charitable choice and faith-based welfare: A call for social work
Social Work 47(3):224-235

Commission for Africa (2005)
Our common interest: Report of the Commission for Africa
London, UK, Commission for Africa

> The comprehensive report for the 'Commission for Africa' argues that African poverty and stagnation is the greatest tragedy of our time. Poverty on such a scale demands a forceful response. And Africa - at country, regional, and continental levels - is creating much stronger foundations for tackling its problems. Recent years have seen improvements in economic growth and in governance. But Africa needs more of both if it is to make serious inroads into poverty. To do that requires a partnership between Africa and the developed world which takes full account of Africa's diversity and particular circumstances.

De Gruchy S (2003)
Of agency, assets and appreciation: Theological themes for social development
Journal of Theology for Southern Africa 117: 20-39

> This essay pursues the dialogue between theological reflection and development theory. It argues, firstly, that the Christian concern for development must be rooted in the 'vocation of the poor', rather than in the compassion of the non-poor. Secondly, it explores the congruence between this theological idea and three key ideas in current development theory, namely, agency, assets and appreciation.

DFID (2006)
Faith in development position paper
London, UK, (DFID) Department for International Development

> This paper considers DFID's work with faith groups, and more broadly the role of faith groups in development. Faith and faith groups are pivotal to how people perceive development and how development assistance reaches poor people. Faith groups can be significant drivers of positive change, but can also act as barriers to change. Within DFID we need to recognise the importance of faith as a social, economic, political and cultural factor in development. Outside DFID, we need to pay attention to how we communicate with UK faith groups and communities and which representational faith groups we support and why.

Erasmus JC (2005)
Meeting unemployment through the faith based sector: A case study in a South African context
Unpublished paper, NRF Project Workshop, November 2005, Stellenbosch, South Africa, (URDR) Unit for Religion and Development Research

Erasmus JC (2005)
Religion and social transformation: A case study from South Africa
Transformation 22(3):139

Everatt D and Solanki G (2003)
A nation of givers? Social giving among South Africans
Centre for Civil Society, SAGA and NDA

Gill R (1996)
Theology and sociology
London, Chapman

Gilson L (2003)
Trust and the development of health care as a social institution
Social Science and Medicine 56: 1453-1468
Manji F and O'Coill C (2002)
The missionary position: NGOs and development in Africa
International Affairs 78(3):567-583

Marshall K (2001)
Development and religion: A different lens on development debates
Peabody Journal of Education 76(3): 339-375

> In much international development work, religion has been a marginal, if not an ignored, topic. The inverse applies for many faith institutions, which have viewed the work and thinking of development institutions with skepticism. Research, operational action, joint reflection, and dialogue on common issues have been patchwork. Recent initiatives, notably the Jubilee 2000 campaign spotlight on issues of poor country debt, have highlighted how significant the linkages and areas for exploration are, yet many opportunities for dialogue on topics of common concern and differing perspectives are still missed. The events of September 11, 2001, have underscored starkly the powerful links between religion and modernization and posed a host of new questions about how the links operate and how thinkers and actors should respond.

Marshall K (2005)
Faith and development: Rethinking development debates
Retrieved 26/10/2006, 2006, from http://web.worldbank.org

Marshall K and Keough L (2005)
Finding global balance: Common ground between the worlds of development and faith
Washington, USA, World Bank

Marshall K and Marsh R (2003)
Millennium challenges for faith and development leaders
Washington, USA, World Bank

Rose-Ackerman S (1996)
Altruism, nonprofits and economic theory
Journal of Economic Literature 34:701-728

Schervish PG, O'Herlihy MA and Havens JJ (2002)
Charitable giving: How much, by whom, to what, and how?
In: Powell W and Steinberg R (eds), The non profit sector: A research handbook. Boston College, Yale Press: 1-65

Schmale M (1993)
The political economy of the Evangelical Lutheran Church in Tanzania (ELCT)
In: Schmale M (ed), The role of local organizations in development: Tanzania, Zimbabwe and Ethiopia. Aldershot, Avebury: 52-153

Sider RJ (2005)
Evaluating the faith-based initiative: Is charitable choice good public policy
Theology Today 61:485-498

Thomas L (2003)
Reflections on agency, assets and appreciation
ARHAP: Assets and Agency Colloquium. Pietermaritzburg, South Africa, August 2003, (ARHAP) African Religious Health Assets Programme

URDR (2004)
Helderberg basin: Transformation project
Stellenbosch, South Africa, (URDR) Unit for Religion and Development Research

2.4 Social capital

Bourdieu P (1983)
Forms of capital
In: Richards JC (ed), Handbook of theory and research for the sociology of education. New York, Greenwood Press

Bourdieu P (1990)
The logic of practice
Cambridge MA, Polity Press

Burt RS (2001)
Social holes versus network closure as social capital
In: Lin N, Cook K and Burt RS (eds), Social capital: Theory and research. New York, Aldine de Gruyter:31-56

Cattell V (2001)
Poor people, poor places, and poor health: The mediating role of social networks and social capital
Social Science and Medicine 52(10): 1501-1516

Cochrane JR (2003)
Religion as social capital in the context of health: Mapping the field
ARHAP: Assets and Agency Colloquium. Pietermaritzburg, South Africa, August 2003, (ARHAP) African Religious Health Assets Programme

Coleman JS (1988)
Social capital in the creation of human capital
American Journal of Sociology 94(S):95-120

Coleman JS (1990)
Foundations of social theory
Cambridge, Harvard University Press

> Combining principles of individual rational choice with a sociological conception of collective action, James Coleman provides a theoretical foundation for linking the behaviour of individuals to organizational behaviour and then to society as a whole.

Coleman JS (1993)
Social capital in the creation of human capital
American Journal of Sociology 94(Supplment):95-120

Djamba YK (2003)
Social capital and premarital sexual activity in Africa: The case of Kinshasa, Democratic Republic of Congo
Archives of Sexual Behaviour 32(4): 327-337

Fafchamps M (2004)
Development and social capital
ESRC, (GPRG) Global Poverty Research Group

Foley MW, McCarthy JD, Chaves M (2001)
Social capital, religious institutions and poor communities
In: Saegert S, Thompson JP and Warren MR (eds), Social capital and poor communities, New York, Russell Sage Foundation: 215-245

Gittell R and Vidal A (1998)
Community organizing: Building social capital as a development strategy
California, Sage Publications

Granovetter MS (1983)
The strength of weak ties: A network theory revisited
Sociological Theory 1:201-233

Gregson S, Terceira N, Mushati P, Nyamukapa C and Campbell C (2004)
Community group participation: Can it help young women to avoid HIV? An exploratory study of social capital and school education in rural Zimbabwe
Social Science and Medicine 58(11): 2119-2133

Grootaert C and Van Bastelaer T (2001)
Understanding and measuring social capital: A synthesis of findings and recommendations from the social capital initiative
Social Capital Initiative Working Paper no.24, Washington DC, World Bank

Harpham T, Grant E and Rodriguez C (2004)
Mental health and social capital in Cali, Colombia
Social Science and Medicine 58(11): 2267-2278

Iannaccone LR (1990)
Religious participation: A human capital approach
Journal for the Scientific Study of Religion 29:297-314

Iannaccone LR and Klick J (2003)
Spiritual capital: An introduction and literature review
Philadelphia, USA, Spiritual Capital Planning Meeting, October 2003, Metanexus Institute

Lin N (1999)
Building a network theory of social capital
Connections 22(1):28-51

Lomas J (1998)
Social capital and health: Implications for public health and epidemiology
Social Science and Medicine 47(9): 1181-1188

Maluccio J, Haddad L and May J (1999)
Social capital and income generation in South Africa, 1993-1888
FCND Discussion Paper No 71, Washington, (IFPRI) International Food Policy Research Institute

MacKian S (2003)
A review of health seeking behaviour: Problems and prospects
(HSD) Health Systems Development Program

Narayan D (1999)
Bonds and bridges: Social capital and poverty
Washington DC, World Bank

Pearce N and Smith GD (2003)
Is social capital the key to inequalities in health?
American Journal of Public Health 93(1): 122-130

Portes A (1999)
Social Capital: Its origins and applications in modern sociology
Annual Reviews Sociology 24:1-24

Prins E and Ewert DM (2002)
Cooperative extension and faith-based organizations: Building social capital
Journal of Extension (40)3

Putnam RD (2000)
Bowling alone: The collapse and revival of American community
New York, Simon and Schuster

Putnam argues there has been a decline in 'social capital' in the USA. He charts a drop in associational activity and a growing distance from neighbours, friends and family. Crucially he explores some of the possibilities that exist for rebuilding social capital.

Putnam RD (ed) (2002)
Democracies in flux: The evolution of social capital in contemporary society
New York, Oxford University Press

Serageldin I and Groontaert C (2000)
Defining social capital: An integrated view
In: Dasgupta D and Serageldin I (eds), Social capital: A multifaceted perspective. Washington DC, World Bank

Smidt C (ed) (2003)
Religion as social capital: Producing the common good
Baylor University Press

Sobel J (2002)
Can we trust social capital?
Journal of Economic Literature 40:139-154

Schuurman FJ (2003)
Social capital: The politico-emancipatory potential of a disputed concept
Third World Quarterly 24(6): 991-1011

Swart I (2005)
Churches as a stock of social capital for promoting social development in Western Cape communities
ASASWEI Conference, Stellenbosch, 6-7 September 2005

Wall E, Ferrazzi G and Schryer F (1998)
Getting the goods on social capital
Rural Sociology 63(2):300-322

Woodberry RD (2003)
Researching spiritual capital: Promises and pitfalls
Spiritual Capital Planning Meeting, Philadelphia, USA, Metanexus Institute

Woolcock M and Narayan D (2000)
Social capital: Implications for development theory, research and policy
World Bank Research Observer 15(2): 225-250

Chapter 3 The field of public health

3.1 The focus of public health

Armstrong D (2000)
Social theorizing about health and illness
In: Albrecht GL, Fitzpatrick R and Scrimshaw S (eds), Handbook of social studies in health and medicine. Beverly Hills, CA, Sage: 24-35

Fee E (1987)
Disease and discovery: a history of the Johns Hopkins School of Hygiene and Public Health, 1916-39
Baltimore, The Johns Hopkins University Press

Feierman S and Janzen JM (eds) (1992)
The social bases of health and healing in Africa
Berkeley, University of California Press

Gunderson GR (1999)
Good news for the whole community: Reflections on the history of the first century of the social gospel movement
http://www.ihpnet.org/goodnews.htm, Accessed 1/11/2005

> Traces the parallel development of and connections between the social gospel movement and the beginnings of public health in the US.

Nussbaum M and Sen A (eds) (1993)
The quality of life
Oxford, Clarendon Press

> This volume gathers the thoughts of academics in economics, social policy, philosophy, and the social sciences as they scrutinize contentions regarding quality of life and the way in which it is, it can be, and ought to be measured. Such debates roughly boil down to the merits and shortcomings of measuring the quality of human life in terms of utility, as well as to the advantages and pitfalls of alternatives to the utilitarian approach. Philosophical inquiries concerning what constitutes thriving human life, engage with concrete policy-making and economic considerations in this work, bridging the customary schism between theory and practice.

Porter D (ed) (1994)
The history of public health and the modern state
Amsterdam, Rodopi

Porter D (1999)
Health, civilization, and the state: A history of public health from ancient to modern times
London, Routledge

Rosen G (1993)
A history of public health, expanded edition
Baltimore, The Johns Hopkins University Press

United-Nations (2005)
The millenium development goals report 2005
New York, USA, (UN) United Nations

3.2 Social determinants of health

Artazcoz L, Artieda L, Borrell C, Cortes I, Benach J and Garcia V (2004)
Combining job and family demands and being healthy: What are the differences between men and women?
European Journal of Public Health 14(1): 43-48

Barker DJP (1998)
Mothers, babies and disease in later life
Edinburgh, Churchill Livingstone

Bartley M (2004)
Health inequality: An introduction to theories, concepts and methods
Cambridge, Polity Press

> Studies show there are large differences in life expectancy between the most privileged and the most disadvantaged social groups in industrial societies. It is necessary to look beyond the figures to underlying social and biological processes to understand why this is. This book provides a key to understanding the most widely accepted theories of what lies behind inequality in healthcare: behavioural, psychosocial, material, and life-course approaches. Health Inequality carefully explains, in simple terms, the methods most commonly employed by health inequality researchers.

Bartley M and Plewis I (2002)
Accumulated labour market disadvantage and limiting long-term illness
International Journal of Epidemiology 31: 336-341

Bartley M, Blane D and Davey-Smith G (eds) (1999)
The sociology of health inequalities
Oxford, Blackwell Publishers

> In this collection of papers leading researchers in the social sciences describe and explain the unequal chances of long and healthy life between groups. The chances of a long and healthy life are unequal: there are large differences between men and women, members of different ethnic groups, regions, and social classes. Health inequality is of increasing concern in all developed countries, forming one of the WHO's Health for All by the Year 2000 targets. To be solved, health inequality has to be studied in a way that breaks down the boundaries between medicine and social science. This collection represents the contribution of the social sciences - sociology, economics, psychology, geography, and social policy.

Berkman LF (1984)
Assessing the physical health effects of social networks and social support
Annual Review of Public Health 5: 413-432

Berkman LF (1985)
The relationships of social networks and social support to morbidity and morality
In: Cohen S and Syme SL (eds), Social support and health. New York, USA, Academic Press: 241-62

Blane D (1999)
The life course, the social gradient and health
In: Marmot M and Willkinson RG (eds), Social determinants of health. Oxford, Oxford University Press

Braveman P and Tarimo E (2002)
Social inequalities in health within countries: Not only an issue for affluent nations
Social Science and Medicine 54(11): 1621-1635

Brunner EJ (1997)
Stress and the biology of inequality
British Medical Journal 314: 1472-1476

Brunner EJ, Hemingway H, Walker BR, Page M, Clarke P, Juneja M, Shipley MJ, Kumari M, Andrew R, Seckl JR, Papadopoulos A, Checkley S, Rumley A, Lowe GDO, Stansfeld SA and Marmot MG (2002)
Adrenocortical, autonomic and inflammatory causes of the metabolic syndrome
Circulation 106: 2659-2665

Bury M (1997)
Health and illness in a changing society
London, Routledge

Book covering the various aspects of social determinants of health including gender and inequality. A critical account of the impact of social change on the experience of health and illness. Also examines the different sociological perspectives that have been used to analyse health matters and highlights those ripe for revision.

Clements WM (ed) (1989)
Religion, aging and health: A global perspective compiled by the World Health Organization
New York, London, Haworth Press

Cohen S and Syme SL (1985)
Issues in the study and application of social support
In: Cohen S and Syme SL (eds), Social support and health. New York, USA, Academic Press

Cohen S and Syme SL (eds) (1985)
Social support and health
New York, USA, Academic Press

CSDH (2005)
Towards a conceptual framework for analysis and action on the social determinants of health
Discussion paper for the Commission on Social Determinants of Health, Draft 5, (WHO) World Health Organization

The Commission on Social Determinants of Health (CSDH) has affirmed its desire to be judged not only on the scientific rigor of its analyses, but on the policy and institutional changes catalysed in countries through Commission advocacy and partnership. To set feasible objectives for its political work and send consistent messages to partners and the public, the CSDH requires clarity on basic conceptual issues. These include: The concept of social determinants of health (SDH); The values that ground the Commission's analysis and policy recommendations; The pathways by which SDH affect health status and outcomes; How SDH relate to health inequities; The most important SDH for the Commission to address, and why; Appropriate intervention levels and entry points for policy action on SDH; The ultimate goal of SDH policies (improving average health status or reducing health inequities). This paper outlines a conceptual framework we hope can serve as a basis for discussion and clarification of these issues within the CSDH.

Denton M, Prus S and Walters V (2004)
Gender differences in health: A Canadian study of the psychosocial, structural and behavioural determinants of health
Social Science and Medicine 58: 2585-2600

Denton M and Walters V (1999)
Gender differences in structural and behavioural determinants of health: An analysis of the social production of health
Social Science and Medicine 49(9): 1221-1235

This paper explores aspects of the social production of health by focussing on the ways in which levels of health are shaped by structures of social inequality and behaviours or 'lifestyles'. Findings suggest the value of models which include a wide range of structural and behavioural variables and affirm the importance of looking more closely at gender differences in the determinants of health.

Dixon J (2000)
Social Determinants of Health
Health Promotion International 15(1): 87-89

Farmer P (1998)
Infections and inequalities: The modern plagues
Berkeley, University of California Press

Farmer P (2003)
Pathologies of power: Health, human rights and the new war on the poor
Berkeley, University of California Press

Graham H (2002)
Socioeconomic change and inequalities in men and women's health in the UK
In: Nettleton S and Gustafsson U (eds), The sociology of health and illness reader. Oxford, Blackwell Publishers

Gregson S, Terceira N, Mushati P, Nyamukapa C and Campbell C (2004)
Community group participation: Can it help young women to avoid HIV? An exploratory study of social capital and school education in rural Zimbabwe
Social Science and Medicine 58(11): 2119-2133

Himsworth H (1984)
Epidemiology, genetics and sociology
Journal of Biosocial Science 16: 159-176

House JS and Kahn RL (1985)
Measures and concepts of social support
In: Cohen S and Syme SL (eds), Social support and health. New York, USA, Academic Press: 83-108

Jabbour S and Houad FM (2004)
Religion-based tobacco control interventions: how should WHO proceed?
Bulletin of the WHO, Geneva, Switzerland, (WHO) World Health Organization

Keating DP and Hertzman C (eds) (1999)
Developmental health and the wealth of nations
New York, Guilford Press

Kim JY, Millen JV, Irwin A and Gershman J (eds) (2000)
Dying for growth: Global inequality and the health of the poor
Monroe, ME, Common Courage Press

Kim JY and Shakow A (2000)
Sickness amidst recovery: Public debt and private suffering in Peru
In: Kim JY, Millen JV, Irwin A and Gershman J (eds), Dying for growth: Global inequality and the health of the poor. Maine, Common Courage Press

Krause N, Ingersoll-Dayton B, Liang J and H. S (1999)
Religion, social support, and health among the Japanese elderly
Journal of Health and Social Behaviour 40(4): 405-421

Krieger N (2003)
Genders, sexes, and health: What are the connections - and why does it matter?
International Journal of Epidemiology 32(4): 652-657

Marmot M (2005)
Social determinants of health inequalities
The Lancet London 365: 1099-1104

> The gross inequalities in health that we see within and between countries present a challenge to the world. That there should be a spread of life expectancy of 48 years among countries and 20 years or more within countries is not inevitable. A burgeoning volume of research identifies social factors at the root of much of these inequalities in health. Social determinants are relevant to communicable and non-communicable disease alike. Health status, therefore, should be of concern to policy makers in every sector, not solely those involved in health policy.

Marmot M (2001)
Economic and social determinants of disease
Bulletin of the World Health Organization 79(10):988-989

Marmot MG, Bosma H, Hemingway H, Brunner E and Stansfeld S (1997)
Contribution of job control and other risk factors to social variations in coronary heart disease incidence
Lancet 350: 235-239

Marmot MG and Stansfeld SA (2002)
Stress and heart disease
London, BMJ Books

Marmot M and Wilkinson RG (eds) (1999)
Social determinants of health
Oxford, Oxford University Press

Social Determinants of Health gives an overview of the social and economic factors which are known to be the most powerful determinants of population health in modern societies. It provides accessible summaries of the scientific justification for isolating different aspects of social and economic life as the primary determinants of a population's health. Recognition of the power of socioeconomic factors as determinants of health came initially from research on health inequalities. This has led to a view of health as not simply about individual behaviour or exposure to risk, but how the socially and economically structured way of life of a population shapes its health.

Marmot M and Wilkinson RG (eds) (2003)
WHO: The solid facts
Geneva, (WHO) World Health Organization

Martikainena P, Bartley M and Lahelmac E (2002)
Psychosocial determinants of health in social epidemiology
International Journal of Epidemiology 31(6): 1091-1093

Mechanic D (2000)
Rediscovering the social determinants of health
Health Affairs 19(3): 269-277

Mechanic D (2002)
Disadvantage, inequality, and social policy
Health Affairs 21(2): 48-59

Eliminating disparities in health is a primary goal of the US federal government and many states. Our overarching objective should be to improve population health for all groups to the maximum extent. Ironically, enhancing population health and even the health of the disadvantaged can conflict with efforts to reduce disparities. This paper presents data showing that interventions that offer some of the largest possible gains for the disadvantaged may also increase disparities, and it examines policies that offer the potential to decrease disparities while improving population health. Enhancement of educational attainment and access to health services and income support for those in greatest need appear to be particularly important pathways to improved population health.

Mehrotra S and Jolly R (eds) (2000)
Development with a human face
Oxford, Oxford University Press

Mitchell R, Blane D and Bartley M (2002)
Elevated risk of high blood pressure: Climate and the inverse housing law
International Journal of Epidemiology 31: 831-838

Montgomery SM, Berney LR and Blane D (2000)
Prepubertal stature and blood pressure in early old age
Archives of Disease in Childhood 82: 358-363

Morris J, Donkin A, Wonderling D and Wilkinson P (2000)
A minimum income for healthy living
Journal of Epidemiology and Community Health 54: 885-889

Moss NE (2002)
Gender equity and socioeconomic inequality: A framework for the patterning of women's health
Social Science and Medicine 54(4): 649-661

Nooney J and Woodrum E (2002)
Religious coping and church-based social support as predictors of mental health outcomes: Testing a conceptual model
Journal for the Scientific Study of Religion 41(2): 359-368

Östlin P, Sen G and George A (2004)
Paying attention to gender and poverty in health research: Content and process issues
Bulletin of the World Health Organization 82(10): 740-745

Pierret J (1993)
Constructing discourses about health and their social determinants
In: Radley A (ed), Worlds of illness. London, Routledge

Sahl IMG, Elkarib AAK and Mohamed EMI (2004)
Towards a new 'silif': Breaking the silence on FGM among the Beja pastoralists of eastern Sudan
Development Practice Series 1, Nairobi and London, (ACORD) Agency for Co-operation and Research in Development

Tarlov A (1996)
Social determinants of health: The sociobiological translation
In: Blane D, Brunner E, Wilkinson R (eds), Health and social organization. London, Routledge: 71-93

Thoits PA (1995)
Stress, coping and social support processes: Where are we? What next?
Journal of Health and Social Behaviour Extra Issue: 53-79

Wallace HM, Giri K and Serrano CV (1990)
Health care of women and children in developing countries
Oakland, California, Third Party Publishing

Wilkinson R (1996)
Unhealthy societies: The afflictions of inequalities
London and New York, Routledge

Among developed countries it is not the richest societies that have the best health, but those that have the smallest income differences between rich and poor. Why? This book shows that social cohesion is crucial to the quality of life.

Wilkinson RG and Marmot M (eds) (2003)
Social determinants of health: The solid facts
Denmark, (WHO) World Health Organization, International Centre for Health and Society

Even in the most affluent countries, people who are less well off have substantially shorter life expectancies and more illnesses than the rich. Not only are these differences in health an important social injustice, they have also drawn scientific attention to some of the most powerful determinants of health standards in modern societies. They have led in particular to a growing understanding of the remarkable sensitivity of health to the social environment and to what have become known as the social determinants of health. This publication outlines the most important parts of this new knowledge as it relates to areas of public policy. The ten topics covered include the lifelong importance of health determinants in early childhood, and the effects of poverty, drugs, working conditions, unemployment, social support, good food and transport policy.

3.3 Health behaviour

- *See Section 4.4 for references on health behaviour in relation to HIV/AIDS*
- *See Section 4.9 for references on "trust"*

Annandale E (1998)
The sociology of health and medicine: A critical introduction
Malden, MA, Polity Press

In this introduction to the sociology of health and medicine, Annandale examines the core issues of the discipline and reassesses them in the light of recent developments in health care and social theory. The Sociology of Health and Medicine considers the way in which recent economic and social change has generated new issues and necessitated a re-evaluation of the traditional concerns in the field of health, illness and health care. Annandale examines how theoretical and methodological developments in social theory - such as post-structuralism and revisions to Marxist, feminist and symbolic interactionist thought - has led to new thinking in a number of areas. These include the processes linking "race", gender and class to health and illness, the sociology of the health service and the division of labour within it, and the experience of health and health care. Through a discussion of both traditional and new topics in the field, this book offers a wide-ranging and up-to-date assessment of the state of the sociology of health, illness and health care. The result is an innovative text that both reflects and advances changes in the discipline.

Benjamins M (2006)
Religious Influences on Preventive Health Care Use in a Nationally Representative Sample of Middle-Age Women
Journal of Behavioral Medicine 29(1): 1-16

Benjamins M and Brown C (2004)
Religion and preventative health care utilization among the elderly
Social Science and Medicine 58: 109-118

Benn C (2002)
The influence of cultural and religious frameworks on the future course of the HIV/AIDS pandemic
Journal of Theology for Southern Africa 113: 3-18

> In the twenty years since the discovery of AIDS this disease has spread throughout the whole world and has developed into the greatest threat to health and development. This is even more tragic as many interventions for HIV prevention are available but effective methods of safer sexual behaviour have not been adopted on a sufficient scale. There are many factors that complicate the issue and prevent widespread behaviour change. Among them are socio-economic conditions of poverty, unhealthy gender roles, violence, lack of information, unequal access to quality health services. A factor that has not received sufficient attention is culture and the philosophical frameworks or paradigms determining our understanding of diseases, their causes and appropriate methods for prevention. All people are more or less influenced by at least three different paradigms: the scientific, the religious and the traditional one. All of them provide different interpretations of HIV/AIDS, its origin, and the most appropriate methods to overcome this dreadful disease. This paper will explore these different frameworks and its influence on HIV/AIDS. It will argue that all of them have to be taken seriously. We need to understand better the sometimes conflicting messages if we really are to move from proper information and good intentions to sustainable behaviour change that will finally lead to decreased rates of HIV transmission and less human suffering.

Campbell C (2000)
Selling sex in the time of AIDS: The psycho-social context of condom use by sex workers on a Southern African mine
Social Science and Medicine 50(4): 479-494

Cleaver F (2003)
Masculinities matter: Men, gender and development
London, Zed Books

> Men appear to be missing from much gender and development policy, but many emerging critiques suggest the need to pay more attention to understanding men and masculinities, and to analyzing the social relationships between men and women. This book considers the case for a focus on men in gender and development, which requires us to reconsider some of the theories and concepts which underlie policies. It includes arguments based on equality and social justice, the specific gendered vulnerabilities of men, the emergence of a crisis of masculinity and the need to include men in development as partners for strategic change.

Garner RC (2000)
Religion as a source of social change in the new South Africa
Journal of Religion in Africa 30(3): 310-343

Garner RC (2000)
Safe sects? Dynamic religion and AIDs in South Africa
Journal of Modern African Studies 38(1): 41-69

Germond P (2001)
Theology, development and power: Religious power and development practice
Journal of Theology for Southern Africa 110: 21-31

> This essay draws contemporary sociological theories of power into relationship with thinking about theology and development. It suggests that power works in two distinct dimensions, namely, intentional and relational; and unintentional and nonrelational. Each of these needs to be understood by religious people working in development, but it is in the second dimension of power that religion is at its most powerful, and therefore this should receive more attention by those working in the area of theology and development.

Germond P and Molapo S (2005)
An ARHAP case study: Lesotho
ARHAP Case Study Colloquium, Johannesburg, June 2005

Gray PB (2004)
HIV and Islam: Is HIV prevalence lower among Muslims?
Social Science and Medicine 58: 1751-1756

Jabbour S and Houad FM (2004)
Religion-based tobacco control interventions: how should WHO proceed?
Bulletin of the WHO, Geneva, Switzerland, (WHO) World Health Organization

Using religion to improve health is an age-old practice. However, using religion and enlisting religious authorities in public health campaigns, as exemplified by tobacco control interventions and other activities undertaken by WHO's Eastern Mediterranean Regional Office, is a relatively recent phenomenon. Although all possible opportunities within society should be exploited to control tobacco use and promote health, religion-based interventions should not be exempted from the evidence-based scrutiny to which other interventions are subjected before being adopted. In the absence of data and debate on whether this approach works, how it should be applied, and what the potential downsides and alternatives are, international organisations such as WHO should think carefully about using religion-based public health interventions in their regional programmes.

Klein M and Coombes Y (2005)
Trust and condom use: The role of sexual caution and sexual assurances for Tanzanian youth (a baseline survey)
Working Paper No. 64, (PSI) Population Services International Research Division

Kleinman A, Eisenberg L and Good B (1978)
Culture, illness, and care: Clinical lessons from anthropologic and cross-cultural research.
Annals of Internal Medicine 88(2): 251-258

Major health care problems such as patient dissatisfaction, inequity of access to care, and spiraling costs no longer seem amenable to traditional biomedical solutions. Concepts derived from anthropologic and cross-cultural research may provide an alternative framework for identifying issues that require resolution. A limited set of such concepts is described as illustrated, including a fundamental distinction between disease and illness, and the notion of the cultural construction of clinical reality. These social science concepts can be developed into clinical strategies with direct application in practice and teaching. One such strategy is outlined as an example of a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application. The implementation of this approach in medical teaching and practice requires more support, both curricular and financial

Lagarde E, Enel C, Seck K, Gueye-Ndiaye A, Piau J, Pison G, Delaunay V, Ndoye I, and Mboup, S (2000)
Religion and protective behaviours towards AIDS in rural Senegal
AIDS 14(13): 2027-2033

Levin B and Browner C (2005)
The social production of health: Critical contributions from evolutionary, biological, and cultural anthropology
Anthropology Today: 14-26

MacKian S (2003)
A review of health seeking behaviour: Problems and prospects
(HSD) Health Systems Development Program

This review of health seeking behaviour outlines the main approaches within the field, and summarises some of the key findings from recent work around the probes. However, it also suggests that health seeking behaviour is a somewhat over-utilised and under-theorised tool. Although it remains a valid tool for rapid appraisal of a particular issue at a particular time, it is of little use as it stands to explore the wider relationship between populations and health systems development. If we wish to move the debate into new and more fruitful arenas, this review reaches the conclusion that we need to develop a tool for understanding how populations engage with health systems, rather than using health seeking behaviour as a tool for describing how individuals engage with services. This opens up into the broader arena of community organisation, social capital and citizenship; of political and non-political pressure points on the system. The paper suggests one way in which we might start to frame the debate in the context of this programme of work, using social capital and reflexive communities as key theoretical and analytical concepts.

Marmot M (2005)
Social determinants of health inequalities
The Lancet London 365: 1099-1104

Marmot M and Singh-Manoux A (2005)
Role of socialization in explaining social inequalities in health
Social Science and Medicine 60(9): 2129-2133

This paper argues that social selection, materialist/structural and cultural/behavioural explanations for social inequalities in health are related to each other through the mechanism of socialization, seen here as a process through which societies shape patterns of behaviour and being that then affect health. Socialization involves the inter- and intragenerational transfer of attitudes, beliefs and behaviours. Parallels between socialization theory and Bourdieu's concept of habitus are also drawn, and the implications for social epidemiology are discussed. Four key areas that would benefit from research within the socialization framework are identified: health behaviours, psychological vulnerability, social skills and future time perspective.

Nonnemaker JA, McNeely CA and Blum RW (2003)
Public and private domains of religiosity and adolescent health risk behaviours: Evidence from the National Longitudinal Study of Adolescent Health
Social Science and Medicine 57: 2049-2054

Paul C, Fitzjohn J, Eberhart-Phillips J, Herbison P and Dickson N (2000)
Sexual abstinence at age 21 in New Zealand: The importance of religion
Social Science and Medicine 51: 1-10

Pease B (2002)
Masculinity as a health hazard? The new men's health
In: Pease B (ed), Men and gender relations. Melbourne, Tertiary Press

Riska E (2002)
From type A man to the hardy man: Masculinity and health
Sociology of Health and Illness 24(3): 347-358

This article describes the transition in American 'stress' literature from a focus on 'Type A man' to the 'hardy man'. These two diagnostic categories were constructed in medical discourse and entailed certain notions of masculinity, class and health. The constructs explained the rise of unhealthy (coronary-prone) American middle-class white men in the 1950s and the emergence of healthy men in the same class, race and gender order in the 1970s. I show that the construction of Type A man rested on the medicalisation of the core values of traditional masculinity, while the term 'hardy man' demedicalised and legitimised these values.

Spiegel J (2004)
Lessons from the margins of globalization: Appreciating the Cuban health paradox
Journal of Public Health Policy 25(1): 85-110

Swatos WH (ed) (1998)
Encyclopedia of religion and society
Walnut Creek, USA, Altamira Press

UNICEF (2004)
Building trust through immunization and belief
New York, NY, (UNICEF) United Nations Children's Fund

Religious leaders, with their tremendous authority at the grass roots, are key to garnering community support for broad immunization coverage. This workbook, designed for communication and programme officers and their immunization partners, provides guidelines on forging alliances with religious leaders and groups on immunization. It also offers advice on options that can be taken when confronting resistance to immunization, illustrated by success stories from three countries.

Van Ness PH (1999)
Religion and public health
Journal of Religion and Health 38(1)

The paper begins by acknowledging several ways in which religious beliefs and behaviour have had a negative impact on people's physical and mental health; fanatical violence, mortifying asceticism, and oppressive traditionalism (e.g., sexism) are mentioned. Three areas of positive influence are explored: 1) the role of religious practices in personal health; 2) the impact of social ministries on community health, and 3) the complementarity of religious ideas of salvation with medical conceptions of health in contemporary conceptions of human well-being. That religion mediates between the social and individual dimensions of well-being is a unifying theme of the paper.

3.4 Political economy

Acheson D (1998)
Independent inquiry into inequalities in health
London, England, The Stationery Office

Bartley M (2004)
Health inequality: An introduction to theories, concepts and methods
Cambridge, Polity Press

Boucher D and Kelly P (eds) (1998)
Social justice: from Hume to Walzer
London, Routledge

Bowen-Reid T and Harrell J (2002)
Racist experiences and health outcomes: A deaminization of spirituality as a buffer
Journal of Black Psychology 28: 18-36

Cochrane JR (2006 - forthcoming)
Fire from above, fire from below: Health, justice and the persistence of the sacred
Theoria, Politics of Health

CSDH (2005)
Towards a conceptual framework for analysis and action on the social determinants of health
Discussion paper for the Commission on Social Determinants of Health, Draft 5, (WHO) World Health Organization

Farmer P (1992)
AIDS and Accusation: Haiti and the Geography of Blame
Berkeley, University of California Press

Farmer P (1996)
Social inequalities and emerging infectious diseases
Emerging Infectious Diseases 2(4): 259-269

> Although many who study emerging infections subscribe to social-production-of-disease theories, few have examined the contribution of social inequalities to disease emergence. Yet such inequalities have powerfully sculpted not only the distribution of infectious diseases, but also the course of disease in those affected. Outbreaks of Ebola, AIDS, and tuberculosis suggest that models of disease emergence need to be dynamic, systemic, and critical. Such models - which strive to incorporate change and complexity, and are global yet alive to local variation - are critical of facile claims of causality, particularly those that scant the pathogenic roles of social inequalities. Critical perspectives on emerging infections ask how large-scale social forces influence unequally positioned individuals in increasingly interconnected populations; a critical epistemology of emerging infectious diseases asks what features of disease emergence are obscured by dominant analytic frameworks. Research questions stemming from such a reexamination of disease emergence would demand close collaboration between basic scientists, clinicians, and the social scientists and epidemiologists who adopt such perspectives.

Farmer P (1998)
Infections and inequalities: The modern plagues
Berkeley, University of California Press

> Paul Farmer has battled AIDS in rural Haiti and deadly strains of drug-resistant tuberculosis in the slums of Peru. A physician-anthropologist with more than fifteen years in the field, Farmer writes from the front lines of the war against these modern plagues and shows why, even more than those of history, they target the poor. This "peculiarly modern inequality" that permeates AIDS, TB, malaria, and typhoid in the modern world, and that feeds emerging (or re-emerging) infectious diseases such as Ebola and cholera, is laid bare in Farmer's harrowing stories of sickness and suffering. Challenging the accepted methodologies of epidemiology and international health, he points out that most current explanatory strategies, from "cost-effectiveness" to patient "noncompliance," inevitably lead to blaming the victims. In reality, larger forces, global as well as local, determine why some people are sick and others are shielded from risk.

Farmer P (2003)
Pathologies of power: Health, human rights and the new war on the poor
Berkeley, University of California Press

GHW (2005)
Global Health Watch 2005-2006
Global Health Watch

> Today's global health crisis reflects widening inequalities within and between countries. As the rich get rich and the poor get poorer, advances in science and technology are securing better and longer lives for a small fraction of the world's population. Meanwhile children die of diarrhoea for want of clean water, people with AIDS die for want of affordable medicines, and people in all regions are increasingly cut off from the political, social and economic tools they can use to create their own health and well-being. Global Health Watch 2005-2006 is a collaboration of public health experts, non-governmental organizations, community groups, health workers and academics. It presents a hard-hitting assessment of inequalities in health and health care - and is aimed at challenging the major institutions, such as the World Health Organization, that influence health.

Gilbert T and Gilbert L (2002)
Globalisation and local power: Influences on health matters in South Africa
Social Science and Medicine 54: 114-127

Graham H (ed) (2000)
Understanding health inequalities
Buckingham, Open University Press

Gruskin S and Tarantola D (2006)
Health and human rights
In: Detels R, McEwen J and Beaglehole R (eds), The Oxford textbook of public health. New York, Oxford University Press. 4th Edition

Kawachi I and Kennedy BP (2002)
The health of nations: Why inequality is harmful to your health
New York, New Press

Kim JY, Millen JV, Irwin A and Gershman J (eds) (2000)
Dying for growth: Global inequality and the health of the poor
Monroe, ME, Common Courage Press

> This collection of fourteen case studies from all over the world examines the root causes and effects of a global economic system that consigns a fifth of the world's population to abject poverty and offers more equitable alternatives.

Krieger N and Birn AE (1998)
A vision of social justice as the foundation of public health: commemorating 150 years of the Spirit of 1848
American Journal of Public Health 88(1603-1606)

Krieger N, Rowley D, Herman A, Avery B and Phillips M (1993)
Racism, sexism, and social class: implications for studies of health, disease, and wellbeing
American Journal of Preventative Medicine 9(Supplment 6): 82-122

Mechanic D (2002)
Disadvantage, inequality, and social policy
Health Affairs 21(2): 48-59

> Eliminating disparities in health is a primary goal of the federal government and many states. Our overarching objective should be to improve population health for all groups to the maximum extent. Ironically, enhancing population health and even the health of the disadvantaged can conflict with efforts to reduce disparities. This paper presents data showing that interventions that offer some of the largest possible gains for the disadvantaged may also increase disparities, and it examines policies that offer the potential to decrease disparities while improving population health. Enhancement of educational attainment and access to health services and income support for those in greatest need appear to be particularly important pathways to improved population health.

Spiegel JM (2004)
Lessons from the margins of globalization: Appreciating the Cuban health paradox
Journal of Public Health Policy 25(1):85-110

Spiegel JM, Labonte R and Ostry, AS (2004)
Understanding 'globalization' as a determinant of health determinants: A critical perspective
International Journal of Occupational and Environmental Health 10(4): 360-367

Starfield B (2000)
Equity in health
Canadian Medical Association Journal 162(3): 346

UNDP (2000)
Human development report 2000: Human rights and human development
New York, Oxford University Press

Walls P and Williams R (2004)
Accounting for Irish Catholic ill health in Scotland: a qualitative exploration of some links between 'religion', class and health
Sociology of Health and Illness 26(5): 527

Wilkinson R (1996)
Unhealthy societies: The afflictions of inequalities
London and New York, Routledge

3.5 Health systems

- *This section particularly corresponds to and is enhanced by material in section 4.1*
- *See Section 4.9 for references to material on "trust" in health systems*

Abdool Karim SS, Ziqubu-Page TT, Arendse R (1994)
Bridging the gap: Potential for a health care partnership between African traditional healers and biomedical personnel in South Africa
Supplement, South African Medical Journal 84: 1-16

Almquist K (1997)
Religion and politics in Sudan: A humanitarian agency's perspective
U.S. Institute of Peace Conference, Washington

ARHAP (2006)
Appreciating Assets: The Contribution of Religion to Universal Access in Africa, Cape Town, Report for the World Health Organization, (ARHAP) African Religious Health Assets Programme

Asante RKO (1998)
Sustainability of church hospitals in developing countries: A search for criteria for success
Geneva, (WCC) World Council of Churches

In the health field, health-care institutions and programmes are increasingly coming under pressure to achieve sustainability. This book presents the findings of a meta-analysis of studies of 43 hospitals in 11 countries of Africa and Asia, and so doing sought to investigate how church health care institutions were faring, what coping and adaptation mechanisms they were adopting, and what was being done to ensure their sustainability.

Ausherman C (1998)
Religious health networks survey report
Los Altos, CA, David and Lucille Packard Foundation

Preliminary assessment of religious health institutions and networks in sub-Saharan Africa

Baer F C (1998)
The role of church groups in managing health districts
Forum, (CCIH) Christian Connections in International Health (November)

Baer FC (2001)
IMA signs $25 Million Contract for SANRU III
Forum, (CCIH) Christian Connections in International Health (May)

Baer F and Kintaudi L (2005)
The DR Congo experience in health system development and management
CCIH Conference, 2005, (CCIH) Christian Connections for International Health

Baird TL (1999)
Christian hospitals in Nigeria provide post abortion care and STD management
CCIH Forum (March)

Bateman C (2003)
Health care workers cracking under HIV/AIDS workload
South African Medical Journal 93:734-736

Belshaw D, Calderisi R and Sugden C (2001)
Faith in development: Partnership between the World Bank and the churches of Africa
Washington, DC, World Bank and Regnum Books International

Benatar SR (2004)
Health care reform and the crisis of HIV and AIDS in South Africa
The New England Journal of Medicine 351(1):81-93

Benn C (2001)
Concepts for church related health care in the 21st century
In: Neglected dimensions in health and healing: Concepts and explorations in an ecumenical perspective,
Tübingen, (DIFAEM) German Institute for Medical Mission. Study Document No 3: 59-73

> In many countries all over the world churches and faith based institutions are running hospitals and health care programs. Traditionally it was their mission to serve particularly the poor and those who had not sufficient access to other services. But increasingly this mission is jeopardized by financial pressures and other constraints. This article looks at the most important concepts in international health that were developed over the last decades such as primary health care and its current relevance for church related health services. Different models for health care financing are introduced. However, it is claimed that the maintenance of institutions cannot and should not be the most important goal for Christians. Rather they should renew their vision and look for the best ways how people can attain their full potential and highest possible level of health given the limitations of the current world economic order. This level can be achieved but only if Christians and non-Christians alike will practice global solidarity and recognize the implications of the universal human right to health.

Benn C (2002)
The future role of church related hospitals and health services in developing countries
Tübingen, (DIFAEM) German Institute for Medical Mission

Benn C (2002)
The influence of cultural and religious frameworks on the future course of the HIV/AIDS pandemic
Journal of Theology for Southern Africa 113 (July): 3-18

> A factor that has not received sufficient attention is culture and the philosophical framework or paradigms determining our understanding of diseases, their causes and appropriate methods for prevention. All people are influenced to some degree by at least three different paradigms: the scientific, the religious and the traditional one. All of them provide different interpretations of HIV/AIDS, its origin and the most appropriate methods to overcome it.

Benn C (2003)
Why religious health assets matter
ARHAP: Assets and Agency Colloquium. Pietermaritzburg, South Africa, August 2003, (ARHAP) African Religious Health Assets Programme

Bitran R (1995)
Efficiency and quality in the public and private sectors in Senegal
Health Policy and Planning 10 (3):271-283

Breger M (et al) (2001)
In good faith: A dialogue on government funding of faith-based social services
Philadelphia, Temple University

Chaves M (2002)
Religious organizations: Data resources and research opportunities
American Behavioural Scientist 45: 1523-1549

Cnaan RA (2002)
The invisible caring hand: American congregations and the provision of welfare
New York, New York University Press

Cnaan RA, Wineburg RJ and Boddie SC (1999)
The newer deal. Social work and religion in partnership
New York, Columbia University Press

Crespo R (2005)
The future of Christian hospitals in developing countries: The call for a new paradigm of ministry
McLean, VA, (CCIH) Christian Connections for International Health

Dejong J (1991)
Non-governmental organization and health delivery in Sub-Saharan Africa
Working Paper 708, Washington DC, World Bank

DFID (2006)
Faith in development position paper
London, UK, (DFID) Department for International Development

DIFAEM (2002)
The future role of church related hospitals and health services in developing countries
Report about an international consultation, Tubingen, (DIFAEM) German Institute for Medical Mission

DIFAEM (2005)
Global assessment of faith-based organisations' access to resources for HIV and AIDS response
(DIFAEM) German Institute for Medical Mission

DOH (2003)
Traditional health practitioners' bill
(DOH) Department of Health, (SAGOV) Government of South Africa

Flessa S (1997)
Costing of health services of the Evangelical Lutheran Church in Tanzania: Methodology and results
Working Paper, Arusha

Flessa S (1998)
The costs of hospital services: A case study of evangelical Lutheran church hospitals in Tanzania
Health Policy and Planning 13(4): 397-407

Gelfand M (1988)
Godley medicine in Zimbabwe
Zimbabwe, Mambo Press

Good CM (1991)
Pioneer medical missions in colonial Africa
Social Science and Medicine 32(1): 1-10

Green A, Shaw J, Dimmock F and Conn C (2002)
A shared mission? Changing relationships between government and church health services in Africa
International Journal of Health Planning and Management 17: 333-353

This article reviews the relationships between government and church health providers within sub-Saharan Africa with a particular focus on East and Southern Africa. This is of particular interest at this time, given the changing configuration of the health sector in many countries as a result of health sector reform policies. The article provides a historical overview of the development and emerging role of the church health services within this changing environment. The factors affecting the relationship between the government and church sector are identified. These include differences in objectives, types of service provided, and the organizational culture and management styles. The paper then explores key issues seen to affect the future pattern of relationships including the changing scene, and identifies different models for relationships and implications for key actors including the Ministry of Health, church health agencies and coordinating bodies. The article concludes that church health services will continue to play a key role in health care in sub-Saharan Africa; however, there are challenges facing them and both parties need to develop a response to these.

Hackney TS (unknown)
The invisible giant: The Christian health system
Atlanta, Emory University

Hearn J (2002)
The 'invisible' NGO: US evangelical missions in Kenya
Journal of Religion in Africa 32: 32-60

Hecht RM and Tanzi VL (1993)
The role of non-governmental organizations in the delivery of health services in developing countries
Background paper prepared for the World Development Report. Washington DC, World Bank

Hogerzeil HV and Lamberts PJN (1984)
Supply of essential drugs for church hospitals in Ghana
Tropical Doctor 14: 9-13

Iversen P B (1999)
Collaboration between NGO's, ministry of health and WHO in drug distribution and supply
Geneva, (WHO) World Health Organization

Kawasaki E (2001)
The drug supply system of missionary organizations in developing countries: Evaluation and analysis of the efficiency and capacity of systems
Department of International Health, Boston University School of Public Health

Low accessibility to essential drugs is a growing concern in many developing countries. High technology and expensive new medications create further financial strain in public health care. While governments' difficulty has been addressed by many researchers, efficient management of missionary organizations and their large contribution in the health field are discussed in only a few papers. However, there are a few detailed studies regarding management of missionary organizations' drug supply systems.

Kiser M and Michael H (1999)
Engaging faith communities as partners in improving community health
Atlanta, GA, United States Centers for Disease Control and Prevention, and The Carter Center.

Kintaudi L, Derstine P and Baer F (2004)
Faith-based co-management of health zones and umbrella projects in DR Congo
APHA presentation, (APHA) American Public Health Association

Lee C, Brewster-Lee D, Devine B, Bingham G (2003)
Global fund responsiveness to faith-based organizations
Virginia, (CCIH) Christian Connections for International Health and Ecumenical Pharmaceutical Network Report

Liebowitz J (2002)
The Impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa
(HEARD) Health Economics and HIV/AIDS Research Division, University of Kwa-Zulu-Natal

Logez S and Everard M (2004)
Multi-country study on drug supply and distribution activities of faith-based supply organizations in sub-Saharan African countries, 2003
EPN/WHO Feedback meeting: Promoting use of effective medicines supply strategies in Africa. Nairobi, Kenya

Martin R (1999)
The future of Christian hospitals in developing countries: The call for a new paradigm of ministry
APHA Meeting, (APHA) Americal Public Health Association

McFarland DA and Cochrane JR (2006)
Aligning religious health assets to strengthen public health systems in Africa
Ethics and Africa Conference, Conference Proceedings, May 29-31, 2006, University of Cape Town, forthcoming

McKnight JL (1999)
Two tools for well-being: Health systems and communities
In: Minkler M (ed), Organizing and community building for health. New Brunswick, Rutgers University Press: 20-29

Moore G D (1982)
Health system: Essential drugs for Kenya's rural population
World Health Forum 3(2):196-199

Munene JAW (2003)
A situational analysis of the church's responses to HIV/AIDS
(PACANet) Christian HIV/AIDS Country Coordinating Mechanisms in Zambia, Swaziland, Uganda and Namibia

Nolan TD (2005)
Perceptions and portrayals of faith-based organizations in education in emergencies: A case study from Sri Lanka
In: Burde D (ed), Education in emergencies and post-conflict situations: Problems, responses and possibilities. New York, Society for International Education Teachers College, Columbia University

Nussbaum S (ed) (2005)
The contribution of Christian congregations to the battle with HIV and AIDS at the community level
Oxford, Global Mapping International for Oxford Centre for Mission Studies

Ogoh-Alubo S (1990)
Debt crisis, health and health services in Africa
Social Science and Medicine 31(6): 639-648

PACANet (2002)
Keeping the promise? African churches speak!
PACANet response to the UN General Assembly Special Session on HIV/AIDS Review of the 2001 Declaration of Commitments

Parry S (2002)
Responses of the churches to HIV/AIDS: Three Southern African Countries
Harare and Geneva, (WCC) World Council of Churches, Ecumenical HIV/AIDS Initiative in Africa, Southern Africa Regional Office

PEPFAR (2004)
The president's emergency plan for AIDS relief: US five-year global HIV/AIDS strategy
Washington, USA, (PEPFAR) The President's Emergency Plan for AIDS Relief

PEPFAR (2005)
The president's emergency plan for AIDS relief: community and faith-based organisations
Washington, USA, (PEPFAR) The President's Emergency Plan for AIDS Relief

Petersen I and Swartz L (2002)
Primary health care in the era of HIV/AIDS. Some implications for health systems reform
Social Science and Medicine 55(6): 1005-1013

The current emphasis on third generation reforms to health systems places at risk the empowering comprehensive agenda of second generation reforms. Using the HIV/AIDS epidemic in South Africa as an exemplar, the authors demonstrate the importance of retaining this agenda. They suggest that the emphasis on 'packaged' priority programmes with measurable outcomes, which characterizes third generation reforms, needs to be accompanied by the reorientation of primary health care providers towards an empowering comprehensive approach to care. In addition, using psychodynamic principles, they also show how certain aspects of the health care system need restructuring to provide containment and support for such care.

Reinikka R and Svensson J (2003)
Working for God? Evaluating service delivery of religious not-for-profit health care providers in Uganda
Wahington, DC, World Bank

Republic of Uganda (2001)
Facility-based private not-for-profit health providers: A quantitative survey
Kampala, Ministry of Health in collaboration with Uganda Catholic, Muslim, and Protestant Medical Bureaux, National Health Consumers Organization and Tropical Business Research.

Republic of Uganda (2001)
Policy for partnership with facility-based private not-for-profit health providers
Kampala, Ministry of Health.

Richter M (2003)
Traditional medicines and traditional healers in South Africa
(TAC) Treatment Action Campaign and Aids Law project

Robinson M and White G (1998)
The role of civic organisations in the provision of social services: Towards synergy
In: Mwabu G, Ugaz C and White G (eds), New patterns of social provision in low income countries. Oxford, Oxford University Press and UNI.WIDER

Rode H (2005)
Capacity building at Mulanje mission hospital
PraxisNote 11, Oxford, (INTRAC) The International NGO Training and Research Centre

Rose-Ackerman S (1996)
Altruism, nonprofits, and economic theory
Journal of Economic Literature 34: 701-28

Schmid B, Cochrane JR, Wanamaker CA, Khalfe H and Holness L (1999)
Health services provided by religious communities
South African Health Review: 121-130

Swilling M and Russell B (2002)
The size and scope of the non-profit sector in South Africa
Durban, Centre for Civil Society

Taylor N (2006)
Working together? Challenges and opportunities for international development agencies and the church in the response to AIDS in Africa
HIV and AIDS Briefing Paper 7, Teddington, UK, Tearfund

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. While there are some exemplary responses in which thousands of volunteers provide care for those affected by HIV and AIDS, at the same time, Tearfund is deeply concerned at the positions found within some parts of the church on critical issues such as gender, stigma and the use of condoms. Given the role and extent of the church in Africa and the interest of international development agencies in working with faith groups, Tearfund commissioned this report to better understand how international development agencies and the church can work together more effectively in the response to AIDS.

Tearfund (2006)
Faith untapped: Why churches can play a crucial role in tackling HIV and AIDS in Africa
Teddington, UK, Tearfund

Thomas S (2004)
Building communities of character: Foreign aid policy and faith-based organizations
SAIS Review 24(2): 133-148

Turshen M (1999)
Privatizing health services in Africa
New Brunswick: Rutgers University Press

UNICEF (2004)
Sharing common goals
Faith-Based Organizations and Children, (UNICEF) United Nations Children's Fund,
http://www.unicef.org/media_4537.html, Accessed June 2004

USAID (2004)
USAID's work with faith and community-based organizations
(USAID) United States Agency for International Development,
http://www.usaid.gov/our_work/global_health/aids?TechAreas/community/fbocbofactsheet.html, Accessed December 2004

Vogel RJ and Stephens B (1989)
Availability of pharmaceuticals in sub-Saharan Africa: Role of the public, private and church mission sectors
Social Science and Medicine 29(4):479-486

Walkup RB (2000)
Faith in the field: Faith-based organizations in the developing world
Virginia, (CCIH) Christian Connections for International Health

WHO (2004)
Changing history
World Organization Report, Geneva, (WHO) World Health Organization

Woldehanna S, Ringheim K, Murphy C, Keikelame MJ, Gibson J, Odyniec G, Clerisme C, Uttekar BP, Nyamongo IK, Savosnick P, Im-Em W, Tanga EO, Atuyambe L and Perry T (2005)
Faith in action: Examining the role of faith-based organizations in addressing HIV/AIDS
A multi country key informant survey, Washington, DC, (GHC) Global Health Council

3.6 Health policy

Bauman Z (1998)
Globalization: The human consequences
Cambridge, Polity Press

Brettell C (2000)
Theorizing migration in anthropology: The social construction of networks, identities, communities, and globalscapes
In: Brettell C and Hollifield JF (eds), Migration theory: talking across disciplines. London and New York, Routledge: 97-135

Brettell C and Hollifield JF (eds) (2000)
Migration theory: Talking across disciplines
New York, Routledge

Casanova J (1994)
Public religions in the modern world
Chicago, University of Chicago Press

Cochrane JR (2003)
Religion in the health of migrant communities: Cultural assets or medical deficits?
International Conference on Health and Migration, Oxford University, Queens University, University of Cape Town

Everett WJ (1999)
Religion in democratic transition
Journal of Theology for Southern Africa 104: 64-68

Flessa S (1998)
The costs of hospital services: A case study of evangelical Lutheran church hospitals in Tanzania
Health Policy and Planning 13(4): 397-407

Jeeves A (2003)
Migration, health, and poverty: South Africa's Department of Public Health and the beginnings of community-oriented primary care
Conference on Migration and Health, UCT

Kearney M (1999)
Borders and boundaries of state and self at the end of empire
In: Vertovec S and Cohen R (eds), Migration, diasporas and transnationalism. Cheltenham, U.K., Edward Elgar Publishing. 9: 539-561

Lurie M (2000)
Migration and AIDS in Southern Africa: A review
South African Journal of Science 96

Schiller NG, Basch L and Blanc-Szanton C (1999)
Transnationalism: A new analytic framework for understanding migration
In: Vertovec S and Cohen R (eds), Migration, diasporas and transnationalism. Cheltenham, U.K., Edward Elgar Publishing. 9: 26-49

Scott JC (1999)
Seeing like a state: How certain schemes to improve the human condition have failed
New Haven, Yale University Press

Smidt C (ed) (2003)
Religion as social capital: Producing the common good
Baylor University Press

Vertovec S and Cohen R (eds) (1999)
Migration, diasporas and transnationalism
The International Library of Studies on Migration. Cheltenham, U.K., Edward Elgar Publishing

Chapter 4 Interventions and responses to HIV/AIDS and other health crises

4.1 Assessing, mapping and evaluating religious entities

- *See section 3.5 for more general material on religious presence in health systems*

Agadjanian V (2005)
Gender, religious involvement, and HIV/AIDS prevention in Mozambique
Social Science and Medicine 61(7): 1529-1539

ARHAP (2006)
Appreciating Assets: The Contribution of Religion to Universal Access in Africa, Cape Town, Report for the World Health Organization, (ARHAP) African Religious Health Assets Programme

> The study, 'Appreciating Assets' documents the contribution made by religion and religious entities to the struggle for health and wellbeing in Zambia and Lesotho, in a context dominated by poverty, stressed public health systems and the HIV/AIDS pandemic. By mapping and understanding these Religious Health Assets (RHAs), the study calls for a greater appreciation of the potential they have for the struggle against HIV/AIDS and for universal access and offers recommendations for action by both public health and religious leaders at all levels. Through respectful engagement, these assets, rooted in the community and already appreciating, have the potential to increase in strength and value and become more effective in the long-term sustainability, recovery and resilience of individuals, families and communities.

ARHAP (2006)
Executive summary: Appreciating Assets
Journal of Theology for Southern Africa 126(November)

Balm in Gilead (2005)
Preliminary needs assessment report on the involvement and participation of religious leaders in HIV prevention, education and care
The Balm in Gilead

Barton T, Thamae S and Ntoanyane M (1997)
AIDS in Lesotho: A community-based response: A summary evaluation of the CHAL-DCA AIDS Project
Maseru, Lesotho, Christian Health Association of Lesotho and DanChurchAid

Birdsall K (2005)
Faith-based responses to HIV/AIDS in South Africa: An analysis of the activities of faith-based organisations (FBOs) in the national HIV/AIDS database
Johannesburg, South Africa, (CADRE) Centre for AIDS Development, Research and Evaluation

> HIV/AIDS strategies in South Africa have generally emphasized the role of the formal health system led by national and provincial governments in providing support to areas such as condom distribution, the treatment of sexually transmitted infections (STIs), voluntary counselling and testing (VCT), prevention of mother-to-child transmission (PMTCT), treatment of opportunistic infections and, more recently, the provision of antiretroviral drugs (ARVs). Less attention has been paid to documenting and analysing the many and diverse activities conducted by non-governmental organisations, community-based organizations and other institutions, including faith-based organisations, at community level. These organisations provide a range of HIV/AIDS-related services across the continuum of prevention, care and support, treatment and rights. Much however 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. This report presents selected findings from an analysis of the National AIDS Database with a view to better understanding HIV/AIDS response in South Africa, including the growth of the non-governmental sector, organisational capacities, absorptive capacities for funding, service areas, duplication and gaps, collaboration and reach.

Birdsall K and Kelly K (2005)
Community responses to HIV/AIDS in South Africa: Findings from a multi-country survey
Johannesburg, South Africa, (CADRE) Centre for AIDS Development, Research and Evaluation

Bura M (1999)
Community health funds and managed health care - a practical guide for provider-based health funds for communities in developing countries
Arusha, (ELCT) Evangelical Lutheran Church in Tanzania

Burket MK (2006)
Advancing reproductive health and family planning through religious leaders and faith-based organizations
Washington, Pathfinder International

Byamugisha G, Steinitz LY, Williams G and Zondi P (2002)
Journeys of faith: Church-based responses to HIV and AIDS in three southern African countries
Pietermaritzburg, Cluster Publications

CBAM (2004)
Speak out on HIV and AIDS: Our prayer is always full of hope
Nairobi, Paulines Publications Africa

CDC (2002)
Faith-based responses to HIV/AIDS in South Africa: Summary of findings
(ASR) Africa Strategic Research Corporation, (CDC) Centres for Disease Control

Church of England (2004)
Telling the story: Being positive about HIV/AIDS
London, UK, Mission and Public Affairs Council, Church of England

Church of Nigeria (2004)
National HIV/AIDS 4 year strategic plan 2004-2008
Church of Nigeria (Anglican Communion)

Clifford P (2001)
One body: Your church and HIV/AIDS in sub-Saharan Africa
London, Christian Aid

Cole J (2006)
Building bridges of hope: An evaluation of the Anglican Church of Southern Africa's response to the HIV and AIDS pandemic - the Isiseko Sokomoleza (Building the Foundation) Programme: 2003-2006
South Africa, Anglican Church of Southern Africa HIV & AIDS Office

CPSA (2002)
From Boksburg to Canterbury: Steps to putting HIV/AIDS on the Anglican map
(CPSA) Church of the Province of Southern Africa HIV/AIDS Ministries

CPSA (2002)
HIV/AIDS ministries strategic planning process report: Strategic plan 2003-2006
(CPSA) Church of the Province of Southern Africa

Cucuzza L and Moch L (2003)
Faith community responses to HIV/AIDS: Integrating reproductive health and HIV/AIDS for non-governmental organizations, faith-based organizations and community-based organizations
Washington, (CEDPA) Centre for Development and Population Activities, and ENABLE Project

Dawad S (2005)
Policy brief: Faith-based organisations and HIV/AIDS in Uganda and Kwa-Zulu Natal (South Africa)
Durban, South Africa, (HEARD) Heath Economics and HIV/AIDS Research Division, University of Kwa-Zulu Natal

DeHaven M, Hunter IB, Wilder L, Walton JW, Berry J (2004)
Health programs in faith-based organizations: Are they effective?
American Journal of Public Health 94(6):1030-1036

De Waal M and Nakedi O (2005)
Turning of the tide: A qualitative study of SACBC funded antiretroviral treatment programmes
(SACBC) South African Catholics Bishops Conference and The University of Pretoria

DIFAEM (2005)
Global assessment of faith-based organisations' access to resources for HIV and AIDS response
(DIFAEM) German Institute for Medical Mission

> FBOs are providing a huge share of the services in response to the HIV and AIDS pandemic. Faith-based organisations, rooted in local structures, have been and continue to be in an excellent position to mobilize communities to respond to the HIV and AIDS crisis. In many countries - particularly in sub-Saharan Africa - religious institutions provide the majority of health and education services. Yet despite substantial efforts and good will by all, churches and other faith-based organisations have not yet been consistently successful in accessing resources for their response to HIV and AIDS from international funding agencies. To help assess the current situation, a survey was undertaken among FBOS.

Dortzbach D (1998)
AIDS in Kenya: The Church's challenge and the lessons learned
Nairobi, MAP International

Dumezweni B (2005)
Enhancing the agency of families affected by AIDS: strategies for the church at Illinge, Queenstown
Department of Religion and Development. Pietermaritzburg, University of KwaZulu Natal. MTh

ESID (2004)
For goodness sake! Asia-Pacific faith-based organizations battle HIV/AIDS
In: ESID (ed), HIV/AIDS prevention, care and support: Stories from the community, (ESID) Emerging Social Issues Division, (UNESCAP) United Nations Economic and Social Commission for Asia and the Pacific

Farrell M (2003)
Condoms and AIDS prevention: A comparison of three faith-based organizations in Uganda
AIDS and Anthropology Bulletin 15(3)

FHI (2000)
HIV/AIDS prevention, care and support across faith-based communities. An annotated bibliography of resources
(FHI) Family Health International and USAID

FHI (2002)
A collection of resources for faith based organisations working on HIV/AIDS
(FHI) Family Health International

> The purpose of this bibliography is to describe and review resources that have proven useful to faith-based organizations addressing the HIV crisis in Africa. The authors state that there are two criteria for selection of materials reviewed here. The first is that they promote dignity and respect for people living with HIV. The second is that they provide correct HIV information. However, the materials have a wide range of perspectives about how to conduct HIV prevention and care, the spiritual basis for HIV activities, and the role of faith-based organizations in addressing HIV/AIDS.

Foster G (2003)
Study of the response by faith-based organizations to orphans and vulnerable children: Preliminary summary report
(WCRP) World Conference of Religions for Peace and (UNICEF) United Nations Children Fund

Futures Group (2005)
An advocacy resource book for HIV and AIDS in Zambia
Bath, UK, Futures Group

Gaie J, Jensen K, Lefa M, Nkomazana F and Sebina L (2005)
Preliminary report: faith-based HIV prevention initiatives in Botswana
Gabarone, Botswana, Tumelo Project, Department of Theology and Religious Studies, University of Botswana

> Our research seeks to better understand what we mean by 'faith' - or "tumelo" in Setswana - in Botswana, across denominational lines, and what our faith demands of us in terms of personal actions and public activism. More specifically, our attention is focused on the involvement of communities of faith in HIV prevention. In this preliminary report of two participatory research workshops with leaders of faith communities in Selebi-Phikwe and Francistown, the second and third hardest hit health districts in Botswana.

Gennrich D and Gill A (2004)
Churches and HIV/AIDS: Exploring how local churches are integrating HIV/AIDS in the life and ministries of the church and how those most directly affected experience these
(PACSA) Pietermaritzburg Agency for Christian Social Awareness.

This is a good localised study on how local churches have integrated HIV/AIDS programs and interventions into their religious practice.

Goodrich DB (1996)
Christians respond to HIV/AIDS across the world
Gaborone, Botswana

Grandia-Feddema M and Samuel NM (2000)
Break the silence! Christian response to the HIV/AIDS pandemic
Amsterdam, The Netherlands, (ICAN) International Christian AIDS Network

Green EC (2000)
Calling on the religious community: Faith-based initiatives to help combat the HIV/AIDS pandemic
Global AIDSLINK 58: 4-5

Green EC (2003)
The AIDS crisis in developing countries
Westport, CT, Praeger Publishers

Green EC (2003)
Faith-based organizations: Contributions to HIV prevention
Washington DC, (USAID) US Agency for International Development and The Synergy Project, TvT Associates, Harvard Center for Population and Development Studies

This report provides examples of faith-based organizations that are making a difference in afflicted communities. Green argues that FBOs are uniquely positioned to educate communities about HIV/AIDS and to provide care and support to those affected by the epidemic. He found that a large proportion of the care and support provided to victims of HIV/AIDS is in fact provided by FBOs. However, he suggests that FBOs should be allowed to educate communities about HIV/AIDS and its spread in terms of their religious teachings. This, according to Green, is based on a study undertaken in Uganda which suggested that FBOs have played a major role in mitigating the effects of the epidemic in that country.

Green EC (2003)
The impact of religious health organizations in promoting HIV/AIDS prevention
In: Green EC (ed), The AIDS crisis in developing countries. Westport, CT, Praeger Publishers

HAI (2000)
Inventory of HIV and AIDS programs in Sub-Saharan Africa
Africa Now! A Leadership Summit to Define African Priorities for AIDS. Cambridge, MA USA, (HAI) Harvard AIDS Institute

Hendriks HJ, Erasmus JC and Mans GG (2004)
Congregations as providers of social service and HIV/AIDS care
NGTT Supplement 45(2):380-402

IHP (2003)
Role and involvement of faith-based organizations in HIV/AIDS pandemic: Brief summary: Inventory of the Catholic Church's response to HIV/AIDS in Kenya
(ICASA) International Conference in HIV/AIDS and STDs in Africa. Kenya, (IHP) Emory Interfaith Health Program

IMAU (1998)
AIDS education through Imams: A spiritually motivated community effort in Uganda,
Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS and (IMAU) Islamic Medical Association of Uganda

IMAU (2001)
Proceedings of the 1st International Muslim leaders consultation on HIV/AIDS
Kampala, Uganda, (IMAU) The Islamic Medical Association of Uganda

Johnson BR, Tompkins RB, Webb D (2002)
Objective hope - Assessing the effectiveness of faith-based organizations: A review of the literature
Philadelphia, Centre for Research on Religion and Urban Civil Society

Josephine SK, Agapit AY and Tatagan-Agbi K (2001)
Churches and the HIV/AIDS pandemic: Analysis of the situation in ten West African countries
(WCC) World Council of Churches, World Alliance of YMCAs

Judge M and Schaay N (2001)
Planning our response to HIV/AIDS: A step by step guide to HIV/AIDS planning for the Anglican communion
Washington, Cape Town, Policy Project and (CAPA) Council of Anglican Provinces of Africa

Kagee A, Toefy Y, Simbayi L and Kalichman S (2005)
The prevalence of HIV in three predominantly Muslim residential areas in the Cape Town metropole
South African Medical Journal 95(7): 512-516

Kagimu M (2003)
Faith-based community mobilisation and education for antiretroviral therapy in Uganda
Sexual Health Exchange 3:1-3

Krakauer M (2004)
Churches responses' to AIDS in two communities in Kwa-Zulu Natal
Development Studies. Oxford, UK, Oxford University. Master of Philosophy

Kubler-Ross E (1987)
AIDS: The ultimate challenge
New York, Macmillan

Liebowitz J (2002)
The Impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa
(HEARD) Health Economics and HIV/AIDS Research Division, University of Kwa-Zulu-Natal

Liebowitz J (2003)
Faith-based organizations and HIV/AIDS in Uganda and KwaZulu-Natal
(HEARD) Health Economics and HIV/AIDS Research Division, University of Kwa-Zulu-Natal

This research points to a correlation between involvement of FBOs and success in HIV/AIDS prevention and mitigation, but it does not get into greater depth on how FBOs promote behaviour change for prevention or carry out care and support in a way that mitigates the epidemic's worst impact. Through community level studies the author begins to disaggregate further exactly how FBOs work in the complex area of HIV/AIDS prevention and mitigation. This community perspective can help answer a number of largely unanswered questions that are essential for designing effective strategies. To answer these questions, the research is focussed on two areas with significantly different experiences in HIV/AIDS prevention and mitigation: Uganda and KwaZulu Natal.

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The churches confronted with the problem of HIV/AIDS: Analysis of the situation in five countries of central Africa
(WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa

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Kampala, USAID/Uganda

Makau N, Makau P and Niemeyer LL (1996)
The response of Kenya churches to the AIDS epidemic and their perceived barriers to behaviour change
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Marazzi M, Guidotti G, Liotta G and Palombi L (2005)
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Geneva, Switzerland, (WHO) World Health Organization

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Faith-based HIV prevention interventions: A technical assistance guide for working with communities of faith
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Grace and Truth, A Journal of Catholic reflection, Hilton, South Africa, St Joseph's Theological Institute

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Belated, but powerful: The response of the Catholic Church to HIV/AIDS in five southern African countries
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Pretoria, South Africa, (SACBC) Southern African Catholic Bishops' Conference

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The contribution of Christian congregations to the battle with HIV and AIDS at the community level
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The role of faith-based organisations in the fight against HIV and AIDS
MAP International

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Keeping the promise? African churches speak!
PACANet response to the UN General Assembly Special Session on HIV/AIDS Review of the 2001 Declaration of Commitments

Parry S (2002)
Responses of the churches to HIV/AIDS: Three Southern African Countries
Harare and Geneva, (WCC) World Council of Churches, Ecumenical HIV/AIDS Initiative in Africa, Southern Africa Regional Office

> In the era of HIV/AIDS, FBOs have been the recipients of many accusations…while (the author) does not deny that, in too many instances, these accusations have tragically and regrettably been justified, it has not been always and everywhere. Whilst the moral debate - particularly around the condom issue - has raged in many circles, stalemating action and in many eyes discrediting the Churches' commitment to tackling AIDS and saving lives, congregations and parishes have themselves been in the forefront of care and support right across Africa. A great number of these initiatives did not wait for funding in order to begin, they just responded. Their courage and determination in the face of so many obstacles is a humbling challenge and is a reflection of deep compassion in a real world of suffering. This report is based on a review of the contributions of FBOs to the continuum of care of HIV/AIDS infected and affected people in 53 countries in Africa.

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Responses of the faith-based organisations to HIV/AIDS in sub-Saharan Africa,
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Faith in action: A united response to HIV/AIDS (A report on the national indaba)
Washington, Cape Town, Policy Project and (SADOH) South African National Department of Health

Policy-Project (2003)
Strengthening faith-based resources, a factsheet
Washington, DC, Policy Project

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Faith-based organizations in HIV/AIDS prevention strategies
San Francisco, Global AIDS Interfaith Alliance

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Working for God? Evaluating service delivery of religious not-for-profit health care providers in Uganda
Washington DC, World Bank

Russell M and Schneider H (2000)
A rapid appraisal of community based HIV/AIDS care and support programmes in South Africa
Durban, (HST) Health Systems Trust

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(SACBC) South African Catholic Bishops Conference

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Journal of Constructive Theology 7(1): 3-16

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The Churches' response to the HIV/AIDS pandemic: A case study of Christian agencies in the Cape Town area
Religious Studies. Cape Town, University of Cape Town. MSocSci

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Health services provided by religious communities
South African Health Review: 121-130

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Nairobi, Paulines Publications Africa

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Confronting AIDS together: Participatory methods in addressing the HIV/AIDS epidemic, including learning from the WCC experience in east and central Africa
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The Christian Century 117(16)

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Many clouds, little rain? The Global Fund and local faith-based responses to HIV and AIDS
HIV/AIDS Briefing paper 4, Teddington, UK, Tearfund

Taylor N (2005)
The warriors and the faithful: The World Bank MAP and local faith-based initiatives in the fight against HIV and AIDS
HIV/AIDS Briefing Paper 5, Teddington, UK, Tearfund

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Working together? Challenges and opportunities for international development agencies and the church in the response to AIDS in Africa
HIV and AIDS briefing paper 7, Teddington, UK, Tearfund

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Faith untapped: Why churches can play a crucial role in tackling HIV and AIDS in Africa
Teddington, UK, Tearfund

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Response of non-governmental organizations, community-based organizations and communities
In: Kelly K, Parker W and Gelb S (eds), HIV/AIDS, economics and governance in South Africa: Key issues in understanding response. Johannesburg, (CADRE) Centre for AIDS Development, Research and Evaluation and USAID

Tiendrebeogo G (2003)
External review of the church response to AIDS in the eastern province in Cameroon
Report to CORDAID, The Hague, Netherlands

Tiendrebeogo G and Buykx M (2004)
Faith-based organisations and HIV/AIDS prevention and impact mitigation in Africa
Amsterdam, Netherlands, (KIT) Koninklijk Instituut voor de Tropen

> This study reviews principles, processes and practical activities of FBOs in sub-Saharan Africa in the efforts to combat the AIDS pandemic. The paper reviews the actual potential role of FBOs in encouraging culturally-appropriate prevention education, in promoting quality pastoral care, and in fostering compassionate non-judgemental service provision to PLWHA.

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Thomas L, Schmid B, Gwele M, Ngubo R and Cochrane JR (2006)
Let us embrace: The role and significance of an integrated faith-based initiative for HIV and AIDS
Cape Town, (ARHAP) African Religious Health Assets Programme

Trinitapoli J and Regnerus R (2005)
Religious Responses to AIDS in Sub-Saharan Africa: An examination of religious congregations in rural Malawi
American Sociological Association Annual Meeting, Philadelphia, PA

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A measure of success in Uganda
UNAIDS case study, Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

UNICEF (2003)
Strategy for the monitoring and evaluation for the Buddhist leadership initiative
New York, NY, (UNICEF) United Nations Children's Fund

USAID (2003)
Multisectoral responses to HIV/AIDS: A compendium of promising practices from Africa
Washington, DC, (USAID) US Agency for International Development, PVO Steering Committee on Multisectoral Approaches to HIV/AIDS

WCC (1997)
The impact of HIV/AIDS and the churches' response: WCC Central Committee statement
Ecumenical-Review 49: 270-276

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Facing AIDS: The challenge, the churches' response
WCC Study Document, Geneva, (WCC) World Council of Churches

> The challenge of AIDS calls for forthright and faithful response from Christians and the churches. This book covers theological and ethical perspectives, human rights and responsibilities, pastoral care in a healing community, and what the churches can do. It also provides a theological, ethical and human rights approach to HIV/AIDS, as well as a practical outline of what faith organisations can do.

WCC (2001)
Churches and the HIV/AIDS pandemic: Analysis of the situation in 10 West/Central African countries
Geneva, (WCC) World Council of Churches Publications

WCC (2001)
Plan of action: The ecumenical response to HIV/AIDS in Africa
Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS in Africa. Nairobi, Kenya, (WCC) World Council of Churches

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Statement by faith-based organizations facilitated by the World Council of Churches for the UN Special General Assembly on HIV/AIDS June 25-27, 2001
International Review of Mission 90: 473-476

WCC (2002)
Plan of action: Church leaders consultation on the ecumenical response to the challenge of HIV/AIDS
Geneva, (WCC) World Council of Churches

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Reaching out? Donor approaches to faith-based organisations in the response to HIV/AIDS
HIV/AIDS Briefing Paper 1, Teddington, UK, Tearfund

Whyte MA (1996)
Talking about AIDS: The biography of a local AIDS program within the church of Uganda
In: Schenker II, Sabar-Friedman G and Sy F (eds), AIDS education: Interventions in multicultural societies. New York, Plenum Press: 221-238

Woldehanna S, Ringheim K, Murphy C, Keikelame MJ, Gibson J, Odyniec G, Clerisme C, Uttekar BP, Nyamongo IK, Savosnick P, Im-Em W, Tanga EO, Atuyambe L and Perry T (2005)
Faith in action: Examining the role of faith-based organizations in addressing HIV/AIDS
A multi country key informant survey, Washington, DC, (GHC) Global Health Council

> Despite widespread acknowledgement that many FBOs provide services and programming around HIV/AIDS, there are limited analytic assessments of FBO activities. In the interests of better informing the dialogue surrounding FBO involvement, the CMMB commissioned the Global Health Council to conduct an independent analysis of the role of FBOs in addressing the HIV/AIDS pandemic. 200 key informants working in Haiti, India, Kenya, South African Thailand and Uganda were interviewed.

World Bank (2004)
Concept note for HIV/AIDS workshop for faith-based organisations and national AIDS councils, Accra, Ghana, January 12-14, 2004
Washington DC, World Bank

Zambezi RN (2005)
Church-based interventions for HIV/AIDS prevention in Ndola, Zambia
Department of Global Health Rollins School of Public Health, University of Exeter, Emory University. MPH

> Though churches were among the first to pay attention to the devastating spread and impact of the HIV/AIDS pandemic in Zambia, their efforts have to a large extent remained static. They have neither gone to scale nor begun to address with rigor, the greatest concern - the prevention of further infections. However, there is little information to explain what challenges churches face in focusing or expanding their efforts. The aim of this study was to explore church leaders' perceptions and involvement in HIV/AIDS prevention in Ndola which is the headquarters of the Copperbelt Province in Zambia.

ZINGO (2002)
Faith-based organizations (FBO) responses to HIV/AIDS in Livingstone, Lusaka and Kitwe - Zambia
Strategic visioning for a Zambia free of HIV/AIDS, (ZINGO) Zambia Interfaith Networking Group on HIV/AIDS and (NAC) The National AIDS Council of Zambia

> This report sets out to document HIV/AIDS programmes and other responses among FBOs, focussing on activities of congregations in 3 Districts of Zambia: Livingstone, Lusaka and Kitwe. Specific objectives are to identify member organizations in three districts, to document existing responses to HIV/AIDS among these organizations, to create an electronic database, and to make recommendations on ways of strengthening programmes and responses.

4.2 Orphans and vulnerable children

Bethany-Project (2000)
Guidelines to starting a community-based orphan programme
Zvishavane, Zimbabwe, The Bethany Project

Calver V (2000)
AIDS Orphans in Africa: Lessons learned and possible strategies for the local church and World Relief
Nairobi, Kenya, World Relief, HIV/AIDS Team

Christian Aid (2006)
A matter of belonging: How faith-based organizations can strengthen families and communities to support orphans and vulnerable children
London, UK, Christian Aid and UNICEF

CRS and USAID (2003)
Report on the mid-term review of the STRIVE project
Zimbabwe, Catholic Relief Services and USAID

Dube MW (2002)
Fighting with God: Children and HIV/AIDS in Botswana
Journal of Theology for Southern Africa 114: 31-42

FHI (2001)
Care for orphans, children affected by HIV/AIDS and other vulnerable children: A strategic framework
Arlington, Virginia, (FHI) Family Health International, The IMPACT Project

Foster G (2003)
Africa's orphaned generations
New York, NY, (UNICEF) United Nations Children's Fund and (WCRP) World Conference of Religions for Peace

Foster G (2003)
The magnitude of faith-based responses to orphans in sub-Saharan Africa
Sexual Health Exchange 1

Foster G (2003)
Study of the response by faith-based organizations to orphans and vulnerable children: Preliminary summary report
(WCRP) World Conference of Religions for Peace and (UNICEF) United Nations Children Fund

> International agencies are increasingly recognizing the role of religious organizations in establishing effective HIV/AIDS interventions. Despite some negative perceptions of their role and impact, faith-based organizations (FBOs) are among the most viable institutions at both local and national levels and have developed experience in addressing the multidimensional impact of AIDS and its particular impact on children. Religious organizations are prevalent throughout Africa. In the six countries chosen for this study, the number of local congregations is estimated to be in excess of 150,000. Yet most faith-based responses are small scale and remain undocumented. It is difficult to measure their cumulative impact compared to the more visible project responses of development agencies. Consequently, FBO HIV/AIDS activities remain undersupported. During 2002 - 2003, the World Conference of Religions for Peace (WCRP) in collaboration with UNICEF carried out a study to survey what religious groups are doing to meet the needs of orphans and vulnerable children (OVC) and to develop an improved and detailed understanding of the responses of religious organizations in east and southern Africa in caring for children affected by AIDS.

Foster G (2005)
Religion and responses to orphans in Africa
In: Foster G, Levine C and Williamson J (eds), A generation at risk: the global impact of HIV/AIDS on orphans and vulnerable children. New York, Cambridge University Press

Foster G and Jiwli L (2001)
Psychosocial support of children affected by AIDS: An evaluation and review of Masiye Camp, Bulawayo, Zimbabwe
Evaluation Report, Draft 5, UNICEF Zimbabwe and (SAWSO) Salvation Army World Service Organization

Friedman S (2002)
Building partnerships for life: The role of religions in caring for children affected by HIV
The African Religious Leaders Assembly on Children and HIV/AIDS, Nairobi, Kenya, African Religious Leaders Assembly on Children and HIV/AIDS

Gillespie A (2000)
The impact of HIV/AIDS on children
Church and Society 91(1): 39-41

Grainger C, Webb D and Elliott L (2001)
Children affected by HIV/AIDS: Rights and responses in the developing world
Working Paper 23, London, Save the Children

Help-Age (2003)
Forgotten families: Older people as carers of orphans and vulnerable children
United Kingdom, Help Age International and International HIV/AIDS Alliance

Huggins J, Baggaley R and Nunn M (2004)
God's children are dying of AIDS: Interfaith dialogue and HIV
London, Christian Aid

IHA (2003)
Building Blocks: Africa-wide briefing notes: Resources for communities working with orphans and vulnerable children
Brighton, United Kingdom, International HIV/AIDS Alliance

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No excuses: Facing up to Africa's AIDS orphans crisis
London, Christian Aid

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Holistic ways to empower Africa's children and young people
Journal of Theology for Southern Africa 114: 69-77

Moore A (1998)
Can foster care be fixed? Churches partner with parents to care for at-risk children
Christianity Today 42: 54-57

Mudekunye L (2002)
Children's rights and access to care and support
Paper, Workshop on Children, HIV and Poverty in Southern Africa, SARPN, HSRC and Save the Children, April 9-10, 2002

Muhangi D (2004)
Documentation study of the responses by religious organizations to orphans and vulnerable children: Uganda country study report
Kampala, (UNICEF) United Nations Children's Fund, (WCRP) World Conference on Religious for Peace and Inter-Religious Council of Uganda

Nielsen NG (2003)
Children of promise: A snapshot of Christian faith-based organisations' response to AIDS orphans in Africa
Cape Town, South Africa, (RICSA) Research Institute on Christianity and Society in Africa, University of Cape Town

Nyambedhaa EO, Wandibbaa S and Aagaard-Hansenb J (2003)
Changing patterns of orphan care due to the HIV epidemic in western Kenya
Social Science and Medicine 57: 301-311

Olson K, Knight ZS and Foster G (2006)
From faith to action: strengthening family and community care for orphans and vulnerable children in sub-Saharan Africa
Santa Cruz, USA, Firelight Foundation

> Every child needs the nurturing support of family and the experience of community in order to thrive. One of the greatest challenges faced by faith-based and community groups serving children on the ground in Africa is that their work is under-recognized and under-funded. It is the intent of this report to make the breadth, depth, and effectiveness of these local groups come to life. We offer From Faith to Action as a guide to faith-based organizations, congregations, and other groups and individuals seeking to contribute their resources to support the needs of children made vulnerable by HIV/AIDS.

Phiri S, Foster G and Nzima M (2001)
Expanding and strengthening community action: A study of ways to scale up community mobilization interventions to mitigate the effect of HIV/AIDS on children and families
Washington, Displaced Children and Orphans Fund and USAID

Richter L, Manegold J and Pather R (2004)
Family and community interventions for children affected by AIDS
Cape Town, (HSRC) Human Sciences Research Council

Rivers EF and Rivers JC (2000)
The fight for the living: AIDS, orphans, and the future of Africa
Sojourners 29(4): 18-22

Ruland C, Finger W, Williamson N, Tahir S, Savariaud S, Schwietzer A and Shears K (2005)
Adolescents: Orphaned and vulnerable in the time of HIV/AIDS
Youth Issues Paper 6, (FHI) Family Health International

Ssekkadde SB (2003)
HIV/AIDS and orphans in Uganda: A church community response from the Diocese of Namirembe, Province of the Church of Uganda
Diocese of Namirembe, Province of the Church of Uganda

Stecker C, Sun T and Mullenix G (2000)
HIV/AIDS: Search for a response
Compassion International

UNAIDS (1999)
Children orphaned by AIDS: Front-line responses from eastern and southern Africa
New York, (UNAIDS) Joint United Nations Programme on HIV/AIDS and (UNICEF) the United Nations Children's Fund

UNICEF (2003)
Faith-motivated actions on HIV/AIDS prevention and care for children and young people in South Asia: A regional overview
Nepal, (UNICEF) United Nations Children's Fund, Regional Office for South Asia

UNICEF (2003)
The role of faith-based organisations in providing support to orphans and vulnerable children in Africa
New York, NY, (UNICEF) United Nations Children's Fund and (WCRP) World Conference of Religions for Peace

This study, published by UNICEF and the World Conference of Religions for Peace, draws attention to the roles of faith-based responses to HIV/AIDS in the six African countries it surveyed (Kenya, Malawi, Mozambique, Namibia, Swaziland and Uganda). The study argues that, despite some negative perceptions of their role and impact, FBOs are among the most viable institutions at both local and national levels and have developed experience in addressing the multidimensional impact of AIDS and its particular impact on children. The study concludes with recommendations on how donors can support FBOs. It notes that congregations have the capacity to implement OVC support activities and receive funds but most receive no external support. External support needs to be guided by experience of local religious partners rather than programmes being designed by external partners with little local involvement. Funding should therefore be provided through small grants funds to support activities initiated by congregations. Finally, donor project proposal and reporting requirements should be made more flexible and accessible to FBOs.

UNICEF (2003)
What religious leaders can do about HIV/AIDS: Actions for children and young people
New York, NY, (UNICEF) United Nations Children's Fund, (WCRP) World Conference of Religious for Peace and (UNAIDS)

UNICEF (2004)
Children on the brink 2004: A joint report of new orphan estimates and a framework for action
(UNICEF) United Nations Children's Fund, UNAIDS and USAID

UNICEF (2004)
Starting from strengths: Community care for orphaned children in Malawi
New York, NY, (UNICEF) United Nations Children's Fund, World Vision, Save the Children (USA) Malawi, and the Ministry of Women, Youth and Community Services of Malawi

WCRP (2002)
African religious leaders assembly on children and HIV/AIDS
Nairobi, Kenya, (WCRP) World Conference of Religions for Peace

Weaver R (2004)
Responding to children affected by HIV and AIDS. Using external support to strengthen community initiative and motivation
Tearfund HIV/AIDS Briefing Paper 3, Teddington, UK, Tearfund

Young H (2005)
More than words? Action for orphans and vulnerable children in Africa: Monitoring progress towards the UN declaration of commitment on HIV/AIDS
Milton Keynes, UK, World Vision

> Fully aligned to 'The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in A World With HIV/AIDS' developed by UNICEF and other partners, World Vision is committed to keeping orphans and vulnerable children high on the global agenda through evidence-based advocacy. As part of this, More than Words? is a qualitative investigation of how far the rights and needs of orphans and vulnerable children are being met in four of the worst-affected countries in sub-Saharan Africa (Ethiopia, Mozambique, Uganda and Zambia) and is intended to inform and challenge leaders on the commitments they have made.

4.3 Religion and stigma

ACORD (2004)
Unravelling the dynamics of HIV/AIDS-related stigma and discrimination: The role of community-based research
Case studies of Northern Uganda and Burundi, London, ACORD

Aggleton P, Wood K, Malcolm A and Parker R (2005)
HIV-related stigma, discrimination and human rights violations: Case studies of successful programmes
UNAIDS Best Practices Collection, Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

Alonzo AA and Reynolds NR (1995)
Stigma, HIV and AIDS: An exploration and elaboration of a stigma trajectory
Social Science and Medicine 41(3): 303-315

Ayers JR (1995)
The quagmire of HIV/AIDS related issues which haunt the church
Journal of Pastoral Care 49: 201-210

> Identifies and explores the extreme difficulties of HIV/AIDS realities for evangelical Christian churches which tend to stymie effective ministry. Discusses the issues of morality, morbidity, mortality, reality, responsibility; and concludes that the church has fallen short in its mission to HIV/AIDS persons. Claims that this shortfall has created an integrity question in the minds of those whose lives have been touched by this contemporary health crisis.

Baggaley R (1994)
Zambia: a church where brothers are not brothers
AIDS Anal. Africa 4(3): 5-5

Bailey RC (1999)
HIV/AIDS and "holy hatred"
Witness 82: 20-21

Balcomb A (2006)
Sex, sorcery, and stigma - probing some no-go areas of the denial syndrome in the AIDS debate
Journal of Theology for Southern Africa 125(July): 104-114

Banteyerga H, Kidanu A, Nyblade L, MacQuarrie K and Pande R (2004)
Yichalaliko (it can be done)! Exploring HIV and AIDS stigma and related discrimination in Ethiopia: Causes, manifestations, consequences and coping mechanisms
Addis Ababa, Ethiopia, Miz-Hasab Research Center

Bond V (2002)
The dimensions and wider context of HIV/AIDS stigma resulting discrimination in Southern Africa
In: Heywood M, Bond V, Barfod T, et al (eds), How can we increase and broaden our responses to HIV/AIDS?
Stockholm, (SIDA) Swedish International Development Cooperation Agency

Bond V, Chilikwela L, Clay S, Kafuma T, Nyblade L and Bettega N (2003)
Kanayaka "the light is on": Understanding HIV and AIDS-related stigma in urban and rural Zambia
Lusaka, Zambia, Zambart Project and (KCTT) Kara Counselling and Training Trust?

Brown L, Macintyre K and Trujillo L (2003)
Interventions to reduce HIV/AIDS stigma: What have we learned?
AIDS Education and Prevention 15(1): 49-69

Campbell ID and Radar A (2001)
HIV/AIDS, stigma and religious responses: An overview of issues related to stigma and the religious sector in Africa
Presentation, UNAIDS Research Consultation, Pretoria, South Africa

Provides an overview of the role of religious organizations in reducing stigma which often surrounds those living with HIV/AIDS in Africa

Clay S, Bond V and Nyblade L (2003)
We can tell them: AIDS doesn't come through being together: Children's experiences of HIV and AID related stigma in Zambia
Lusaka, Zambia, Zambart Project and (KCTT) Kara Counselling and Training Trust

Cogan J and Herek G (1998)
Stigma
In: Smith RA (ed), The Encyclopedia of AIDS: A Social, Political, Cultural, and Scientific Record of the HIV Epidemic. Chicago, Fitzroy Dearborn

Crowley PG (1997)
Rahner's Christian pessimism: A response to the sorrow of AIDS
Theological Studies 58: 286-307

EAA (2002)
Understanding HIV/AIDS related stigma and discrimination
(EAA) Ecumenical Advocacy Alliance, UNAIDS

EAA (2003)
The next steps: For positive change in attitudes that cause HIV and AIDS-related stigma and discrimination
Signs of Hope: Steps for Change, Geneva, (EAA) Ecumenical Advocacy Alliance

Futures Group (2005)
An advocacy resource book for HIV and AIDS in Zambia
Bath, UK, Futures Group

Hadjipateras A (2004)
Unravelling the dynamics of HIV/AIDS-related stigma and discrimination: The role of community-based research
Research Report Series 1, Northern Uganda and Burundi, (ACORD) Agency for Co-operation and Research in Development

HSRC (2006)
The nature and extent of HIV and AIDS-related stigma in the Anglican Church of the Province of Southern Africa: A quantitative study
Human Sciences Research Council; Outsourced Insight for the Anglican Provincial AIDS Office; DFID; Christian Aid

This report provides an overview of a conceptual and contextual review of the literature on HIV and AIDS-related stigma and the results of a rapid assessment of the nature and extent of stigma in the Anglican Church in the Province of South Africa. The survey instrument used for the rapid assessment focused primarily on gathering quantitative evidence about individual knowledge, attitudes and practices as a measure of the form and social acceptability of stigma and discrimination in the church. We interrogate other social and structural factors to help us interpret these findings and make recommendations for action and further research. The aim of the project as a whole is to help reduce HIV and AIDS-related stigma and discrimination within the Church.

ICASA (2003)
The role of religious leaders in reducing stigma and discrimination related to HIV/AIDS
(ICASA) International Conference in HIV/AIDS and STDs in Africa, Satellite Session, Nairobi, Kenya, 21 September 2003

Iwere N, Ojidoh JC and Okide N (2000)
Engaging religious communities in breaking the silence on HIV/AIDS
The XIIIth International AIDS Conference. Durban, South Africa

The authors of this paper argue that an issue which could be a factor in the effectiveness of faith based organisations in mitigating the effects of HIV/AIDS is that of co-operation between themselves and non-governmental organisations, governments and other institutions, and the often-negative perceptions that other organisations may have toward them. They go on to state that faith based organisations could contribute more than they are presently allowed to if their assistance were accepted without prejudice.

Kaleeba N, Namulondo J, Kalinki D and Williams G (2000)
Open secret: People facing up to HIV/AIDS in Uganda
London, Action Aid

Kamaara E (2004)
Stigmatization of persons living with HIV/AIDS in Africa: Pastoral challenges
African Ecclesial Review 46(1): 35-54

Katongole EM (2001)
Christian ethics and AIDS in Africa today: Exploring the limits of a culture of suspicion and despair
Missionalia 29(2): 144-160

Louw DJ (2006)
The HIV pandemic from the perspective of a theologia resurrectionis: Resurrection hope as a pastoral critique on the punishment and stigma paradigm
Journal of Theology for Southern Africa 126(November)

Massicame EZ (2005)
Mozambique: stigmatization
In: Knox-Seith E (ed), One body: North-south reflections in the face of HIV and AIDS. Oslo, Norway, The Nordic-Foccisa Church Cooperation. 1

Mbwambo J, Kilonzo GP, Kopoka P and Nyblade L (2004)
Understanding HIV and AIDS-related stigma and resulting discrimination in Tanzania
Dar es Salaam, Tanzania, (MUCHS) Muhimbili University College of the Health Sciences

Monico SM, Tanga EO and Nuwagaba A (2001)
Uganda: HIV and AIDS-related discrimination, stigmatization and denial
Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

Nyblade L, Pande R, Mathur S, MacQuarrie K, Kidd R, Banteyerga H, Kidanu A, Kilonzo G, Mbwambo J and Bond V (2003)
Disentangling HIV and AIDS stigma in Ethiopia, Tanzania and Zambia
Washington, DC, International Center for Research on Women

Ogden J and Nyblade L (2005)
Common at its core: HIV-related stigma across contexts
(ICRW) International Center for Research on Women

Parker R and Aggleton P (2003)
HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action
Social Science and Medicine 57: 13-24

Parker W and Birdsall K (2005)
HIV/AIDS, stigma and faith-based organisations: A review
Johannesburg, (CADRE) Centre for AIDS Development, Research and Evaluation and DFID Futures Group MSP

Stigma and discrimination have often been identified as primary barriers to effective HIV prevention, as well as the provision of treatment, care and support. Such viewpoints tend to employ stigma and discrimination as a catch-all for the multiplicity of negative beliefs, attitudes and actions related to the disease. There is, however, a need to be cautious. The weighting given to stigma and discrimination as primary and ultimate barriers impeding HIV/AIDS response is problematic as such weighting often implies that stigma and discrimination are pervasive throughout society. This has the effect of stigmatising many communities as being uncaring and inhumane - a process that can perpetuate existing marginalisation. Stigma and discrimination therefore need to be carefully defined, cautiously analysed and critically reviewed if we are to understand impacts and develop appropriate responses. This review explores theoretical and definitional aspects of stigma and discrimination in relation to HIV/AIDS. It then reviews faith-based organization (FBO) responses to HIV/AIDS, considering factors that contribute to stigma and discrimination, as well as those which mitigate against them. This is followed by reflections on research processes for exploring stigma and discrimination.

Paterson G (2005)
AIDS-related stigma - thinking outside the box: the theological challenge
Geneva, Switzerland, (EAA) Ecumenical Advocacy Alliance, (WCC) World Council of Churches

Paterson G (2003)
Church, AIDS and stigma,
(EAA) Ecumenical Advocacy Alliance

PolicyProject (2003)
Siyam'kela: Tackling HIV/AIDS stigma: Guidelines for faith based organizations
Cape Town, South Africa, Policy Project, Centre for the Study of AIDS, USAID, and the Department of Health

Presents findings of research related to HIV/AIDS and faith based organizations and recommendations for FBOs working in the field of HIV/AIDS. Provides a theoretical understanding of the origin, and manifestation of HIV/AIDS stigma and highlights the challenge for a stigma-mitigation process.

PolicyProject (2003)
Siyam'kela research project - A literature review
Cape Town, South Africa, Policy Project

PolicyProject (2004)
Siyam'kela research project - Promising practices of stigma mitigations efforts from across South Africa: Reflections from faith-based organisations, people living with HIV/AIDS who interact with media and HIV/AIDS managers in the workplace
Cape Town, South Africa, Policy Project, Centre for the Study of AIDS, USAID, and the Department of Health

Describes best practices in stigma mitigation identified during the Siyam'kela research project fieldwork from: the faith-based response to HIV/AIDS, media reporting on HIV/AIDS particularly, the relationship with people living with HIV/AIDS, and national government departments as workplace environments. This report has outlined promising practices for HIV/AIDS stigma mitigation in three areas: faith-based organisations, the government workplace, and PLHAs who interact with the media. It is clear from the findings that different contexts require a range of differing responses.

Rankin W (2000)
Remarks given at Anglican Church of Tanzania Conference
Living With Hope. Dar es Salaam

Saayman W and Kriel J (1992)
AIDS, the leprosy of our time?
Johannesburg, Orion Publishers

Tallis V (2002)
Gender and HIV/AIDS
Bridge: Development - Gender, Institute of Development Studies

UNAIDS (2000)
Comparative analysis: Research studies from India and Uganda HIV and AIDS-related discrimination, stigmatization and denial
Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

UNAIDS (2002)
A conceptual framework and basis for action: HIV/AIDS, stigma and discrimination,
Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

UNAIDS (2004)
HIV and AIDS related stigma: A Framework for Theological Reflection
A report of a theological workshop focusing on HIV and AIDS-related stigma, 8th-11th December 2003, Windhoek, Namibia. Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

> The report is the outcome of the first-ever UN-sponsored meeting of Christian theologians. 36 Christian theologians from most historic churches were present, with the African contingent the most numerous. The workshop had two primary objectives: to sharpen the response to HIV and AIDS-related stigma among theological educators and church leaders; and to develop a framework that might provide a useful basis for theological reflection in the contexts of theological education, church councils and synods, and pastoral formation. The document represents the efforts to grapple with the serious and complex issues related to stigmatizing and discriminatory reactions to HIV and AIDS, and to discern the values and beliefs that underlie a justice-based response to such negative phenomena.The consultation identified a number of theological themes relevant to this task: God and Creation; Interpreting the Bible; Sin; Suffering and Lamentation; Covenantal Justice; Truth and Truth-telling; and The Church as a Healing, Inclusive and Accompanying Community.

USAID (2000)
Combating HIV/AIDS stigma, discrimination and denial: What way forward?
Washington, DC, (USAID) US Agency for International Development

USCJ (2001)
Judaism and HIV/AIDS
(USCJ) United Synagogue of Conservative Judaism

WCC (2001)
Plan of action: The ecumenical response to HIV/AIDS in Africa
Global Consultation on the Ecumenical Response to the Challenge of HIV/AIDS in Africa. Nairobi, Kenya, (WCC) World Council of Churches

WCC (2001)
Statement by faith-based organizations facilitated by the World Council of Churches for the UN Special General Assembly on HIV/AIDS June 25-27, 2001
International Review of Mission 90: 473-476

Wylie-Kellermann J and Wortman JA (1999)
HIV/AIDS: Overcoming religious barriers to prevention
Witness 82: 30-31

4.4 Sexuality, gender and behaviour change

Abate E (2001)
Human sexuality and AIDS: An Ethiopian church perspective
Word and World 21(2): 152-159

Agadjanian V (2001)
Religion, social milieu, and the contraceptive revolution
Population Studies 55: 135-148

Agadjanian V (2005)
Gender, religious involvement, and HIV/AIDS prevention in Mozambique
Social Science and Medicine 61(7): 1529-1539

Using survey and semi-structured interview data collected in various religious congregations in urban and rural areas of Mozambique, this study analyzes how gender differences in perceptions of HIV/AIDS and preventive behaviour are mediated by religious involvement. Logistic regression is employed to examine the effects of gender and of the interactions between gender and type of denomination-"mainline" (Catholic and Presbyterian) or "healing" (Assembly of God, Zionist, and Apostolic)-on female and male members' exposure to HIV/AIDS-related prevention messages, knowledge and perception of risks and practice of prevention. The analysis detects women's disadvantage on several measures of knowledge and prevention but also suggests that gender differences are less pronounced among members of "mainline" churches. The semi-structured interview data further highlight how gender differences are shaped in different religious environments. Although the potential of faith-based institutions in combating the HIV/AIDS pandemic is undeniable, policy-makers need to heed important differences among these institutions when devising ways to harness this potential.

Amoah E, Akintunde D and Akoto D (eds) (2005)
Cultural practices and HIV/AIDS: African women's voice
Accra, SWL

Anane M (1999)
The soul is willing: Religion, men and HIV/AIDS in Ghana
In: Foreman M (ed), AIDS and men: Taking risks or taking responsibility? London, Panos, Zed Books: 79-94

Barker G and Ricardo C (2005)
Young men and the construction of masculinity in sub-Saharan Africa: Implications for HIV/AIDS, conflict, and violence
Washington, (WB) The World Bank

Barnett T and Parkhurst J (2005)
HIV/AIDS: Sex, abstinence and behaviour change
The Lancet Infectious Diseases, opinion piece

Bature R (2004)
Zip up!
Nigeria AIDS eForum (August)

A mass media campaign run by the Society for Family Health (SFH) in conjunction with some of Nigeria's faith-based organisations (FBOs), and in support of the National Action Committee on AIDS (NACA). The campaign uses television, radio, and billboards in an effort to empower young Nigerians with the confidence and street savvy necessary to delay sex until they are old enough to deal with the consequences or get married. The campaign uses the slogan "Zip Up, Sex is Worth Waiting for" and attempts to create a language that teens can identify with Partnership with FBOs was a key strategy in the programme design and implementation. Zip Up was developed in conjunction with a steering committee including representatives from both Muslim and Christian organisations. These groups participated in the scripting and development of the campaign messages. In addition, several FBOs have held Zip Up rallies, seminars, and workshops, with the support of SFH.

Baylies C and Bujra J (2000)
AIDS, sexuality and gender in Africa: Collective strategies and struggles in Tanzania and Zambia
London and New York, Routledge

Benn C (2002)
The influence of cultural and religious frameworks on the future course of the HIV/AIDS pandemic
Journal of Theology for Southern Africa 113(July):3-18

Boring WS, Geter JA and Penna S (1999)
A maternal body and a body with AIDS: Theological reflections on carnal knowledge of the incarnate God
Theology and Sexuality 10: 7-15

Bruce PF (2003)
"The mother's cow": A study of Old Testament references to virginity in the context of HIV/AIDS in South Africa
In: Phiri IA, Haddad B and Masenya M (eds), African Women, HIV/AIDS and Faith Communities, Pietermaritzburg, Cluster Publications: 44-70

Buga G, Amoko D and Ncayiyana D (1996)
Adolescent sexual behaviour, knowledge and attitudes to sexuality among school girls in Transkei, South Africa
East African Medical Journal 73(2): 95-100

Bujra J (2000)
Targeting men for a change: AIDS discourse and activism in Africa
Agenda 44: 6-23

Burggraeve R (2000)
From responsible to meaningful sexuality: An ethics of growth as an ethic of mercy for young people in this era of AIDS
In: Keenan JF (ed), Catholic ethicists on HIV/AIDS prevention. New York and London, Continuum: 303-316

Burket MK (2006)
Advancing reproductive health and family planning through religious leaders and faith-based organizations
Washington, Pathfinder International

Burkhalter H (2004)
The politics of AIDS: Engaging conservative activists
Foreign Affairs 83(1)

Byamugisha GB (1998)
AIDS, the condom and the Church: Are science and morality antagonistic?
The theological and pastoral implications of AIDS to Uganda Series Vol 1, Kampala, Uganda, Tricolour

Byamugisha GB (2000)
Breaking the silence on HIV/AIDS in Africa: How can religious institutions talk about sexual matters in their communities?
International Symposium of the Africa Regional Forum of Religious Health Organizations in Reproductive Health, XIII World AIDS Conference. Durban, South Africa

Cahill LS (1994)
Sexuality and Christian ethics: How to proceed
In: Nelson JB and Longfellow SP (eds), Sexuality and the sacred: Sources for theological reflection. Louisville, Kentucky, Westminster/John Knox Press: 19-27

Cahill LS (1996)
Sex, gender and Christian ethics
Cambridge, Cambridge University Press

Cahill LS (2000)
AIDS, justice and the common good
In: Keenan JF (ed), Catholic ethicists on HIV/AIDS prevention. New York and London, Continuum: 282-293

Caldwell J, Caldwell P, Anarfi J, Awusabo-Asare K, Ntozi J, Orubuloye IO, Marck J, Cosford W, Colombo R and Hollings E (eds) (1999)
Resistance to behavioural change to reduce HIV/AIDS infection in predominantly heterosexual epidemics in third world countries
Health Transition Center, Canberra

CADRE (2003)
Gender-based violence and HIV/AIDS in South Africa: A bibliography
Johannesburg, South Africa, (CADRE) Centre for Development and Research Evaluation, and (DOH) Department of Health

Chikwendu E (2004)
Faith-based organizations in anti-HIV/AIDS work among African youth and women
Dialectical Anthropology 28(3/4): 307-327

Cohen J and Tate T (2005)
The less they know, the better: Abstinence-only HIV/AIDS programs in Uganda
Human Rights Watch 17(4(a))

Coplan P, Kaufman J, Okonofua F, Temin M, Heggenhougen K and Renne E (1998)
Determinants of STDs among Nigerian youth and reported STD prevention methods: Targets for intervention
Int Conf AIDS 12(640)

Denis P (2003)
Sexuality and AIDS in South Africa
Journal of Theology for Southern Africa 115: 63-77

Dick A (2000)
Knowledge, attitudes and practices baseline survey
Wheaton, IL , World Relief

DFID (2006)
Promoting women's rights through sharia in Northern Nigeria
Zaria, Nigeria, (DFID) Department for International Development, and Centre for Islamic Legal Studies, Ahmadu Bello University

This report from DFID and the British Council documents both exemplary and harmful practices affecting Muslim women in Northern Nigeria, and evaluates them according to Sharia, which expects both men and women to be equally educated.

DON (1998)
STI, HIV/AIDS and adolescent sexuality: Improving teenage reproductive health
The study of adolescents' knowledge, attitudes and practices, Diocese of Namirembe Health Department, HIV/AIDS Project

Dube MW and Kanyoro M (eds) (2004)
Grant me justice: HIV/AIDS and gender reading of the bible
Pietermaritzburg, Cluster Publications

Eaton L, Flisher AJ and Aarb LE (2003)
Unsafe sexual behaviour in South African youth
Social Science and Medicine 56: 149-165

Ellingson S and Green MC (eds) (2002)
Religion and sexuality in cross-cultural perspective
New York and London, Routledge

Erasmus JC and Mans G (2005)
Churches as service providers for victims of sexual violence and crime: A case study from the Paarl community
Acta Criminologica 18 (1):140-163

Farley MA (2004)
Partnership in hope: Gender, faith, and responses to HIV/AIDS in Africa
Journal of Feminist Studies in Religion 20(1):Spring

Farrell M (2003)
Condoms and AIDS prevention: A comparison of three faith-based organizations in Uganda
AIDS and Anthropology Bulletin 15(3)

Foreman M (ed) (1999)
AIDS and men: Taking risks or taking responsibility?
London, Panos, Zed Books

Garner RC (1999)
Religion in the AIDS crisis: Irrelevance, adversary or ally?
AIDS Analysis Africa 10: 6-7

Garner RC (2000)
Safe sects? Dynamic religion and AIDS in South Africa
Journal of Modern African Studies 38(1): 41-69

> The HIV/AIDS epidemic in South Africa is rapidly escalating, and its demographic and social impact is beginning to be felt. Although the damage to the macro-economy is projected to be slight, the consequences for affected households will be dire, and social indicators such as life expectancy will deteriorate dramatically. A large majority of South Africans are affiliated to Christian Churches, but this has not prevented the types of sexual behaviour that promote the epidemic. Based on research in a KwaZulu township, this article presents evidence on the level of extra- and pre-marital sex (EPMS) among members of different church types. It is argued that only Pentecostal churches significantly reduce EPMS among members; and that they achieve this by maintaining high levels of four crucial variables: indoctrination, religious experience, exclusion and socialisation.

Garvey M (2003)
Dying to learn: Young people, HIV and the churches
Christian Aid

Germond P (2004)
Sex in a globalising world
Journal of Theology for Southern Africa 119 (July): 46-68

Germond P and de Gruchy S (eds) (1997)
Aliens in the household of God: Homosexuality, and Christian faith in Southern Africa
Cape Town, David Phillip

Gray PB (2004)
HIV and Islam: Is HIV prevalence lower among Muslims?
Social Science and Medicine 58: 1751-1756

Green EC (2003)
The impact of religious health organizations in promoting HIV/AIDS prevention
In: Green EC (ed), The AIDS crisis in developing countries. Westport, CT, Praeger Publishers

Green EC, Nantulya V, Oppong Y and Harrison. T (2003)
Literature review and preliminary analysis of 'ABC' factors (abstinence, being faithful or partner reduction, condom use) in six developing countries
Cambridge, Mass, Harvard Center for Population and Development Studies

Gruenais ME (1999)
Does religion protect from AIDS? Congolese religious congregations face pandemic HIV infection
Cahiers d'Etudes Africaines 39(2): 253-270

Gundani, PH (2001)
Church, media and healing (A case study from Zimbabwe)
Word and World, St Paul's, Minnesota: 34-55

Haddad B (2001)
Spirituality
Life without violence - women and men together: Proactive responses to domestic violence and HIV/AIDS, Gaberone, Botswana, Norwegian Church Aid

Haddad B (2002)
Gender violence and HIV/AIDS: A deadly silence in the church
Journal of Theology for Southern Africa 114: 93-106

Haram L (1996)
The gendered epidemic: Sexually transmitted diseases and AIDS among the Meru people of Northern Tanzania
Reproductive health research in developing countries (summary report no 4), S Bergstrom and GH Otlesen (eds), Oslo, Centre for Development and Environment

James JS (2004)
Abstinence, abstinence-only, faith-based, and the psychology of stigma
AIDS Treatment News 402: 6-7

If abstinence is 100% effective in preventing sexual transmission, why does abstinence-only not work well? And what is the personal psychology of the stigma that prevents individuals, communities, and nations from protecting themselves against the epidemic? This studies offers some analysis that has been largely overlooked in the public discussion.

Jantzen G (1994)
AIDS, shame and suffering
In: Nelson JB and Longfellow SP (eds), Sexuality and the sacred: Sources for theological reflection.
Louisville, Kentucky, Westminster/John Knox Press: 305-313

Jewkes RK, Levin JB and Penn-Kekana LA (2003)
Gender inequalities, intimate partner violence and HIV preventive practices: Findings of a South African cross-sectional study
Social Science and Medicine Vol56(1): 125-134

JHU (2004)
Stop AIDS love life in Ghana "shatters the silence"
(CCP) Center for Communication Programs, (JHU) Johns Hopkins University

John TJ (1995)
Sexuality, sin and disease: Theological and ethical issues posed by AIDS to the churches: Reflections by a physician
Ecumenical Review 47:373-384

Jordan MD (2002)
The ethics of sex
Oxford, Blackwell Publishers

Kagimu M, Marum E and Serwadda D (1995)
Planning and evaluating strategies for AIDS health education interventions in the Muslim community in Uganda
AIDS Education and Prevention 7: 10-21

Kagimu M, Marum E, Wabwire-Mangen F, Nakyanjo N, Walakira Y and Hogle J (1998)
Evaluation of the effectiveness of AIDS health education interventions in the Muslim community in Uganda
AIDS Education and Prevention 10(3): 215-228

Kalyowa F and Kiwanuka R (1998)
Promoting abstinence for AIDS control in the Uganda youth
International Conference on AIDS 12: 1156

Kanyoro M (2003)
Sex, stigma and HIV/AIDS: African women challenging religion, culture and social practices
3rd Pan African Conference of the Circle of Concerned African Women Theologians, Addis Ababa, Ethiopia

Keenan JF, Fuller J, Cahill LS and Kelly K (eds) (2000)
Catholic ethicists on HIV/AIDS prevention
New York and London, Continuum

Takes stock of current debate within Catholic moral teaching, with 33 articles from different authors. Part one deal with case studies from around the world, while part two addresses ethical problems that theologians recognize in HIV prevention.

Kelly KT (1998)
New directions in sexual ethics: Moral theology and the challenge of AIDS
London, Geoffrey Chapman

Kelly K, Parker W, Fox S and Fawcett C (2001)
Pathways to action: HIV/AIDS prevention, children and young people in South Africa - A literature review
Johannesburg, (CADRE) Centre for AIDS Development, Research and Evaluation, and Save the Children

> There appears to be a pervasive belief in South African society that young people have not responded to HIV/AIDS. This report is an attempt to take stock of what has happened in respect of the response to HIV/AIDS by children and young people in South Africa, as well as the societal response to the needs of young people.

Kelly K, Parker W, Oyosi S (2001)
Pathways to action: HIV/AIDS prevention, children and young people in South Africa - A bibliography
Johannesburg, South Africa, (CADRE) Centre for AIDS Development, Research and Evaluation, and Save the Children

Kiiti N, Ijumba P and Dortzbach D (1995)
AIDS prevention and Kenya's church leaders: Assessment of knowledge, attitudes, and practices
MAP International, FHI, AIDSCAP and USAID

King U (ed) (1995)
Religion and gender
Oxford, Blackwell Publishers

Kirby D (2002)
Do abstinence-only programs delay the initiation of sex among young: Challenging the evidence that abstinence-only programmes are effective
The National Campaign to Prevent Teen Pregnancy

Kit-fong T, Boone TL, Lefkowitz ES and Sigman M (2003)
No sex or safe sex? Mothers' and adolescents' discussions about sexuality and AIDS/HIV
Health Education Research 18(3): 341-351

Klein M and Coombes Y (2005)
Trust and condom use: The role of sexual caution and sexual assurances for Tanzanian youth (a baseline survey)
Working Paper No. 64, (PSI) Population Services International Research Division

Kugle SSH (2003)
Sexuality, diversity, and ethics in the agenda of progressive Muslims
In: Safi O (ed), Progressive Muslims, World Publication: 191-203

Lagarde E, Enel C, Seck K, Gueye-Ndiaye A, Piau J, Pison G, Delaunay V, Ndoye I, and Mboup, S (2000)
Religion and protective behaviours towards AIDS in rural Senegal
AIDS 14(13): 2027-2033

> The objective of this study was to describe the association between religion and factors related to sexually transmitted diseases (STD)/AIDS in a country where religious leaders were involved early in prevention. A total of 86% of men and 87% of women reported religion to be very important to them. Individuals who considered religion to be very important were not more likely to report intending to or actually having become faithful to protect themselves from AIDS. Conclusion: These findings stress the need to intensify the involvement of religious authorities in HIV/STD prevention at the local level.

Leclerc-Madlala S (2001)
Virginity testing: Managing sexuality in a maturing HIV/AIDS epidemic
Medical Anthropology Quarterly 15(4): 533-552

Leclerc-Madlala S (2001)
Demonising women in the era of AIDS: On the relationship between cultural constructions of both HIV/AIDS and feminity
Society in Transformation 32(1): 38-46

Lefkowitz E, Gillen M, Shearer C and Boone T (2004)
Religiosity, sexual behaviours, and sexual attitudes during emerging adulthood
Journal of Sex Research 41(2): 150-159

The study examined associations between religiosity and sexual behaviours and attitudes during emerging adulthood. Two hundred and five emerging adults completed surveys about five aspects of their religiosity (group affiliation, attendance at religious services, attitudes, perceptions of negative sanctions, and adherence to sanctions) and their sexual behaviours (abstinence, age of onset, lifetime partners, condom use) and attitudes (conservative attitudes, perceived vulnerability to HIV, and condom-related beliefs). Associations were found between the measures of religiosity and sexuality, although the patterns differed by measures used. Religious behaviour was the strongest predictor of sexual behaviour.

Lewis IM (1990)
Exorcism and male control of religious experience
Ethnos 55(1-2): 26-40

Liberman LD, Gray H, Wier M, Fiorentino R and Maloney P (2000)
Long-term outcomes of an abstinence-based, small-group pregnancy prevention program in New York City schools
Family Planning Perspectives 32(5):237-245

Liebowitz J (2002)
The Impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa
(HEARD) Health Economics and HIV/AIDS Research Division, University of Kwa-Zulu Natal

Liebowitz argues that faith based organisations have significant advantages in influencing behaviour and initiating interventions in order to mitigate the HIV/AIDS epidemic. This is partly due to the fact that they have networks of people, institutions and infrastructure, particularly in rural areas, where few other institutions exist. They also have jurisdiction over a number of areas relevant to HIV/AIDS interventions, such as morality, sexual activity, and spiritual bases of disease and rules of family life.

Lom MM (2001)
Senegal's recipe for success
Africa Recovery 15(1-2):24

Low-Beer D and Stoneburner RL (2004)
Behaviour and communication change in reducing HIV: Is Uganda unique?
Johannesburg, South Africa, (CADRE) Centre for AIDS Development, Research and Evaluation (CAN)
Communicating AIDS Needs Project

Makau N, Niemeyer LL and Okello N (1996)
The response of Kenya churches to the AIDS epidemic and their perceived barriers to behaviour change
Nairobi, Kenya, MAP International

Maluleke T and Nadar S (2003)
Breaking the covenant of violence against women
Journal of Theology for Southern Africa (114): 5-17

Mananzan M, Oduyoye, Tamez, Clarkson, Grey and Russell (eds) (1996)
Women resisting violence: Spirituality for life
New York, Orbis

Manteuffel B, Soet JE, DiIorio C and Dudley B (1996)
Ethnic differences in HIV/AIDS prevention knowledge, attitudes and behaviours of female college students
International Conference on AIDS 11(1): 178

Marshall M and Taylor N (2006)
Tackling HIV and AIDS with faith-based communities: learning from attitudes on gender relations and sexual rights within local evangelical churches in Burkina Faso, Zimbabwe, and South Africa
Gender and Development 14(3): 363-374

The AIDS pandemic in Africa is devastating the continent. The institution of marriage does not appear to be protecting women – in some countries rates of infection among married women are higher than those among unmarried, sexually active women. Recognising that unequal gender relations are a driving force behind the AIDS pandemic, this article explores the position of local evangelical churches in Africa with respect to gender relations and sex, and the implications for HIV and AIDS.

Mash R and Kareithi R (2005)
Youth and sexuality research: Ages 12-19 years in the Diocese of Cape Town South Africa
Cape Town, Fikelela AIDS Project

> This report aimed at establishing if church-going young people adhere to the principle of 'no sex before marriage', or if there other competing 'voices' and pressures that young people succumb to. Are they practising risky sexual behaviour, with multiple partners, no protection and what are the levels of sexual violence? The authors conducted a survey in order to understand the gravity of the challenge, and to identify ways in which the Anglican Church might become more effective in dealing with issues of the sexuality of young people. This booklet is not designed as an academic paper; rather it is a tool for church leaders and those involved in ministry with young people.

Morgan TC and Peterson A (2004)
As complicated as ABC: Condoms and abstinence can both play a role in AIDS prevention
Christianity Today 48(2): 25

Mukhopadhyay M (2001)
Muslim women and development: Action research project
Amsterdam, (KIT) Koninklijk Instituut voor de Tropen, Gender Women and Development Division, Ministry of Foreign Affairs

Negerie M (1994)
The association of religious beliefs with AIDS risk behaviour among Kenyan males
Loma Linda University. PhD

Nelson JB and Longfellow SP (eds) (1994)
Sexuality and the Sacred: Sources for theological reflection
Louisville, Kentucky, Westminster/John Knox Press

Nicholas L and Durrhiem K (1995)
Religiosity, AIDS and sexuality knowledge, attitudes, beliefs and practices of black South African first-year university students
Psychological Reports 77: 1328-1330

Oliver M (1996)
Adolescents' perceptions of sexuality
South African Journal of Education 16(1): 5-8

Ornelas G, Farill E, Romero M and Urbina M (1992)
Sex education for priests
International Conference on AIDS 8(2): 435

Orubuloye IO, Caldwell JC and Caldwell P (1993)
The role of religious leaders in changing sexual behaviour in Southwest Nigeria in an era of AIDS
Health Transition Review 3: 93-104

Orubuloye IO, Caldwell J and Caldwell P (1997)
Perceived male sexual needs and male sexual behaviour in southwest Nigeria
Social Science and Medicine 44: 1195-1207

> Part of a research programme studying methods of combating the AIDS epidemic was a survey and accompanying qualitative research focused on attitudes toward male sexuality and male sexual behaviour outside marriage and the extent and success of female attempts to control it. The majority of the community believes that males are by nature sexually polygynous, although about half the community believes that male sexuality can and should be confined to marriage. These beliefs arise out of the nature of the traditional society and are being changed by new ways of life, education and imported religions. Nevertheless, sufficiently rapid change is unlikely, even if promoted by government, to successfully combat a major AIDS epidemic, and the major strategy should attempt to reduce the rate of transmission, especially in high-risk relationships.

Paterson G (1996)
Love in a time of AIDS: Women, health and the challenge of HIV
Geneva, (WCC) World Council of Churches

Paterson G (1996)
Women in the time of AIDS: women, health and the challenge of HIV
Maryknoll, Orbis

Paterson G (1997)
Women and HIV/AIDS: A challenge to market economies
Mission Studies 14(1-2): 223-227

Paterson G (2000)
The global HIV/AIDS epidemic: Understanding the Issues
Oslo, Norway, Norwegian Church Aid

Patient D and Orr N (2004)
B in ABC
Strategic Thinking, (Comminit) The Communication Initative (December 20)

Pfeiffer J (2004)
Condom social marketing, Pentecostalism, and structural adjustment in Mozambique: A clash of AIDS prevention messages
Medical Anthropology Quarterly 18: 77-103

Phiri AI and Nadar S (eds) (2006)
African women, religion and health. Essays in honor of Mercy Amba Ewudziwa Oduyoye
Maryknoll, Orbis

Phiri IA, Haddad B and Masenya M (eds) (2003)
African women, HIV/AIDS and faith communities
Pietermaritzburg, Cluster Publications

Pillay M (2004)
See this woman? Toward a theology of gender equality in the context of HIV and AIDS
The challenge of HIV/AIDS to Christian Theology. University of the Western Cape, University of the Western Cape

Qakisa M (2001)
The media representation of women and HIV/AIDS: How it affects preventative messages
Missionalia 29(2):304-320

Qakisa M (2002)
Let's talk about sex: Reaching young people through the media in the age of AIDS
Journal of Theology for Southern Africa 114: 79-92

Rajput NOF (2001)
Faith communities dealing with issues of sexuality: The Islamic perspective
12th International Conference on HIV/AIDS and STDs in Africa (ICASA), UNAIDS Round Table on Faith-base Strategies, Achievements and Challenges in their Response to the HIV/AIDS pandemic, Ouagadougou, Burkina Faso

Rankin S, Lindgren T, Rankin W and Ng'oma J (2005)
Donkey work: women, religion, and HIV/AIDS in Malawi
Health Care for Women International 26(1): 4-16

Rankin W and Wilson C (2000)
African women with HIV, faith-based answers might ease the social problems that lead to AIDS
British Medical Journal 321: 1543-1544

Rimal RN, Tapia M, Böse K, Brown J, Joshi K and Mkandawire G (2004)
Exploring community beliefs, attitudes and behaviours about HIV/AIDS in eight Malawi BRIDGE districts
Baltimore, MD, Center for Communication Programs, Johns Hopkins University

Ruden S (2000)
AIDS in South Africa: Why the Churches matter
Christian Century 117(16): 566-570

Ruteikara S, Miiro H, Byamugisha G, Marum E, Wabwire D and James T (1996)
Religious beliefs and dogmas on population issues and HIV and AIDS prevention
The XIth International AIDS Conference. Vancouver, Canada. 11: 496

Seele PC (1995)
The church's role in HIV/AIDS prevention
Anglican Theological Review 77(Fall): 550-551

Setel PW (1999)
A plague of paradoxes. Aids, culture, and demography in Northern Tanzania.
Chicago, The University of Chicago Press

Seur H (1992)
Sowing the good seed: The interweaving of agricultural change, gender relations and religion in Serenje District, Zambia
Wageningen, Agricultural University Wageningen

Shelp EE (1994)
AIDS, High-risk behaviours, and moral judgements
In: Nelson JB and Longfellow SP (eds), Sexuality and the sacred: Sources for theological reflection. Louisville, Kentucky, Westminster/John Knox Press: 314-325

Singh S, Darroch JE and Bankole A (2002)
The role of behaviour change in the decline of HIV prevention in Uganda
New York, The Alan Guttmacher Institute

Singh S, Darroch JE and Bankole A (2004)
A, B and C in Uganda: The roles of abstinence, monogamy and condom use in HIV decline
Reproductive Health Matters 12(23): 129-131

Simpson A (2005)
Sons and fathers / boys to men in the time of AIDS: Learning masculinity in Zambia
Journal of Southern African Studies 31(3): 569-586

Smith DJ (2003)
Imagining HIV/AIDS: Morality and perceptions of personal risk in Nigeria
Medical Anthropology 22: 343-372

Smith DJ (2004)
Youth, sin and sex in Nigeria: Christianity and HIV/AIDS-related beliefs and behaviour among rural-urban migrants
Culture, Health and Sexuality 6(5): 425-437

> In Nigeria, popular understandings of HIV/AIDS and individual risk assessment and behaviour unfold within an interpretative grid that draws on a religious moral framework. This paper reports results from a two-year study of HIV/AIDS-related beliefs and behaviour among adolescent and young adult rural-urban migrants in two Nigerian cities. The young people in the study originate from south-eastern Nigeria, they almost uniformly identify themselves as Christian and they commonly situate their understandings and explain their behaviours in response to the HIV/AIDS epidemic in terms of religion, especially in relation to the increasingly popular and dominant religious discourses of evangelical and Pentecostal Christianity. Findings suggest that popular religious interpretations of HIV risk pose real dangers, leading many young migrants to imagine themselves as at little or no risk, and contributing to inconsistent protective practices. The study highlights the limitations of intervention strategies that ignore the extent to which religion, health, sexuality and morality intersect in people's everyday lives.

Solomon S (1996)
Religious beliefs and HIV / AIDS / STD health promotion
AIDS-STD Health Promotion Exchange 2: 1-3

Strassberg B (2003)
"The plague of blood": HIV/AIDS and ethics of the global health-care challenge
Zygon 38(1): 169-184

Stuart E and Thatcher A (eds) (1996)
Christian perspectives on sexuality and gender
Leominster, England, Gracewing

Sunder M (1998)
AIDS prevention and Christian teachings
Religion and Society 45: 112-125

Susser I and Stein Z (2000)
Culture, sexuality, and women's agency in the prevention of HIV/AIDS in Southern Africa
American Journal of Public Health 90(7): 1042-1048

Swindler A (1993)
Homosexuality and world religions
Valley Forge, Pennsylvania, Trinity Press International

Takyi BK (2003)
Religion and women's health in Ghana: Insights into HIV/AIDS preventive and protective behaviour
Social Science and Medicine 56: 1221-1234

> This article contributes to the discourse on religion and health in Africa by analysing the interrelationship between religion and AIDS behaviour in Ghana, a West African country at the early stages of the AIDS epidemic, and one where religious activities are more pronounced. It explores whether a woman's knowledge of HIV/AIDS is associated with her religious affiliation, and whether religious affiliation influences AIDS preventive (protective) attitudes. Findings indicate that religious affiliation has a significant effect on knowledge of AIDS; it is however not associated with changes in specific protective behaviour, particularly the use of condoms.

Theilen U (2003)
Gender, race, power and religion: Women in the Methodist church of southern Africa in post-apartheid society
Philipps-Universität Marburg. D Phil

Trinitapoli J and Regnerus MD (2005)
Religion and HIV risk behaviours among men: Initial results from a panel study in rural sub-Saharan Africa
Working Paper Series 2004-2005, Austin, Texas, (PRC) Population Research Center, University of Texas

> Although some scholars have identified religion as a possible protective factor in the AIDS pandemic in sub-Saharan Africa, evidence concerning the relationship between religion and AIDS behaviour there remains sparse. Using a sample of married men from rural Malawi, the authors examine whether or not AIDS risk behaviour and perceived risk are associated with religious affiliation or with religious involvement. Their analyses of data from the Malawi Diffusion and Ideational Change Project (2001) reveal few differences in perceived risk according to religious affiliation. Men belonging to Pentecostal churches consistently report lower levels of both HIV risk behaviour and perceived risk. Regular attendance at religious service is associated both with reduced odds of reporting extramarital partners and with lower levels of perceived risk of infection. Strong regional differences imply that contextual effects may play a key role in HIV risk, suggesting that religious influences may be tempered or augmented by local norms.

UNAIDS
Safe sex and Islamic values
Geneva, (UNAIDS) and (IMAU) Islamic Medical Association

Van Rossem R and Meekers D (2004)
Individual and contextual factors affecting secondary abstinence among youth in Madagascar and Cameroon
Working Paper No. 63, Washington, D.C., (PSI) Population Services International Research Division

Ward N, Kader R and Dankyau M (2004)
Bridging the gaps between religion and sexual and reproductive health and rights: The role of faith-based organisations in Africa
Sexual Health Exchange 1

Wawer M, Serwadda D, Gray R, Sewankambo N, Li C and Kiwanuka N (1996)
Religion, behaviours, and circumcision as determinants of HIV dynamics in rural Uganda
International Conference on AIDS 11(2): 483

> To determine the association between religion and HIV infection, and to assess the behaviours and characteristics that might explain differentials in HIV between religious denominations in rural Uganda. Lower rates of HIV infection among Pentecostals appear to be associated with less alcohol consumption, sexual abstinence and fewer sexual partners, whereas the low HIV prevalence in Muslims appears to be associated with low reported alcohol consumption and male circumcision.

Webster A (1995)
Found wanting - Women, Christianity and sexuality
London, Cassell

Wimberley K (1995)
From backsliding to manoeuvring: Adolescent girls, salvation and AIDS in Ankole, Uganda
Copenhagen, Centre for Development Research

Wimberley K (1996)
Saved by God - Saved from AIDS: The manoeuvres of adolescent girls in Ankole, Uganda
Institut for Antropology. Copenhagen, University of Copenhagen: 102

Woog V (2003)
Annotated bibliography on HIV/AIDS and youth in Sub-Saharan Africa
New York and Washington, The Alan Guttmacher Institute

> This annotated bibliography summarizes research findings from studies specifically focused on youth and HIV/AIDS in Sub-Saharan Africa since 1995. It was developed as background material for a project, Protecting the Next Generation: Understanding HIV Risk Among Youth, that is currently being carried out by The Alan Guttmacher Institute and partners in Burkina Faso, Ghana, Kenya, Uganda and Malawi. The goal of this project is to provide an in-depth understanding of adolescent behaviours, attitudes and motivations to reduce the spread of HIV/AIDS.

4.5 Blending African religion, health and culture

Adongo P, Phillips J and Binka F (1998)
The influence of traditional religion on fertility regulation among the Kassena-Nankana of northern Ghana
Stud Fam Plann 29(1): 23-40

Amadiume I (1997)
Reinventing Africa: Matriarchy, religion and culture
London and New York, Zed Books

Amanze JN (2002)
African traditional religions and culture in Botswana: A comprehensive textbook
Gaborone, Pula Press

Anderson A (1992)
Moya: The holyspirit in an African context
Pretoria, University of South Africa

ARHAP (2006)
Appreciating Assets: The Contribution of Religion to Universal Access in Africa, Cape Town, Report for the World Health Organization, (ARHAP) African Religious Health Assets Programme

Arhem K (1989)
Why trees are medicine: Aspects of Maasai cosmology
In: Jacobson-Widding A and Westerlund D (eds), Culture, experience and pluralism: Essays on African ideas of illness and healing. Stockholm, Acta Universitatis Upsaliensis: 75-84

Ashforth A (2001)
AIDS, witchcraft, and the problem of public power in post-apartheid South Africa
AIDS in Context Conference, University of the Witwatersrand

Badri M (1997)
The AIDS crisis: an Islamic sociocultural perspective
Kuala Lumpur, Malaysia, International Institute of Islamic Thought and Civilization

Balcomb A (2006)
Sex, sorcery, and stigma - probing some no-go areas of the denial syndrome in the AIDS debate
Journal of Theology for Southern Africa 125(July): 104-114

Bastian M (1993)
Bloodhounds who have no friends: Witchcraft and locality in the Nigerian popular press
In: Comaroff J and Comaroff J (eds), Modernity and its malcontents. Chicago, University of Chicago Press: 129-166

Bate SC (1995)
Inculturation and healing: Coping-healing in South African Christianity
Pietermaritzburg, Cluster Publications

Benn C (2002)
The influence of cultural and religious frameworks on the future course of the HIV/AIDS pandemic
Journal of Theology for Southern Africa 113(July):3-18

Berglund AI (1989)
Zulu thought-patterns and symbolism
London and Cape Town, Hurst and David Philip

Bjerke S (1989)
Witchcraft as explanation: The case of the Zinza
In: Jacobson-Widding A and Westerlund D (eds), Culture, experience and pluralism: Essays on African ideas of illness and healing. Stockholm, Acta Universitatis Upsaliensis: 219-233

Bosa GB (2000)
Traditional beliefs a stumbling block in HIV prevention and AIDS care
AIDS Abstracts-on-disk

Bruce PF (2003)
"The mother's cow": A study of Old Testament references to virginity in the context of HIV/AIDS in South Africa
In: Phiri IA, Haddad B and Masenya M (eds), African Women, HIV/AIDS and Faith Communities, Pietermaritzburg, Cluster Publications: 44-70

Caprara A, Seri D, De Gregorio GC, Parenzi A, Salazar CM and Goze T (1993)
The perception of AIDS in the Bete and Baoule of the Ivory Coast
Social Science and Medicine 36(9): 1229-1235

> The purpose of this study was to gain a better understanding of the socio-cultural aspects of transmissible diseases, in particular AIDS perceptions, among the two major Ivorian ethnic groups, the Bete and Baoule, in order to implement more suitable educational programmes. Interpretations according to traditional ways of thinking are widespread among both the Bete and Baoule. Urinating where an AIDS patient has urinated and sorcery attacks are considered possible ways of transmitting AIDS according to traditional categories of pure-impure and supernatural powers intervention. Educational level is the factor which most influences a person's knowledge of AIDS and prevention methods through western categories. The content of health education messages on AIDS, in the rural environment, cannot be separated from the Betes or Baoules conceptions of transmissible diseases.

CEDPA (2003)
Engaging community health advocates, traditional leaders and youth
(CEDPA) Centre for Development and Population Activities

Chavunduka GL (1978)
Traditional healers and the Shona patient
Gwelo, Mambo Press

Chepkwony AKA (2004)
Christian and traditional African attitudes towards HIV/AIDS
African Ecclesial Review 46(1): 55-66

Chipfakacha VG (1997)
STD/HIV/AIDS knowledge, beliefs and practices of traditional healers in Botswana
AIDS Care 9(4): 417 - 425

The study investigated knowledge, beliefs, practices and experiences of traditional healers in relation to sexually transmitted diseases (STDs), HIV and AIDS. Traditional healers see about 70% of the African patients, with all kinds of ailments. The advent of HIV/AIDS and the introduction of home-based care in most African countries has increased the case-load of many traditional healers and increased the risk of contact with people living with HIV/AIDS. Rapport between traditional healers and scientific medical personnel is essential for an effective and successful HIV/AIDS prevention and control programme.

Chitando E (2002)
Rewrapping the Christian faith indigenously
Journal of Theology for Southern Africa(112): 3-21

D'Cruz P (2002)
Engulfing darkness: The impact of HIV/AIDS on the family
Families in Society 83(4): 416-430

Douglas M (1997)
Sorcery accusations unleashed: The Lele revisited, 1987
Africa 69(1):177-193

Drews A (2000)
Guardians of the society: Witches among the Kunda and the Yoruba
Leipzig, Germany, Institut für Afrikanistik, Universität Leipzig

Ejituwu NC (1995)
Yók-òbòlò: The influence of a traditional religion on the socio-cultural life of the Andoni people
Africa: Journal of the International African Institute 65(1): 97-113

Farmer P (1992)
New disorder, old dilemmas: AIDS and anthropology in Haiti
In: Herdt G and Lindenbaum S (eds), The time of AIDS: Social analysis, theory and method. London, New Delhi, Sage Publications: 287-317

Forster PG (1998)
Religion, magic, witchcraft, and AIDS in Malawi
Anthropos 93(4-6): 537-545

Gausset Q (2001)
AIDS and cultural practices in Africa: The case of the Tonga (Zambia)
Social Science and Medicine 52: 81

Geschiere P (1997)
Witchcraft and sorcery
In: Middleton J (ed), Encyclopedia of Africa South of the Sahara. New York, Charles Scribner's Sons: 376-381

Germond P and Cochrane JR (2005)
Healthworlds: Ontological, anthropological and epistemological challenges on the interface of religion and health
Reasons of Faith: Religion in Modern Public Life, University of Witwatersrand, Johannesburg, (WISER) Wits Institute for Social and Economic Research (WISER)

Germond P and Molapo S (2005)
An ARHAP case study: Lesotho
ARHAP Case Study Colloquium, Johannesburg, June 2005

Germond P and Molapo S (2006)
In search of bophelo in a time of AIDS: Seeking a co-herence of economies of health and economies of salvation
Journal of Theology for Southern Africa 126(November)

Gifford, P (1998)
African Christianity. Its public role
Bloomington and Indianapolis, Indiana: Indiana University Press

Gray RH, Kiwanuka N, Quinn TC, Sewankambo NK, Serwadda D, Mangen FW, Lutalo T, Nalugoda F, Kelly R, Meehan M, Chen MZ, Li C, Wawer MJ and Team RP (2000)
Male circumcision and HIV acquisition and transmission: Cohort studies in Rakai, Uganda
AIDS 14: 2371-2381

Green EC (1994)
AIDS and STDs in Africa: Bridging the gap between traditional healers and modern medicine
Boulder, Colorado, Westview Press

Green EC (1999)
Involving healers
AIDS Action 46(3)

> Increasing recognition of the potential for traditional healers to prevent and control STIs and HIV/AIDS has led to a growth in STI/HIV/AIDS-prevention programs in Africa. These programs have enabled traditional healers to improve their capacity to diagnose, treat, and provide counselling. Policy and program recommendations for collaborating with traditional healers include: (1) select healers for training through a fair and democratic system, (2) work with healers who are respected in their communities, (3) do not require membership in an association, and (4) encourage healers to promote sexual abstinence for youth and fidelity for married couples.

Green EC, Zokwe B and Dupree JD (1995)
The experience of an AIDS prevention program focused on South African traditional healers
Social Science and Medicine 40(4): 503-515

Gregson S, Zhuwau T, Anderson RM and Chandiwana SK (1999)
Apostles and Zionists: The influence of religion on demographic change in rural Zimbabwe
Population Studies 53: 179-193

Gundani PH (2004)
Continuity and change in the Zimbabwean religio-cultural landscape in the era of HIV/AIDS
In: Harold-Berry D (ed), Zimbabwe: The past is the future. Harare. Jewel

Gwele M (2005)
Medical pluralism in Khayamandi, Stellenbosch
Dissertation, University of Cape Town, South Africa

Hammond-Tooke WD (1989)
Rituals and medicines: Indigenous healing in South Africa
Johannesburg, Donker

Homsy J, King R, Balaba D and Kabatesi D (2004)
Traditional health practitioners are key to scaling up comprehensive care for HIV/AIDS in sub-Saharan Africa
AIDS 18(12): 1723-1725

Homsy J, King R, Tenywa J, Kyeyune P, Opio A and Balaba D (2004)
Defining minimum standards of practice for incorporating African traditional medicine into HIV/AIDS prevention, care, and support: A regional initiative in eastern and southern Africa
Journal of Alternative and Complementary Medicine 10(5): 905-910

Hurskainen A (1989)
The epidemiological aspect of spirit possession among the Maasai of Tanzania
In: Jacobson-Widding A and Westerlund D (eds), Culture, experience and pluralism: Essays on African ideas of illness and healing. Stockholm, Acta Universitatis Upsaliensis: 139-150

Ingstad B (1989)
Healer, witch, prophet or modern health worker? The changing role of Ngaka ya Setswana
In: Jacobson-Widding A and Westerlund D (eds), Culture, experience and pluralism: Essays on African ideas of illness and healing. Stockholm, Acta Universitatis Upsaliensis: 247-276

Jansen G (2001)
The labyrinth of medical pluralism in Africa: A missiological appraisal, AD 2000
Missionalia 29(1): 69-91

Janzen JM (1978)
The quest for therapy in lower Zaire
Berkeley, University of California Press

Janzen JM (1982)
Lemba, 1650-1930; A drum of affliction in Africa and the new world
New York, Garland

Janzen JM (1991)
Ngoma: Discourses of healing in central and southern Africa
Berkeley, University of California Press

Jilek W (1993)
Traditional medicine relevant to psychiatry
In: Sartorius N, Girolamo GD, Andrews G and German GA (eds), Treatment of mental disorders.
Washington, DC, Geneva, (WHO) World Health Organization and American Psychiatric Press: 341-390

Kalu OU, Hofmeyr JW and Maritz PJ (eds) (2005)
African Christianity - an African story
Pretoria, University of Pretoria

Kapungwe A (2003)
Traditional cultural practices of imparting sex education and the fight against HIV/AIDS: The case of initiation ceremonies for girls in Zambia
African Sociological Review 7(1): 35-52

Kealotswe ON (2001)
Healing in the African Independent Churches in the era of AIDS in Botswana: A comparative study of the concept of diagelo and the care of home-based patients in Botswana
Missionalia 29(2): 220-231

Keane E (1993)
Zambia
In: Wicks RJ and Estadt BK (eds), Pastoral counselling in a global church: Voices from the field. Maryknoll, NY, Orbis: 70-81

Kiernan J (1994)
Variations on a Christian theme: The healing synthesis of Zulu Zionism
In: Stewart CS, R (ed), Syncretism/Anti-syncretism: The Politics of Religious Synthesis. London, Routledge: 69-84

Kiernan J (1995)
The African Independent Churches
In: Prozesky M and De Gruchy J (eds), Living Faiths in South Africa. Cape Town, David Philip: 116-128

Kiiti NC (2002)
The role of indigenous knowledge in HIV/AIDS communication and education in Eastern Kenya: A perspective from the Kamba community
Cornell University. PhD

King R (2000)
Collaboration with traditional healers in HIV/AIDS prevention and care in sub-Saharan Africa: A literature review
Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

King R (2002)
Ancient remedies, new disease: Involving traditional healers in increasing access to AIDS care and prevention in east Africa
UNAIDS Best Practice Collection, Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

Kwenda CV (1999)
Affliction and healing: Salvation in African religion
Journal of Theology for Southern Africa 103: 1-12

Leclerc-Madlala S (2002)
On the virgin cleansing myth: Gendered bodies, AIDS and ethnomedicine
African Journal of AIDS Research 1: 87-95

MacDonald D (1996)
Notes on the socio-economic and cultural factors influencing the transmission of HIV in Botswana
Social Science and Medicine 42(9):1325-1333

Magesa L (2000)
Taking culture seriously: Recognizing the reality of African religion in Tanzania
In: Keenan JF (ed), Catholic Ethicists on HIV/AIDS Prevention. New York and London, Continuum: 76-84

Magezi V and Louw DJ (2006)
Congregational Home-based pastoral care: Merging the African family and church family systems for effective HIV ministry
Journal of Theology for Southern Africa 125(July): 64-79

Mahlke R (1995)
Aspects of healing in Zionist churches in Southern Africa
Africana Marburgensia 28(1-2): 14-31

Maluleke T (2000)
The rediscovery of the agency of Africans
Journal of Theology for Southern Africa 108: 19-37

Malungo JRS (2001)
Sexual cleansing (kusalazya) and levirate marriage (kunjilila mung'anda) in the era of AIDS: Changes in perceptions and practices in Zambia
Social Science and Medicine 53: 371-382

Masterson JM and Swanson JH (2000)
Female genital cutting: Breaking the silence, enabling change
(ICRW) International Center for Research on Women

McElroy A and Jezewski MA (2000)
Cultural variation in the experience of health and illness
In: Albrecht GL, Fitzpatrick R and Scrimshaw SC (eds), The handbook of social studies in health and medicine. London, Sage

Moila MP (2000)
Caring in traditional African society
Bulletin for Contextual Theology in Africa 7(1): 21

Mudoola DM (1996)
Religion, ethnicity and politics in Uganda
Kampala, Fountain Publishers

Mugambi JNK (2000)
African heritage and contemporary Christianity
Nairobi, Kenya, Longhorn Publishers

Murray C (1979)
The work of men, women and the ancestors: Social reproduction in the periphery of Southern Africa
In: Wallman S, The social anthropology of work. New York, Academic Press

Ngubane H (1977)
Body and mind in Zulu medicine: An ethnography of health and disease in Nyuswa-Zulu thought and practice
London/New York/San Francisco, Academic Press

Ngubane H (1981)
Clinical practice and organization of indigenous healers in South Africa
Social Science and Medicine 15(b): 361-366

Ntsimane R (2000)
The challenge of AIDS in the rural AICs
Bulletin for Contextual Theology in Africa 7(1): 22-25

Nzioka C (2000)
The social meanings of death from HIV/AIDS: An African interpretive view
Culture, Health and Sexuality: 1-14

Olsson T (1989)
Philosophy of medicine among the Maasai
In: Jacobson-Widding A and Westerlund D (eds), Culture, experience and pluralism: Essays on African ideas of illness and healing. Stockholm, Acta Universitatis Upsaliensis: 235-246

Omar, R (2002)
Muslims and religious pluralism in post-apartheid South Africa
Journal of Muslim Minority Affairs 22(10):220-224

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The healer-prophet in Afro-Christian churches
Leiden, E. J. Brill

Oosthuizen GC, Edwards SD, Wessels WH and I.Hexham (eds) (1989)
Afro-Christian religion and healing in Southern Africa
Lewiston, NY, Edwin Mellen

Paris P (1995)
The spirituality of African peoples: The search for a common moral discourse
Minneapolis: Fortress Press

Parry S (2002)
Responses of the churches to HIV/AID: Three Southern African Countries
Harare and Geneva, (WCC) World Council of Churches, Ecumenical HIV/AIDS Initiative in Africa, Southern Africa Regional Office

Patel V, Mutambirwa J and Nhiwatiwa S (1995)
Stressed, depressed, or bewitched? A perspective on mental health, culture and religion
Development in Practice: an Oxfam Journal 5(3): 216-224

Pato LL (1997)
Being fully human: From the perspective of African culture and spirituality
Journal of Theology for Southern Africa 97: 53-61

Pearce TO (2002)
Cultural production and reproductive issues: The significance of the charismatic movement in Nigeria
In: Ellingson S (ed), Religion and sexuality in cross-cultural perspective. New York and London, Routledge: 21-50

Pfeiffer J (2002)
African independent churches in Mozambique: Healing the afflictions of inequality
Medical Anthropology Quarterly 16: 176-199

Price N (1995)
The value of children amongst the Kikuyu of Central Province, Kenya: An anthropological perspective on fertility
Swansea, University College of Swansea. Centre for Development Studies

Probst P (1996)
Mchape '95, or, the sudden fame of Billy Goodson Chisupe: Healing, social memory and the enigma of the public sphere in post-Banda Malawi
Africa 69(1): 108-138

Prozesky M and De Gruchy J (eds) (1995)
Living Faiths in South Africa
Cape Town, David Philip

Richter M (2003)
Traditional medicines and traditional healers in South Africa
(TAC) Treatment Action Campaign and Aids Law project

Traditional healers have a crucial role to play in building the health system in South Africa and strengthening and supporting the national response to HIV/AIDS. This paper sketches a background to traditional healing in South Africa and discusses international policies, guidelines and the South African legal framework on traditional health practitioners. It argues for the regulation of traditional healers and traditional medicine, as well as for the application of human rights principles within the traditional healing profession. The paper concludes with advocacy strategies and ways of aligning traditional healing with a human rights framework.

Rozin P, Markwith M and Nemeroff C (1992)
Magical contagion beliefs and fear of AIDS
Journal of Applied Social Psychology 22: 1081-1092

Sahl IMG, Elkarib AAK and Mohamed EMI (2004)
Towards a new 'silif': Breaking the silence on FGM among the Beja pastoralists of eastern Sudan
Development Practice Series 1, Nairobi and London, (ACORD) Agency for Co-operation and Research in Development

Saayman WA (1992)
AIDS, healing and culture in Africa: A Christian mission perspective
Journal of Theology for Southern Africa 78: 41-56

Schoffeleers JM (1991)
Ritual healing and political acquiescence: The case of Zionist churches in Southern Africa
Africa 61(1): 1-25

Schoffeleers JM (1999)
The AIDS pandemic, the prophet Billy Chisupe, and the democratisation process in Malawi
Journal of Religion in Africa 29(4): 406-441

Schott J and Henley A (1996)
Culture, religion and childbearing in a multiracial society: A handbook for health professionals
Oxford, Butterworth Heinemann.

Scorgie F (2005)
Weapons of faith in a world of illness: Zionist prophet-healers confront HIV/AIDS in rural KwaZulu-Natal, South Africa
Reasons of Faith: Religion in Modern Public Life, WISER, University of the Witwatersrand

This paper sets out preliminary findings from an ongoing ethnographic study, based in the area of Centocow (the vicinity of St. Apollinaris mission hospital), in rural southern KwaZulu-Natal. The study, which dates from late 2004 but also draws on data from earlier field experience, seeks to map local interpretations of HIV/AIDS at a critical point in the history of the epidemic in South Africa and to locate these interpretations within a framework of regional religious traditions. More narrowly, the portion of the study represented in this paper is particularly concerned with Zionist Pentecostal healing practices. It asks not only how these practices are being mobilized to treat people who are very ill, but also what perceptions of HIV/AIDS they are helping to sustain in these communities.

Staugård F (1985)
Traditional healers: Traditional medicine in Botswana
Gaborone, Ipelegeng Publishers

Thorpe SA (1993)
Shamans, medicine men and traditional healers: A comparative study of shamanism in Siberian Asia, southern Africa and North America
Pretoria, University of South Africa

UNAIDS (2002)
Ancient remedies, new disease: Involving traditional healers in increasing access to AIDS care and prevention in East Africa
Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

UNFPA (2004)
Culture matters: Working with communities and faith-based organizations: Case studies from country programmes
New York, (UNFPA) United Nations Population Fund

Van Dijk RA (1995)
Fundamentalism and its moral geography in Malawi: The representation of the diasporic and the diabolical
Critique of Anthropology: A Journal for the Critical Reconstruction of Anthropology 15(2): 171-191

Vambe MT (1971)
The isangoma: An adaptive agent among urban Zulu
Anthropological Quarterly 44(2): 51-65

Vambe MT (2003)
HIV/AIDS, African sexuality and the problem of representation in Zimbabwean literature
Journal of Contemporary African Studies 21(3): 473-488

Van Binsbergen WMJ and Schoffeleers JM (eds) (1985)
Theoretical explorations in African religion
London/Boston, Kegan Paul International

Vaughn M (1991)
Curing their ills: Colonial power and African illness
Cambridge, Polity

Vaughan M (1994)
Healing and curing: Issues in the social history and anthropology of medicine in Africa
Social History of Medicine 7(2):283-295

Vilakazi HW (2003)
Traditional medicine and modern medicine
National Research Foundation

West M (1975)
The shades come to town: Ancestors and urban independent churches
In: Whisson MG and West M (eds), Religion and social change in Southern Africa. Cape Town, David Phillip: 185-206

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Penicillin, battery acid and sacrifice - cures and causes in Nyole medicine
Social Science and Medicine 16(23): 2055-2064

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Anthropological approaches to African misfortune, from religion to medicine
In: Jacobson-Widding A and Westerlund D (eds), Culture, experience and pluralism: Essays on African ideas of illness and healing. Stockholm, Uppsala: 289-301

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Traditional healers as tuberculosis treatment supervisors: precedent and potential
International Journal of Tubercle and Lung Disease 3(9):838-842

Wreford J (2005)
'We can help!' - A literature review of current practice involving traditional African healers in biomedical HIV/AIDS interventions in South Africa
Working paper, Cape Town, (CSSR) Centre for Social Science Research, University of Cape Town

> This review describes the available research literature involved with efforts at collaboration between Traditional African Healers (TAHs) and biomedical practitioners in HIV/AIDS interventions in Southern Africa. The paper draws on academic texts including published and unpublished research papers, books and reports, and press comments on the subject. The focus is on Southern African literature, but selected texts from elsewhere on the continent are also included. The paper interrogates, in particular, the roles assigned to more spiritually inspired practitioners, such as sangoma, in these interventions. The paper considers the effects on relationships between biomedicine and the traditional health sector and explores some of the obstacles in the way of successful future collaborations. The analysis addresses the following questions: What are the roles assigned to sangoma and other traditional health practitioners in biomedically constructed HIV/AIDS interventions to date? What has been the experience of sangoma and traditional health practitioners of these interventions, and how have biomedical professionals involved in these interventions responded to the traditional health practitioners? What factors contribute to negative responses where these occur, and how might these be addressed? Could the roles of sangoma and traditional health practitioners be enhanced to improve the effectiveness of HIV/AIDS interventions?

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4.6 Challenges, calls for change and increased partnership

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Department of Religion and Development. Pietermaritzburg, University of KwaZulu Natal. MTh

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Pretoria, Catholic Theological Society of Southern Africa and Cluster Publications

> "Responsibility in a time of AIDS" was the theme of a conference held to develop a better Southern African Catholic theological response to the HIV/AIDS pandemic. This manual includes material generated for the conference. It contains 6 parts: 1) responsibility in Catholic tradition and its link to HIV/AIDS; 2) responsibility and the prevention of HIV/AIDS; 3) responsibility in caring for one another; 4) responsibility and African culture; 5) responsibility and the media; 6) responsibility in religious and cultural healing.

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International Review of Mission 90(359): 471-472

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Geneva, Switzerland, (EAA) Ecumenical Advocacy Alliance

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The theological and pastoral implications of AIDS to Uganda Series, Vol. 2., Kampala, Uganda, Tricolour

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London, UK, TALC

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London, UK, Mission and Public Affairs Council, Church of England

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Theology and the HIV/AIDS epidemic
London, Christian Aid

Cochrane JR (2006)
Of bodies, barriers, boundaries and bridges: Ecclesial practice in the face of HIV and AIDS
Journal of Theology for Southern Africa 126(November)

> Are the churches competent to understand and respond to the crisis represented by HIV and AIDS? What kind of ecclesial practice is required for an adequate response? And why should HIV and AIDS take front place when so many other challenges exist? Three main points, interwoven with each other and linked to field research on the faith-based Masangane project's comprehensive response to HIV and AIDS, are argued. First, that HIV and AIDS present not just a health challenge, but a socially comprehensive one, and therefore, a properly targeted response to HIV and AIDS concerns social systems and people's lifeworlds, including their religious ways of being and seeing. The second point concerns what churches hold as assets, tangible and intangible, that may be crucial to our capacity to deal with HIV and AIDS. The third notes that these religious health assets are deeply rooted in the foundational norms of the Christian faith tradition, for which reason a concern for health, understood comprehensively, is not a sectoral issue but a central one for the self-understanding of the churches in the world.

Cochrane JR (2006)
Religion, public health and a church for the 21st century
International Review of Mission 95(376-377): 59-72

In the midst of enormous challenges threatening the public health systems in sub-Saharan Africa, faith based organizations (FBOs) are making a substantial contribution to the health of communities. This paper offers a brief retro-spective into the development of such collaboration; and how scientific 'religion blindness' made it all but invisible. The paper emphasizes the connection between (ill-)health, power and justice as essential area of concern for people of faith. It closes by stressing the need for collaboration, not only between the religious and public health sectors, but also among those who are seeking to understand this area.

Cochrane JR (2007)
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The challenge of HIV/AIDS to Christian Theology. University of the Western Cape

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How then shall we be saved? AIDS, community and redemption
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Journal of Theology for Southern Africa 117: 20-39

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Talk to Religion and Health connection Luncheon, of the Interfaith Health Program of Rollins School of Public Health, Emory University

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Journal of Theology for Southern Africa 114: 31-42

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HIV and AIDS campaign 2005-2008: Keep the promise
Bulletin no. 3, Geneva, Switzerland, (EAA) Ecumenical Advocacy Alliance

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Bath, UK, Futures Group

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Religion as a source of social change in the new South Africa
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(PACSA) Pietermaritzburg Agency for Christian Social Awareness.

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A shared mission? Changing relationships between government and church health services in Africa
International Journal of Health Planning and Management 17: 333-353

Haddad B (2005)
Reflections on the church and HIV/AIDS
Theology Today 62(1): 29-37

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We pray but we canno heal: Theological challenges posed by the HIV/AIDS crisis
Journal of Theology for Southern Africa 125(July): 80-90

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Public-private partnerships for public health
Harvard, Harvard Center for Population and Development Studies

> Global health problems, one might argue, require global solutions, and public-private partnerships are increasingly called upon to provide these solutions. Such partnerships involve private corporations, governments, international agencies, and non-governmental organisations. They can produce the desired outcomes, but they also bring their own problems. This volume examines the organisational and ethical challenges of partnerships, and ways to address them. How do organisations with different values, interests, and world-views come together to address and resolve critical public health issues? How are shared objectives and shared values created within a partnership? How are relationships of trust fostered and sustained to address the conflicts, uncertainties, and risks of partnerships? This book focuses on public-private partnerships that seek to expand the use of specific products to improve health conditions in poor countries. The volume features case studies of international partnerships focusing on diseases such as trachoma and river blindness, international organisations such as the World Health Organization and multinational pharmaceutical companies, and particular technologies such as pharmaceutical products and immunisation. Individual chapters draw lessons from successful as well as troubled partnerships to help guide efforts to reduce global health disparities.

Iwere N, Ojidoh JC and Okide N (2000)
Engaging religious communities in breaking the silence on HIV/AIDS
The XIIIth International AIDS Conference. Durban, South Africa

The authors of this paper argue that an issue which could be a factor in the effectiveness of faith based organisations in mitigating the effects of HIV/AIDS is that of co-operation between themselves and non-governmental organisations, governments and other institutions, and the often-negative perceptions that other organisations may have toward them. They go on to state that faith based organisations could contribute more than they are presently allowed to if their assistance were accepted without prejudice.

Kanyoro M (2003)
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3rd Pan African Conference of the Circle of Concerned African Women Theologians, Addis Ababa, Ethiopia

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HIV and AIDS: A justice perspective
Lusaka, Zambia, The Jesuit Centre for Theological Reflection

Jesuit priest and scholar, Kelly suggests a dynamic framework within which to look at the prevention and treatment of HIV by linking justice concerns such as poverty, gender disparities and power structures, stigma and discrimination, and global socioeconomic structures and practices. He does this by linking justice concerns such as poverty, gender disparities and power structures, stigma and discrimination, and global socio-economic structures and practices.

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Cape Town, South Africa, Fikelela Aids Project

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The reality of HIV/AIDS
Christian perspectives on development issues. Ireland and London, Trocaire, Veritas and CAFOD

Messer D (2004)
Breaking the conspiracy of silence: Christian churches and the global AIDS crisis
Minneapolis, Augsberg Fortress

> More than twenty years into the global AIDS pandemic, the efforts of Christian congregations and denominations have been less than minimal. This book is aimed to awaken Christian compassion in the coming years to this fathomless tragedy. "At this unprecedented kairos moment in human history," says Messer, "God is calling the church to a new mission and ministry." Drawing on his own involvement in global AIDS education in Asia, Latin America, and Africa, Messer uses stories, basic factual information, and theological insights to motivate lay and clerical Christians to assume leadership and form partnerships with Christians around the world in this struggle. Just as individuals must change their behaviour to prevent and eliminate AIDS, so must congregations and church leaders. Compassion, not condemnation, is desperately needed, says Messer. But financial resources for education and prevention programs are also urgently required from churches. Messer shows how churches can partner with ecumenical organizations, relief agencies, volunteer mission programs, healthcare programs, and other agencies to engage global AIDS directly and effectively.

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Project Project and USAID (RHAP) Regional HIV/AIDS Program for Southern Africa

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Richardson N (2006)
A call for care: HIV/AIDS challenges the church
Journal of Theology for Southern Africa 125(July): 38-50

> The motivating question may seem simple: why should Christian churches be involved in caring for those infected and affected by HIV/AIDS? The answer, however, turns out to be a complex one, requiring a carefully nuanced ecclesiological perspective. The very nature and function of the church - what the church is and what it does, obliges the church to be active in responding to HIV/AIDS.

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Journal of Theology for Southern Africa 125(July): 91-103

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New York, The Alan Guttmacher Institute

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4.7 Pastoral care through education

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Kampala, Uganda, Tricolour

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Theology and the HIV/AIDS epidemic
Christian Aid.

> This paper offers a theological framework for discussion of issues relating to HIV/AIDS that is based on the work of Karl Barth and Jurgen Moltmann. Case studies from sub-Saharan Africa and elsewhere help illustrate the situation of people living with HIV and the commitment of those who seek to help them. The paper is intended as a basis for discussion and is addressed particularly to church leaders, academics and those with some knowledge of theology. It is also suitable for use in church groups and other forums for discussion and debate.

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Bulawayo, Zimbabwe, Scripture Union Africa

Dortzbach K and Kiiti N (1996)
Helpers for a healing community: A pastoral counselling manual for AIDS
Nairobi, Kenya, MAP International

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Africa praying: A handbook on HIV/AIDS sensitive sermons guidelines and liturgy
Geneva, (WCC) World Council of Churches: 29

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HIV/AIDS and the curriculum: Methods of integrating HIV/AIDS in theological programmes
Geneva, (WCC) World Council of Churches

> In response to HIV/AIDS and its consequences, this collection of essays by young African scholars proposes a pattern of Christian education designed to equip churches for ministry in a time of crisis. This is a collection of essays that "represents our efforts in the continent of Africa to contribute towards the struggle against HIV/AIDS". The collection came out of workshops to train theological educators on how to implement the HIV/AIDS curriculum in their educational institutions. It is also for those in the church who need to deal with HIV/AIDS in their preaching, Sunday-school sessions and liturgy.

Gennrich D (ed) (2004)
The Church in an HIV+ world: A practical handbook
Pietermaritzburg, South Africa, Cluster Publications

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Liturgical Study Group Material, (CPSA) Church of the Province of Southern Africa

HARP (2001)
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(HARP) HIV/AIDS, Malaria and Tuberculosis Resource Project, (CCIH) Christian Connections for International Health
Bibliography of mixed materials on Christian responses to HIV/AIDS from around the world.

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Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS and (IMAU) Islamic Medical Association of Uganda.

This report discusses the community-based health efforts of IMAU, an association of medical practitioners who believe that if HIV/AIDS education efforts are to reach Muslim communities, they must involve religious leaders. The report examines the epidemiology of HIV/AIDS in Uganda and around the world and provides statistics on the practice of Islam in Uganda. The report discusses three community-based HIV/AIDS prevention education programs and discusses ways to mobilize volunteers in the Muslim setting, to empower women so that they may take a more active role in HIV/AIDS prevention, and to make condom use more socially acceptable among more orthodox groups. Throughout the report are personal anecdotes concerning HIV/AIDS education within an Islamic framework in Uganda.

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Cape Town, Fikelela AIDS Project

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African Ecclesiastical Review 46(1): 1-99

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HIV/AIDS our greatest challenge yet! The road ahead for the church in South Africa
Wellington, South Africa, Lux Verbi

Positive Muslims (2004)
HIV, AIDS and Islam: Reflections based on compassion, responsibility and justice
Observatory, South Africa, Positive Muslims

Richardson RN (2000)
HIV and AIDS in the theological curriculum? Reflections of the HIV and AIDS consultation for theological institutions in eastern and southern Africa, Nairobi, Kenya, June 2000
Bulletin for Contextual Theology in Africa 7(1)

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Geneva, (WCC) World Council of Churches, Ecumenical HIV/AIDS Initiative in Africa

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Community counselling: A handbook for facilitating care and change
London, Salvation Army International, The HIV and AIDS Programme Facilitation Team

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Meeting Christ in HIV/AIDS 2001
Salt River, Cape Town, Methodist Publishing House

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4.8 Intervention through community care

- *See Section 4.1 for more general references on religious responses to HIV/AIDS and other health crises*

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International Journal of Palliative Nursing 6(3): 108

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Interpretation 69(2): 117-129

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Liturgical Study Group

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Association of Nurses in AIDS Care 14(4): 25-36

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Healing in the African Independent Churches in the era of AIDS in Botswana: A comparative study of the concept of diagelo and the care of home-based patients in Botswana
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Missionalia 29(2): 200-219

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How to avoid HIV/AIDS ministry burnout
Church and Society 85: 61-66

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New York, Macmillan

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Community, care, change, and hope: local responses to HIV in Zambia
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Congregational Home-based pastoral care: Merging the African family and church family systems for effective HIV ministry
Journal of Theology for Southern Africa 125(July): 64-79

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Guide to HIV/AIDS pastoral counselling
Geneva, (WCC) World Council of Churches

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Journal of Social Issues 5(2): 177-193

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Social Science and Medicine 56(2): 259-269

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Models of community/home-based care for people living with HIV/AIDS in Southern Africa
Journal of Association of Nurses in Aids Care 16(3) 33-40

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Missionalia 29(2): 282-303

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Department of Practical Theology, (UNISA) University of South Africa. M Th

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Military Chaplains' Review 17(1): 1-139

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The contribution of Christian congregations to the battle with HIV and AIDS at the community level
Oxford, Global Mapping International for Oxford Centre for Mission Studies

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Chicago, Wadsworth Publishing Company

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The unveiling of tombstones among the African Independent Churches
In: Oosthuizen GC and Hexham I (eds), Empirical studies of African Independent/Indigenous Churches. New York, Edwin Mellor: 129-140

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London, SCM Press

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American Journal of Pastoral Counselling 3(3): 207-228

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Working for God? Evaluating service delivery of religious not-for-profit health care providers in Uganda
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The home health care agency: A new setting for pastoral care
Journal of Pastoral Care 40(3): 247-251

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Constructing death: The sociology of dying and bereavement
Cambridge, Cambridge University Press

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Terminal care for people with AIDS
London, Edward Arnold

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American Behavioural Scientist 42(7): 1175

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The response of religious congregations to the spiritual needs of people living with HIV/AIDS
Journal of Pastoral Care 51 (4): 415-426

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Working with dying people
In: Obholzer A (ed), The unconscious at work: individual and organizational stress in the human services. London, Routledge: 106

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Facing death: Where culture, religion, and medicine meet
New Haven, Yale University Press

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Safer Text: Reading Biblical Laments in the Age of AIDS
Theology and Sexuality 10: 16-27

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Faith untapped: Why churches can play a crucial role in tackling HIV and AIDS in Africa
Teddington, UK, Tearfund

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Breaking the fine rain of death: African American health issues and a womanist ethic of care
New York, Continuum

UNAIDS (2000)
Caring for the carers: Managing stress in those who care for people with HIV and AIDS
UNAIDS Best Practices Collection, Geneva, (UNAIDS) Joint United Nations Programme on HIV/AIDS

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Expanding the care continuum for HIV/AIDS: Bringing carers into focus
Population Council, USAID

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An evaluation of the integrated community based home care model
Pinelands, South Africa, Hospice Association of Southern Africa

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The church and HIV/AIDS (a Ugandan pastoral experience)
African Ecclesiastical Review 46(1): 23-34

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Historical and cultural variants on the good death
British Medical Journal 327: 218-220

Wuthnow R (1991)
Acts of compassion: Caring for others and helping ourselves
Princeton, Princeton University Press

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Social capital in church-related volunteerism
In: Seven essays on Scandinavian civil society, Stockholm, Handelshogskola: 141-172

4.9 Spiritual mechanisms

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Appreciating Assets: The Contribution of Religion to Universal Access in Africa, Cape Town, Report for the World Health Organization, (ARHAP) African Religious Health Assets Programme

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Inculturation of the Christian mission to heal in the South African context
New York, NY, Edwin Mellen Press

Bate SC (1995)
Inculturation and healing: Coping-healing in South African Christianity
Pietermaritzburg, Cluster Publications

Benn C (2001)
Does faith contribute to healing? Scientific evidence for a correlation between spirituality and health
In: Neglected dimensions in health and healing: Concepts and explorations in an ecumenical perspective, Tübingen, (DIFAEM) German Institute for Medical Mission. Study Document No 3: 49-58

Benn C, Jakob B and Senturias E (eds) (2001)
Neglected dimensions in health and healing: Concepts and explorations in an ecumenical perspective
Tübingen, (DIFAEM) German Institute for Medical Mission. Study Document No 3

Bolland JM (2003)
Hopelessness and risk behaviour among adolescents living in high-poverty inner-city neighbourhoods
Journal of Adolescents 26: 145-158

Cannell T (2006)
Funerals and AIDS, resilience and decline in KwaZulu-Natal
Journal of Theology for Southern Africa 125: 21-37

> Extravagance and selfishness in funerals are often cited as an example of social decline due to the HIV epidemic in KwaZulu-Natal. In this paper these claims are put into an historical context and contrasted with the claim that Zulu rituals are evolving adaptively to face the challenges that high mortality and HIV stigma present to faith communities. Decline and resilience are contained within a single event, the funeral, and it is for ministers to lead their parishioners in a meaning interpretation of their faith practices that fosters care for the bereaved.

Cochrane JR (2006)
Religion in the health of migrant communities: Cultural assets or medical deficits?
Journal of ethnic and migration studies 32(4): 715-736

Commission for Africa (2005)
Our common interest: Report of the Commission for Africa
London, UK, Commission for Africa

Coulson A (ed) (1998)
Trust and contracts. Relationships in local government, health and public services
Bristol, The Policy Press

Culliford L (2002)
Spirituality and clinical care
British Medical Journal 323: 1434-1435

Dane B (2000)
Thai women: Meditation as a way to cope with AIDS
Journal of Religion and Health 39(1)

> Mental-health professionals often ignore the spirituality and religious beliefs that can aid a person's ability to cope with a life-threatening illness such as HIV/AIDS. The purpose of this study was to explore the role of meditation in Thai Buddhist women who are infected with HIV/AIDS.

Droege T (1991)
The faith factor in healing
Trinity Press International

Dube MW
Healing where there is no healing: Reading the miracles of healing in an AIDS context
In: Reading communities, reading scripture. Harrisburg, Trinity: 121-133

Dubree M and Vogelpohl R (1980)
When hope dies - so might the patient
American Journal of Nursing 80(11): 2046-2049

Du Toit C (2002)
The place of values in the science-religion dialogue: biology, human nature and the cultural environment
Journal of Theology for Southern Africa 113: 75-95

Fowler JW (1993)
Alcoholics Anonymous and faith development
In: McCrady BS and Miller WR (eds), Research on Alcoholics Anonymous. New Brunswick, NJ, Rutgers Center of Alcohol Studies: 113-135

Froestad J (2001)
Interest, knowledge and identity: The potential for building administrative systems based on trust in the health sector, some lessons from the Western Cape Province, South Africa
Cape Town, South Africa, University of Bergen, School of Government and (UWC) University of the Western Cape

Froestad J (2002)
Health, democracy and governance in South Africa: Two case studies
Unpublished book manuscript

> Excellent research on the Hout Bay community, its history and the polity governing its divisions and health programmes. The essay is detailed in its tracking of historical developments to do with the settling and governing of Hout Bay, and offers a superb analysis of the many complex factors that inhibit a satisfactory resolution of its health problems, particularly in Imizamo Yethu. These include local dynamics, the patterns of local governance, the contradictions in provincial and municipal health structures, the role of NGOs. His conclusion is that there can not be much expectation of any resolution of the situation as long as things stand they way they are. In this respect, he suggests that human factors, such as trust, honesty, willingness to work in solidarity, and the like, will have a greater impact than any formal policy shifts.

Gilson L (2003)
Trust and the development of health care as a social institution
Social Science and Medicine 56: 1453-1468

> Health systems are inherently relational and so many of the most critical challenges for health systems are relationship and behaviour problems. Yet the disciplinary perspectives that underlie traditional health policy analysis offer only limited and partial insights into human behaviour and relationships. The health sector, therefore, has much to learn from the wider literature on behaviour and the factors that influence it. A central feature of recent debates, particularly, but not only, in relation to social capital, is trust and its role in facilitating collective action, that is cooperation among people to achieve common goals. The particular significance of trust is that it offers an alternative approach to the economic individualism that has driven public policy analysis in recent decades. This paper considers what the debates on trust have to offer health policy analysis by exploring the meaning, bases and outcomes of trust, and its relevance to health systems. It, first, presents a synthesis of theoretical perspectives on the notion of trust. Second, it argues both that trust underpins the co-operation within health systems that is necessary to health production, and that a trust-based health system can make an important contribution to building value in society. Finally, five conclusions are drawn for an approach to health policy analysis that takes trust seriously.

Gilson L (2005)
Building trust and value in health systems in low- and middle-income countries
Editorial, Social Science and Medicine 61(7):1381-1384

Gilson L, Palmer N and Schneider H (2005)
Trust and health worker performance: Exploring a conceptual framework using South African evidence
Social Science and Medicine 61(7): 1418-1429

Two relationships of particular importance to health care provision are those between patient and provider, and health worker and employer. This paper presents an analytical framework that establishes the key dimensions of trust within these relationships, and suggests how they may combine in influencing health system responsiveness. The analysis suggests that respectful treatment is the central demand of primary care service users, in terms of positive attitudes/behaviours, thoroughness, and technical competence, as well as institutions that support fair treatment. The findings also suggest that the notion of workplace trust (combining trust in colleagues, supervisor and employing organisation) has relevance to provider experiences of their workplaces, and so can provide important insights for strengthening management.

Goudge J and Gilson L (2005)
How can trust be investigated? Drawing lessons from past experience
Social Science and Medicine 61(7): 1439-1451

Although the concept of trust has gained popularity in public debate and academic analysis over recent years, it continues to be regarded by many as difficult to define and so to investigate. In the authors provide guidance on how to conduct future work on trust in the health sector, by reviewing the methods used in earlier studies. The review suggests that appropriate definitions of trust are highly context dependent.

Harrison RL (1997)
Spirituality and hope: Nursing implications for people with HIV disease
Holistic Nursing Practice 12(1): 9-16

James R (2005)
Building organisational resilience to HIV/AIDS: Implications for capacity building
Praxis Paper No. 4, (INTRAC) The International NGO Training and Research Centre

HIV/AIDS is fast becoming the worst ever human disease disaster; it is also having an immense impact on the internal organisation of civil society organisations (CSOs) as staff themselves become both infected and affected. There is therefore a desperate need to build not just individual, but organisational resilience to the disease. This paper highlights the vital role of capacity building providers in ensuring that organisational resilience to HIV/AIDS is brought onto the agenda of their clients. This is especially important because many CSOs may feel overwhelmed by the possible impacts of HIV/AIDS on their own organisation. Capacity builders need to be very aware of the issues and have the competencies to support clients in addressing HIV/AIDS mainstreaming in their external programmes and relationships as well as in their internal organisation. It will require HIV/AIDS specialists to develop OD skills as well as OD practitioners developing knowledge and skills in HIV/AIDS. HIV/AIDS will require capacity building practitioners to adapt both the content of their services and methods of delivery.

Klein M and Coombes Y (2005)
Trust and condom use: The role of sexual caution and sexual assurances for Tanzanian youth (a baseline survey)
Working Paper No 64, (PSI) Population Services International Research Division

Koenig HG (1999)
The healing power of faith: Science explores medicines last great frontier
New York, Simon and Schuster

Kwenda CV (1999)
Affliction and healing: Salvation in African religion
Journal of Theology for Southern Africa 103: 1-12

Kylma J, Vehvilainen-Julkunen K and Lahdevirta J (2001)
Hope, despair and hopelessness in living with HIV/AIDS: A grounded theory
Journal of Advanced Nursing 33(6): 764

Limandri BJ and Boyle DW (1978)
Instilling hope
American Journal of Nursing 78: 79-80

Mahlke R (1995)
Aspects of healing in Zionist churches in Southern Africa
Africana Marburgensia 28 (1-2): 14-31

Mallmann SA (2003)
Building resilience in children
Cape Town, Namibia, Maskew Miller Longman, Catholic AIDS Action

This handbook is aimed at helping parents, caregivers and teachers to understand children who are nursing a diseased parent or who have lost a parent. It provides practical advice for teachers and caregivers on how to support children who have experienced loss and death in order to help them cope. It offers ideas for discussions that can be held on a one-to-one basis in the child's home or with a group of children in the classroom. The handbook consists of a collection of ideas, theories, tasks and exercises that should help us to understand the behaviour and feelings of children affected by HIV/AIDS.

Messer DE (1999)
HIV/AIDS: Love, forgiveness and healing
Second International Conference: AIDS India. Chennai (Madras), India

Most major world religions affirm the values of love, forgiveness, and healing. Mobilizing the manifestation of these values in the lives of individuals, faith communities, and the society could contribute to understanding and addressing the HIV/AIDS crisis in India. Religious leaders and communities can help the culture and society to move beyond denial and discrimination to ethical responses that recognize human realities, protect human rights, promote prevention by education, and ensure supportive care and relationships for persons with HIV/AIDS.

Newshan G (1998)
Transcending the physical: Spiritual aspects of pain in patients with HIV and/or cancer patients
Journal of Advanced Nursing 28(6): 1236-1241

Obbo, Christine (1996)
Healing: Cultural fundamentalism and syncretism in Buganda
Africa 66(2): 183-201

Olivier J (2005)
Hope in view of HIV/AIDS in South Africa: Public discourse, faith and the future
Sociology. Cape Town, (UCT) University of Cape Town. Mphil in HIV/AIDS and Society

Olivier J (2006)
Hope in view of HIV/AIDS in South Africa: "Our" nation, "your" HIV/AIDS'
2nd Global Conference on Hope, Oxford, UK

Olivier J (2006)
Where does the Christian Stand? Considering a public discourse of hope in the context of HIV/AIDS in South Africa
Journal of Theology for Southern Africa 126(November)

Paraklyea A (1991)
Hope work in the care of the terminally ill patient
Qualitative Health Research 1(417-443)

Reinikka R and Svensson J (2003)
Working for God? Evaluating service delivery of religious not-for-profit health care providers in Uganda
Washington DC, World Bank

This paper exploits a unique micro-level data set on primary health care facilities in Uganda to address the question: What motivates religious not-for-profit (RNP) health-care providers? It uses two approaches to identify whether an altruistic (religious) effect exists in the data. First, using cross-section variation, the authors show that RNP facilities hire qualified medical staff below the market wage; are more likely to provide pro-poor services and services with a public good element; and charge lower prices for services than for-profit facilities, although they provide a similar (observable) quality of care. RNP and for-profit facilities both provide better quality care than their government counterparts, although government facilities have better equipment. These findings are consistent with the view that RNP are driven (partly) by altruistic concerns and that these preferences matter quantitatively. Second, the study exploits a near natural experiment in which the government initiated a program of financial aid for the RNP sector, and show that financial aid leads to more laboratory testing of suspected malaria and intestinal worm cases, and hence higher quality of service, and to lower prices, but only in RNP facilities. These findings suggest that working for God matters.

Sebahire M (1987)
Healing through faith? The Afro-Christian churches
Pro Mundi Vita: Dossiers Africa Dossier(42): 1-26

Somlai AM, Heckman TG, Kelly JA, Mulry GW and Multhauf KE (1997)
The response of religious congregations to the spiritual needs of people living with HIV/AIDS
Journal of Pastoral Care 51 (4): 415-426

Thomas L and Alkire J (1992)
Healing as a parish ministry: Mending body, mind and spirit
Notre Dame, Indiana, Ave Maria

Thomas L, Schmid B, Gwele M, Ngubo R and Cochrane JR (2006)
Let us embrace: The role and significance of an integrated faith-based initiative for HIV and AIDS
Cape Town, (ARHAP) African Religious Health Assets Programme

This study is an evaluation of Masangane, an AIDS programme linked to the Moravian church in the Eastern Cape, South Africa that provides a range of integrated services to a predominantly rural poor population, including anti retroviral treatment. The research addresses the question what the potential role of faith based organisations could be in the rollout of ART, especially in resource-poor areas. The study describes the activities of the Masangane ARV programme, assesses the various stakeholders' views of the activities and evaluates the impact of these activities on beneficiaries and their communities. After the descriptive chapters, the study assesses what 'value added' is contributed to Masangane as a result of its faith based nature and explores how beneficiaries of the ART programme 'mix' the multiple health systems - biomedical, traditional, faith healing - simultaneously or consecutively. The study ends with policy recommendations and further areas for research. It suggest that the public health system could benefit by noting the critical role of a faith dimension and traditional culture on treatment. It urges public health and religious leaders to explore the potential for partnership not only in ART provision but also for addressing stigma and mobilising for treatment. It recommends that religious leaders be trained in order to be able to mobilise their important religious assets for these purposes.

Thiede M (2005)
Information and access to health care: Is there a role for trust?
Social Science and Medicine 61(7): 1452-1462

Tibandebage P and Mackintosh M (2005)
The market shaping of charges, trust and abuse: Health care transactions in Tanzania
Social Science and Medicine 61(7): 1385-1395

Effective health care is a relational activity, that is, it requires social relationships of trust and mutual understanding between providers and those needing and seeking care. The breakdown of these relationships is therefore impoverishing, cutting people off from a basic human capability, that of accessing of decent health care in time of need. In Tanzania as in much of Africa, health care relationships are generally also market transactions requiring out of-pocket payment. This paper analyses the active constitution and destruction of trust within Tanzanian health care transactions, demonstrating systematic patterns both of exclusion and abuse and also of inclusion and merited trust.

Tuck I, McCain NL and Elswick Jr. RK (2001)
Spirituality and psychosocial factors in persons living with HIV
Journal of Advanced Nursing 33(6): 776-783

Uslaner E (1997)
Faith, hope and charity: Social capital, trust and collective action
College Park, Department of Government and Politics, University of Maryland

Wilkinson J (1998)
The bible and healing. A medical and theological commentary
Edinburgh, The Handsel Press

ZINGO (2002)
Faith-based organizations (FBO) responses to HIV/AIDS in Livingstone, Lusaka and Kitwe - Zambia
Strategic visioning for a Zambia free of HIV/AIDS, (ZINGO) Zambia Interfaith Networking Group on HIV/AIDS and (NAC) The National AIDS Council of Zambia

Chapter 5 Conclusions and recommendations

- *See Sections 3.5 and 4.1 for more material on faith-based presence in the public health system in general.*

Arora NK (2000)
Progress towards polio eradication: Service delivery, socio-cultural and communication barriers in pulse polio immunization in high burden zone in India
New Delhi, Clinical Epidemiology Unit. All India Institute of Medical Sciences

Avants SK, Margolin A and Warburton LA (2001)
Spiritual and religious support in recovery from addiction among HIV-positive injection drug users
Journal of Psychoactive Drugs 33(1): 39-45

Baird TL (1999)
Christian hospitals in Nigeria provide post abortion care and STD management
CCIH Forum (March)

Colvin M, Gumede L, Grimwade K, Maher D and Wilkinson D (2003)
Contribution of traditional healers to a rural tuberculosis control programme in Hlabisa, South Africa
International Journal of Tuberculosis Lung Disease 7(9):86-91

Gunderson G (2003)
The least we can do: Why an African religious health assets project?
African Religious Health Assets Programme: Assets and Agency, Colloquium. Pietermaritzburg, South Africa

Jabbour S and Houad FM (2004)
Religion-based tobacco control interventions: how should WHO proceed?
Bulletin of the WHO, Geneva, Switzerland, (WHO) World Health Organization

Logez S and Everard M (2004)
Multi-country study on drug supply and distribution activities of faith-based supply organizations in sub-Saharan African countries, 2003
EPN/WHO Feedback meeting: Promoting use of effective medicines supply strategies in Africa. Nairobi, Kenya

Masterson JM and Swanson JH (2000)
Female genital cutting: Breaking the silence, enabling change
(ICRW) International Center for Research on Women

Max-Neef MA (1991)
Development and human needs
In: Max-Neef MA (ed), Human scale development: Conception, application and further reflections. New York, The Apex Press

Mhango L (2001)
Highlights of Presbyterian Church (USA) bednet program
Mzuzu, Malawi, Presbyterian Church (USA)
Gives history and details of bednet programs against Malaria infection in Dwangwa and Chibavi, northern Malawi

Palmer M and Finlay V (2003)
Faith in conservation: New approaches to religions and the environment
Washington, USA, The World Bank

Wilkinson D, Gcabashe L, Lurie M (1999)
Traditional healers as tuberculosis treatment supervisors: Precedent and potential
International Journal of Tuberculour Lung Disease (3): 838-842

Chapter 6 Useful websites for further research

- The following is by no means an exhaustive list, but should assist in further enquiry

Anglican Communion: www.anglicancommunion.org

Anglican AIDS Programmes: www.anglicanaids.org

ARHAP: www.arhap.uct.ac.za

Catholic AIDS Action's Website: www.caa.org.na

Catholic Relief Services (CRS): www.catholicrelief.org

Christian Aid: www.christian-aid.org.uk

Christian Connections for International Health (CCIH): www.ccih.org

The Centre for AIDS Development, Research and Evaluation (CADRE): www.cadre.org.za

The Christian AIDS Bureau for Southern Africa: www.cabsa.co.za/newsite/index.asp

The Circle of Concerned African Women Theologians: www.thecircle-cawt.org

The Commission for Africa: http://www.commissionforafrica.org

The CORE Initiative: www.coreinitiative.org

The Council for a Parliament of the World's Religions (CPWR): www.cpwr.org

Churches Health Association of Zambia (CHAZ): www.chaz.org.zm/

German Institute for Medical Mission (DIFAEM): //difaem.de

Ecumenical HIV/AIDS Initiative in Africa (EHAIA): www.wcccoe.org/wcc/what/mission/ehaia-e.html

Family Health International (FHI): www.fhi.org

Fikelela (Anglican AIDS Outreach): www.fikelela.org.za

Global AIDS Interfaith Alliance (GAIA): www.thegaia.org

Health Economics and Research Division (HEARD): www.und.ac.za/und/heard

Human Sciences Research Council (SA): www.hsrc.ac.za/

Islam and HIV/AIDS Project, Mauritania: www.jhuccp.org/africa/regional/islam.shtml

Islamic Medical Association of Uganda (IMAU): www.imauuganda.org

Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs: www.jhuccp.org/africa/faith_based

Lutheran World Federation: www.lutheranworld.org

National Religious Association for Social Development: www.sarpn.org.za/index.php

The POLICY Project: www.policyproject.com

Positive Muslims: www.positivemuslims.co.za

Sexual Health Exchange: www.sexualhealthexchange.org

Southern African Catholic Bishops' Conference: www.sacbc.org.za

Spiritual Capital Research Program (METANEXUS): http://www.metanexus.net/spiritual%5Fcapital/rfp_intro.asp

Tearfund: www.tearfund.org and www.tilz.info

Traditional Healers and Modern Practitioners Together Against AIDS (THETA): www.aidsuganda.org/response/govt_sectors/cso_programs/theta.htm

UNAIDS: www.unaids.org.za

The United Religions Initiative: www.uri.org

The Unit for Religion and Development Research: //academic.sun.ac.za/tsv/Centres/Egon/urdr.htm

The World Conference of Churches: www.wcc.org

World Conference of Religions for Peace (WCRP): www.wcrp.org

The World Congress of Faiths: www.worldfaiths.org

The World Council of Churches: www.wcc-coe.org

The World Faiths Development Dialogue: www.wfdd.org.uk

The World Fellowship of Inter-religious Councils: www.interfaithstudies.org/network/wfirc

The World Health Organization: www.who.int

World Vision's Website: www.worldvision.org

Zambia Interfaith Networking Group on HIV/AIDS: www.zingo.co.zm/index.htm