

Faith in Action

*Examining the Role of Faith-Based Organizations
in Addressing HIV/AIDS*



Commissioned By
CMMB
CATHOLIC MEDICAL MISSION BOARD

A Multi-Country, Key Informant Survey



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Ten years after the fall of apartheid in my homeland, South Africa, we are faced with a “new apartheid” on a global scale. Today’s perpetrator is a virus, in close alliance with poverty, ignorance, complacency, discrimination and inequity. Unlike apartheid, AIDS’ devastating impact is not restricted to the tip of Africa. It can be felt in every country, in every community, in every corner of the globe—but its impact is greatest in areas where inequality rules. We must remember that HIV/AIDS is an injustice for all, regardless of one’s nationality, faith or race. However, injustice will not have the last word.

We are the agents of transformation, capable of turning the tide against the disease. Since the beginning of the pandemic, I have seen faith in action not only in South Africa, but worldwide. Before the important governmental and multilateral initiatives of today, it was often the faith community that provided support to those affected by and infected with HIV. Whether it be the provision of food, love, care and concern, the faith community has often been the first and last place to which those who feel the impact of HIV/AIDS have turned.

Nevertheless, we have much to do. We must remove the stigma attached to the virus at all costs and embrace those with HIV as our brothers and sisters. We must do more to care for those with HIV/AIDS, not forgetting the most vulnerable. We should truly seek to become a community of faith that seeks to serve all, without judgment. United in love, we can fight with our highly effective weapons of courage and compassion.

There is an expression we use in South Africa called *Ubuntu*, loosely translated as “a universal bond of sharing that connects all humanity.” *Ubuntu* stresses that we belong together; our destinies are bound in one another’s. We must recognize our interconnection, regardless of geographical, cultural or religious constructs, if we are to make any lasting impact against the disease. You are my sisters and my brothers, whether you consider yourself a Buddhist, Christian, Hindu, Jew, Muslim or agnostic, and we must treat each other as such. We must respect each other, as each one of us is a precious individual. We must stand shoulder to shoulder, heart to heart in the fight against HIV/AIDS.

We are all family. Let us join as family and end the unacceptable affliction and injustice experienced by millions affected by the virus. We did it with apartheid, we can do it again. This is my vision. I invite you, my brothers and my sisters, to help realize my dream.

A handwritten signature in black ink, appearing to read 'Desmond', followed by several horizontal strokes that suggest a flourish or the end of a signature.

Desmond M. Tutu, Archbishop Emeritus
Anglican Church of the Province of South Africa

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It is with considerable interest and enthusiasm that we share with you the Global Health Council's newest research study, *Faith in Action: Examining the Role of Faith-Based Organizations in Addressing HIV/AIDS*, commissioned by the Catholic Medical Mission Board (CMMB). It has been our privilege to underwrite it.

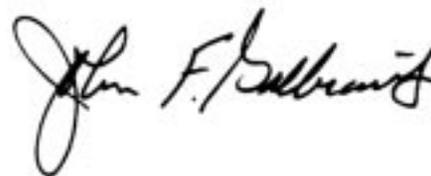
CMMB has been providing health care to those in need throughout the developing world, without regard to race, region or religion, since our founding in 1928. Through our own programs, and through our relationships with hospitals, clinics and health-care professionals in Africa, Latin America, the Caribbean, Asia and the Pacific, CMMB is able to mobilize and focus significant resources on the challenge presented by the AIDS pandemic.

Thankfully, we are not working alone. Faith-based organizations such as our own are integral partners in the global response to the AIDS crisis, often comprising sizable percentages of total health-care capacity in a country or region. We initiated this study to better understand the perceptions and priorities of these key members of the global public health community about the past, present and future roles of faith-based organizations in AIDS prevention, treatment and support.

As we and our local partners continue to work to help those in need wherever they may be, we acknowledge the vital importance of collaboration in this historic struggle. This implacable pandemic is so vast as to threaten to overwhelm any single enterprise that stands against it. Only by standing together and pooling our resources will we be successful in devising the health-care programs and protocols needed to end the scourge.

We extend special thanks to the Global Health Council for agreeing to take on this important research effort, and for carrying it out with such commendable energy and intelligence.

We commend this report to our friends and colleagues working in governments, international authorities and the global health care industry, as well as all who fight the AIDS pandemic in their home countries. We trust you will find its insights useful in your work. Our hope is that it will add significantly to the global knowledge base of the community seeking solutions to the crisis.



John F. Galbraith
President and Chief Executive Officer
CMMB

In today's discussions of issues critical to improving health and health equity around the world, few topics seem to generate the amount of heat, largely in the absence of facts, as the role of faith-based organizations (FBOs) in combating AIDS. Given the level of resources now being devoted to such efforts, the Global Health Council was delighted to be asked by the Catholic Medical Mission Board (CMMB) to conduct an independent review of the role of FBOs in addressing the pandemic.

We all recognized from the start that the credibility, and therefore the ultimate utility, of such a study would rest on the integrity of the research process; the world is replete with "sponsored research" in which the conclusions are pre-ordained. CMMB agreed from the onset that the study design, choice of locations and respondents, and analysis and conclusions would be rigorously independent. This in itself was an act of faith, which we have worked hard to validate through the rigor of the study.

Our first – and initially disappointing – finding was just how scant the objective documentation was as to the effectiveness and impact of FBO efforts to address AIDS. It quickly became apparent that a quantitative meta-analysis was simply not possible in the absence of the basic data to work with. We, therefore, adopted a research approach based on qualitative assessments made on the basis of semi-structured interviews with key informants in a set of countries representative of the scope and stages of the pandemic. This analysis is enormously strengthened by the depth and breadth of knowledge – and the diversity of experience and viewpoints – that the 200 plus

key informants collectively represent. If the world's leading front-line experts in addressing AIDS were to be assembled in one place, the interviewees in our study would constitute a large share of the group. We deeply appreciate the amount of time they contributed to this research.

It would be nice to be able to summarize with a simple "It works," or "It doesn't work." Nevertheless, the world is a complex place, HIV/AIDS is still a young field, and there is still much that has not yet been rigorously studied. We are confident that the analysis presented in this study will bring the global health community to a better understanding of the role that FBOs are playing in the struggle against AIDS including the benefits, constraints and untapped potential. We commend CMMB for its courage in supporting this contribution to the evidence base. The report is as relevant for the questions it frames as for the ones it manages to answer. We still have a great deal of work ahead of us, and it is our hope and intention that this study will engender an active and ongoing dialogue between members of the faith community and others active in the vital task of curtailing HIV/AIDS. As always, the Global Health Council is committed to do its part to facilitate such a dialogue.

Sincerely,



Nils Daulaire, MD, MPH
President and CEO
Global Health Council



BACKGROUND

The HIV/AIDS pandemic has already claimed 23 million lives, 3 million in 2004 alone.¹ With 39 million people now living with HIV/AIDS,¹ the international community is working diligently to identify effective mechanisms to prevent HIV transmission and provide care, support and treatment for those living with or affected by HIV/AIDS. Human and financial resources are woefully inadequate to meet the overwhelming level of existing need. It is, therefore, imperative that existing resources be used wisely, based on the best available evidence of what works.

Recently, there has been significant interest on the part of both multilateral and governmental agencies to increase the role of faith-based/religious organizations (FBOs) in mobilizing HIV efforts. The World Health Organization (WHO) reports that one in five organizations currently engaged in HIV/AIDS programming is faith-based.² However, the plan to increasingly involve FBOs in delivering HIV/AIDS services is not without controversy. The opportunities made available for faith-based organizations to compete for funding have generated concern that ideological considerations are overtaking sound empirical evidence of their effectiveness in delivering health services as the basis for funding decisions.³

ABOUT THE STUDY

Despite widespread acknowledgement that many FBOs provide services and programming around HIV/AIDS, there are limited analytic assessments of FBO activities.⁴ In the interest of better informing the dialogue surrounding FBO involvement, the Catholic Medical Mission Board (CMMB) commissioned the Global Health Council to conduct an independent analysis of the role of FBOs in addressing the HIV/AIDS pandemic. Recognizing that stakeholder perceptions have a significant bearing on this issue, we interviewed key decision makers actively involved in HIV/AIDS activities in six countries chosen to represent different regions, stages of the epidemic, and religious traditions. More than 200 key informants working in Haiti, India, Kenya, South Africa, Thailand and Uganda and the international arena were interviewed. Using an interview guide based on *The Global Strategy Framework for HIV/AIDS*,⁵ we asked our informants to provide their perspectives and perceptions, based on their own experience, on the past, present and optimal future roles of FBOs.

Faith in Action reports on the in-depth analysis of these interviews and explores the following key questions:

- What actions are FBOs perceived to have taken to mitigate the impact of HIV through the provision of HIV/AIDS-related care, support and treatment?
- What behavior-change communication strategies are FBOs perceived to have used to reduce risk of transmission?
- What measures are FBOs perceived to have taken to affect the environment or circumstances that contribute to vulnerability of women?
- What is the perceived accountability of FBO programs in terms of basis for programming and empirical assessment of program effectiveness?
- How are FBOs perceived to have contributed to the formation of HIV/AIDS public policy within countries?

FINDINGS

Mitigating the Impact of HIV/AIDS: Providing Care, Treatment and Support. In most study countries, most notably in Kenya and Uganda, FBOs are thought to successfully utilize their existing networks of hospitals and clinics to serve the health-care needs of persons living with HIV/AIDS (PLWAs). Although the extent of their health infrastructures varies con-

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siderably by country, FBOs are believed to play a very substantial role in HIV/AIDS clinical and home-based care, especially where public health services are insufficient. In areas where FBO health-care infrastructure is perceived to be strong, interviewees also cite examples of FBO involvement in expanding access to anti-retroviral drugs (ARVs) and supporting other sectors in the administration of treatment. FBOs are noted for their important provision of spiritual and social support to the individuals and families affected. However, secular informants note that a few FBOs engage in proselytism and the promotion of disinformation about the value of treatment.

Communication to Change Risky Behaviors.

In all study countries, the engagement of FBOs in communications aimed to decrease risk is the most controversial element of their involvement. While FBOs are said to cover the spectrum of behavior-change strategies, many FBOs are perceived to focus exclusively on abstinence and faithfulness. Whereas most informants recognize these as useful components of a broader prevention strategy, they note that adhering to these behaviors is often beyond the control of the individual. FBOs are at times criticized for failing to fully collaborate in providing a comprehensive prevention message, thereby contributing to stigma and

vulnerability to the virus. FBOs are generally perceived to be improving in this regard, as they are coming to grips with the reality and enormity of the HIV/AIDS epidemic. Nevertheless, clergy, particularly at the level of the parish, are perceived to lack sufficient information about HIV, and vulnerability to effectively shape prevention messages. FBOs are urged to consider the limitation of individual behavior change messages and to collaborate with organizations providing comprehensive information and services.

Empowering Vulnerable Groups: Women.

Numerous FBO efforts to address the vulnerability of women through improved livelihoods and increased access to social and health-care services are cited by respondents from both faith- and non-faith-based sectors. Since women are the primary care-givers to those affected by AIDS, respondents note that the FBO response to HIV may impose an increasing burden on them. Informants also cite the inherent contradiction in patriarchal faith-based organizations being able to effectively address women's vulnerability to HIV/AIDS. The entrenched inequality of women at the familial level and within some faith-based organizations are noted as significant barriers to decreasing vulnerability. There is also widespread acknowledgement that women will not

be empowered without constructively involving men in HIV/AIDS education and awareness programs.

Accountability: Evidence-Based Foundations.

FBO strategies and programs are perceived to be based on a varying mix of religious philosophy and empiricism. Science is not thought to be generally ignored, but the message is often tailored to be consistent with moral beliefs. This weakens the efforts and accountability of FBOs in the view of some informants. In addition, although some FBOs appear to be trying to assess community needs and evaluating their work, FBOs are perceived as weak in terms of program documentation and evaluation. Informants discuss the need for developing the technical capacity of FBOs in a range of areas including data collection, program design, implementation and administration. However, lack of funds acts as a barrier to the development of FBO capacity in these areas. Key informants advise that capacity building in an environment of limited resources necessarily lies in partnerships with other FBOs and non-governmental organizations working in the same field.

Participation in Public Policy Dialogue.

Our informants provide a number of examples where FBOs have exemplified leadership in

influencing public policy within their respective countries. This is perceived to be greatest in Uganda where the significant participation of all major religious groups in the national policy dialogue, based on their grassroots experience, is credited with contributing to a strong national AIDS policy. FBOs are perceived to play an important, yet growing, role in policy development in Kenya and South Africa. In the remaining study countries, the potential for greater leadership and engagement on the part of faith-based groups, while expanding, has not been fully utilized. FBOs in Haiti are perceived to be late in getting involved, but are now seen to be collaborating and developing long-range strategic plans. FBOs in India and Thailand are not thought to have been very visible in the public policy arena, but are perceived to be well positioned if theological and social obstacles to their participation are overcome.

FOUNDATION FOR DIALOGUE

We acknowledge the complexities in assessing the contributions of a wide range of FBOs that are involved in the response to the pandemic: from small rural churches, mosques and temples with no financial backing to large faith-based development organizations, from mission hospitals to monks providing home-based care, from large religious NGOs able to participate

in national policy dialogue to individual clerics defying official church policy. All bring different assets and issues to the table.

We also acknowledge that we have uncovered no one model for the optimal engagement of faith-based organizations in the response to the pandemic. In the two countries that have been widely cited as models of success, Uganda and Thailand, we see very different roles for religious organizations within the society and also within the HIV/AIDS public policy arena. Whereas in Thailand, the religious sector is seen as removed from such worldly political matters but is becoming more engaged in grassroots work. In Uganda, the three main religious faiths are very much a part of the political process to a point where key informants state that no national policy gets made without consultation of the three leading groups. Yet both countries have been successful in curbing the epidemic. We surmise that the common element in these cases is strong political will and commitment.

While *Faith in Action* illustrates a myriad of views surrounding the optimal role of FBOs in the fight against HIV/AIDS, all 206 key informants acknowledge that FBOs have an important and sometimes unique contribution to make to this fight. Indeed, in our six study

countries and among our international experts, the enormity of the pandemic is so well recognized that help from virtually all sectors is encouraged. As seen by our key informants, the assets that FBOs offer include their roots in communities, the breadth and depth of their infrastructures and networks, and the respect and trust of their communities.” At the same time, there is a general acknowledgement that the response of FBOs needs to be improved and coordinated, not just expanded. We, therefore, conclude with recommendations to serve as a foundation for dialogue among faith-based and non-faith based stakeholders as to how the best efforts of all can be brought forward.

Engage in Cross-Sectoral Collaboration. Both FBOs and secular groups are urged to work in a more coordinated fashion, appreciating one another’s assets and making better use of development partners who aim to meet similar objectives.

Create and Sustain Global Faith-Based Partnerships. In order to maximize the comparative advantage of local FBOs to serve those in need, FBOs in high-income countries are encouraged to expand financial and technical support through partnerships with FBOs in resource-poor countries.

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Promote Understanding and Dissuade Stigma. FBO strategies and services can be highly effective in reducing stigma when grounded in compassion and inclusion. Religious-based groups are encouraged to continue educating community members and supporting persons infected with and affected by HIV/AIDS, maximizing religious philosophies that promote understanding.

Involve Persons Living with HIV/AIDS. FBOs are encouraged to engage PLWAs in leadership roles in the design, implementation and evaluation of FBO programs. This will yield more programs that are relevant and contribute to the reduction of stigma and economic vulnerability.

Expand Linkages with Non-Medical Programs. To facilitate a coordinated and comprehensive response, FBOs can better link their strong health infrastructure and services to non-health sector interventions effective

against HIV/AIDS, including primary and secondary education and income generation.

Reduce Vulnerability among Women and Girls. FBOs are urged to expand educational opportunities for girls through their existing network of quality schools. FBOs are urged to confront underlying gender inequality within their communities and institutional structures that interferes with successful strategies to reduce the vulnerability of women and girls.

Improve the Evidence-Base of Strategies. FBOs are encouraged to seek out and replicate scientifically evaluated interventions and to partner with other organizations to ensure that the full spectrum of information and services is available.

Develop Monitoring and Evaluation Capacities. In order to enhance credibility and lessons learned, and enable the scaling up of successful strategies, FBOs are encouraged to

better document and evaluate their work, including through collaborations with organizations that can provide technical support.

Contribute to Public Policy Discourse. FBOs can use their power and influence to promote justice and social good. The constituencies of FBOs offer an important vehicle for heightening attention among policymakers to issues that contribute to AIDS' impact, vulnerability and risk.

The perceptions presented in *Faith in Action* substantiate the significant contributions that faith-based groups have already made, but more importantly, serve as a starting point for optimizing their future contributions for the benefit of those infected and affected by HIV/AIDS.



HIV/AIDS is poised to become the most devastating epidemic in human history. In the absence of a cure or vaccine, by 2020 the AIDS epidemic will have killed more people than the plague. There are 39 million people now living with HIV/AIDS, and an estimated 3 million people died from the disease in 2004 alone.¹ Although the international community is working diligently to identify effective mechanisms to prevent HIV transmission and provide care, support and treatment for those affected by the virus, human and financial resources are woefully inadequate to meet the already overwhelming level of existing need. It is, therefore, imperative that existing resources be used wisely, based on the best available evidence of what works.

One sector that has received increasing attention and resources for expanding the response to the epidemic is faith-based organizations (FBOs). Religious organizations have long delivered social, educational and health services in many countries.⁶ By one estimate, 20 percent of all external health aid to developing countries is provided by non-governmental organizations (NGOs), many of which have religious affiliation.⁷ In a number of the poorer countries, private religious organizations provide up to 40 percent of all health care.⁸

THE ROLE OF FBOs IN ADDRESSING HIV/AIDS

Leading health organizations such as the World Health Organization and the United Nations Children Fund (UNICEF), as well as donor organizations such as the United States Agency for International Development (USAID) have all called for increased integration of faith-based organizations within the international health community in fighting HIV/AIDS.^{2, 9, 10} Many religiously affiliated health providers are already deeply engaged in HIV programs and have been for many years. WHO reports that one in five organizations currently involved in HIV/AIDS programming is faith-based.² To achieve greater coordination and a more effective global AIDS response, the Joint United Nations Program on HIV/AIDS (UNAIDS) calls for “partnerships of key social groups, government service providers, non-governmental organizations, community-based groups and religious organizations.”⁵ The US President's Emergency Plan for AIDS Relief (PEPFAR), launched in 2002, also gives a high profile to the role of FBOs to the extent of reserving a significant level of funding for FBO activities in the 15 countries receiving PEPFAR aid.¹¹

However, the plan to increase the involvement of FBOs in delivering HIV/AIDS services is not without debate. The opportunities made

available for faith-based organizations to be active partners in implementing public health interventions as well as to compete for funding with secular groups have generated concern that ideological considerations are replacing sound empirical evidence of effectiveness in delivering health services.³ 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 instead be used to support religious agendas; these critics call into question FBO credentials to deliver public health services.¹² Others are concerned that government funding of faith-based institutions undermines the separation of church and state and threatens public service beneficiaries' right to religious freedom.¹³ Therefore, plans to increase the role of the faith-based sector in responding to HIV/AIDS warrant a balanced and impartial examination of the past and present contributions of FBOs, in order to establish their strengths and optimize future efforts.

In the interest of producing a better-informed dialogue on FBO involvement in this crucial work, the Catholic Medical Mission Board (CMMB) commissioned the Global Health Council to conduct an independent analysis of the role of FBOs in addressing the HIV/AIDS pandemic.

EXAMINING FAITH IN ACTION: WHAT'S THE EVIDENCE?

In framing this study, *Faith in Action*, within the context of existing research, we found limited analytic assessments of FBO activities. Despite widespread acknowledgement that many FBOs actively provide services and programming around HIV/AIDS, an examination of their role is hampered by the lack of empirical or evaluative information on the work that they do.⁴ Reasons cited for this limited attention include the contentious issue of church versus state and the lack of capacity among FBOs to document and evaluate their work.¹⁴

The scant research that has been conducted assessing the work of FBOs in HIV/AIDS includes surveys, evaluations and literature reviews of varying quality, scope and geographical focus. A summary of identified research on the role and effectiveness of FBOs with relevance to our study now follows.¹

Surveys Assessing FBO Involvement in HIV-Related Activities

Few surveys have explored FBO participation in HIV activities, programs or collaborations. A recent survey assessed the degree to which congregations in New York offered HIV/AIDS

services including HIV/AIDS education, counseling and testing referral.¹⁵ Highlighting potential barriers that may inhibit congregations from offering such programs, researchers found that less than 17 percent of congregations offered the above services. Congregations cited “attitudinal and resource-related reasons” for not offering the services. The researchers pointed out that there was an overwhelming lack of awareness among congregations of the need for HIV/AIDS services in their communities.

The Christian Connections for International Health and the Ecumenical Pharmaceutical Network conducted a survey to determine the level of participation of FBOs in proposals made to the Global Fund to Fight AIDS, TB and Malaria.¹⁶ Based on responses from 173 religious institutions, the survey found that the majority of FBO representatives did not have adequate knowledge of the Global Fund. Of those who were aware of the Global Fund, a majority expressed dissatisfaction with their ability to participate effectively.

Evaluations of FBO Health-Related Programs and Services

We found few published studies that evaluate the health-service-related work of FBOs. The role of FBOs in providing care and support for

orphans and vulnerable children was examined in a collaborative effort by the World Conference of Religions for Peace (WCRP) and UNICEF.¹⁷ Researchers interviewed 690 FBOs, religious coordinating bodies (RCBs)ⁱⁱ and congregations in six countries. The report noted that many FBOs, including small and/or new ones, had comparative advantages in conducting such work, including adequate management in terms of governance and operation. The report recommended that donors provide small grants to RCBs to support their activities.

A World Bank evaluation of 155 randomly selected health-care facilities across Uganda examined general health services provided by religious non-profit health providers in comparison with government and private for-profit service delivery.¹⁸ While not focused on HIV/AIDS, the study assessed health infrastructure, supervision and delivery of care on a district and health facility level as well as from the viewpoint of the patient. It indicated that faith-based health providers, generally altruistically motivated, often provided services of better quality than government facilities.

ⁱ We attempted to systematically identify relevant literature of an evaluative nature assessing the effectiveness of FBOs in addressing HIV. Databases accessed include Public Affairs Information Service (PAIS), Medline, Lexis-Nexis Academic, leading Internet search engines, literature recommendations from key informants and reference lists of identified literature (search dates: June 2004, November 2004). Keywords used: (faith OR religion OR "faith-based" OR FBO OR "faith-based organization") AND (HIV OR AIDS OR "HIV/AIDS"). Strategy further refined through various combinations of the following key words: spirituality; church; priests; imams; monks; missionaries; Hinduism; Buddhism; Christianity; Catholicism; Islam; Africa; Asia; Caribbean; South Africa; India; Uganda; Thailand; Kenya; Haiti; global. Due to the volume of literature available on the Internet and the likelihood of a significant number of unpublished studies, some relevant research may not have been identified through our literature search.

ⁱⁱ Intermediary organizations responsible for coordinating and supporting congregations.

Literature Reviews/Secondary Research on the Role of FBOs

Literature reviews on the work of FBOs tend to be unsystematic, selective or specific to one region or faith. Furthermore, reviews of the evidence are limited by the shortage of primary research assessing the role of FBOs.

The World Council of Churches (WCC) conducted a review of the work of FBOs in sub-Saharan Africa, relying on reports, emails, discussions and interviews.¹⁹ The WCC report described the significant facilitators, challenges and areas of improvement for FBOs in their response to the pandemic. The study concluded that “information was not always easily accessible as FBOs are busy ‘doing’ but are notoriously bad about, or are not trained for, monitoring, evaluating, and documenting their efforts.”

USAID commissioned a review of FBO contributions to HIV-prevention efforts, based on case studies of FBO activities in Uganda, Senegal, Jamaica and the Dominican Republic.²⁰ With illustrations of positive examples of FBO participation in these countries, the report recommended that “steps should be taken to overcome any conflict or antagonism between a faith-based approach and a secular, public health approach” and presented comparative advantages of FBOs in prevention activities.

The Royal Tropical Institute (Amsterdam) published a literature review examining activities of Christian and Islamic FBOs in combating HIV/AIDS in sub-Saharan Africa.²¹ The authors found few evaluative studies of the “actual and potential role of FBOs.” The report concluded that the faith-based response to HIV/AIDS has been “uneven,” with care and support for persons living with HIV/AIDS (PLWAs) being particularly strong while positions on condom use and mandatory testing before marriage were controversial. Calling for scaling-up and support of FBOs’ activities and collaboration among all sectors, the report also asserted that “more research is needed to document the influence of religion on behavior change and to assess the effects and processes of FBO work.”

Two studies, which did not address HIV/AIDS specifically, examined whether the health initiatives of FBOs have had a measurable impact on health outcomes. The American Journal of Public Health published a systematic reviewⁱⁱⁱ of the literature on faith-based health programs in the United States²² aimed at examining the effectiveness of faith-based organizations in providing community-based health care. The review, which included 53 studies, found that faith-based programs were effective in improving health outcomes that could be measured, as well as in “increasing knowledge of dis-

ease, improving screening behavior and readiness to change, and reducing the risk associated with disease and disease symptoms.”

The Center for Research on Religion and Urban Civil Society also conducted a systematic review of the literature to examine the influence of faith-based activities on health outcomes.⁴ The researchers contend that much of the literature on FBO efficacy and efficiency is published by faith-based organizations themselves and is overreaching in its praise. This study, based on a comprehensive search of all relevant literature, found that even large faith-based organizations often have not evaluated the efficacy of their own programs. Ultimately, only 25 studies were identified that assessed the efficacy of FBOs. Although these studies indicated that the activities of faith-based organizations have resulted in positive health outcomes, the authors recommend that more ‘accurate and unbiased’ qualitative and quantitative research is undertaken.

A number of organizations now produce guidelines for action research and assessments as well as strategic planning frameworks for faith and community leaders to utilize.^{23, 24, 25}

ⁱⁱⁱ Systematic reviews reduce bias through the systematic identification, appraisal and synthesis of all relevant studies according to a predetermined and explicit method. Benefits include transparency and replicability.⁶⁰



As much of the information regarding the efficacy of faith-based organizations in the fight against HIV/AIDS is not grounded in empirically based evidence, we conclude that it is not feasible to review past or ongoing work of FBOs. Conversely, there is an abundance of strong, often conflicting opinions on if and how FBOs should best be involved in providing services, support and care for those living with the virus. With a dearth of quantifiable data and wealth of viewpoints, we recognize the importance of stakeholder perceptions in informing decisions that affect FBO involvement and ultimately persons living with the virus.

Because much of the work of faith-based groups has not been documented and is largely anecdotal, we undertook a study based on conversations with key decision makers who are intimately familiar with HIV prevention, care, treatment and support at both the country and international level. We sought to understand how this community perceives the role of FBOs, because, in a phrase, “Perception is reality.”

We designed our questions using *The Global Strategy Framework on HIV/AIDS*⁵ to ground the study conceptually in elements judged important for addressing the pandemic comprehensively on all fronts. We did not explore all of the elements of an expanded response outlined in the Framework, but focused on our

Key informants are individuals who have unique, in-depth knowledge of the programs or processes under study and who are willing to share those observations with the researcher.

interviewees’ perceptions of FBO involvement in key strategies to mitigate impact, decrease risk and reduce vulnerability (See Box on page 21).

Faith in Action shares these insights with the aim of informing the policy dialogue and improving programs.

RESEARCH OBJECTIVE

Our objective in *Faith in Action* is to explore perceptions of key decision makers about the past, present and optimal future roles of FBOs in HIV/AIDS work.

Elements of the Framework in which FBO performance is analyzed through the views of global key informants include:

- **Mitigating impact to decrease vulnerability and improve the lives of those affected and infected.** What actions are FBOs perceived to have taken to mitigate the impact of HIV/AIDS through the provision of care, support and treatment?

- **Decreasing risk of infection to slow the epidemic.** What behavior-change communication strategies are FBOs perceived to have used to reduce risk of transmission?

- **Reducing vulnerability to reduce the risk of infection and the impact of the epidemic.** What actions are FBOs perceived to have taken to affect the environment or circumstances that contribute to the vulnerability of women?

- **Maintaining an environment of accountability to ensure that efforts to respond to the pandemic are effective.** What is perceived to be the basis for the development of FBO programs? How are FBOs thought to monitor and evaluate program effectiveness?

- **Contributing leadership to strengthen policy.** How are FBOs perceived to have contributed, collaborated and shown leadership in the formation of HIV/AIDS public policy within countries?

We envision that these perspectives will provide a basis for informed decision-making. We believe that the findings will also help FBOs to a better understanding of how they are perceived, and how people in a variety of sectors think that they can most usefully collaborate, contribute and provide leadership. Armed with this information, they can capitalize on perceived strengths and address perceived weaknesses to improve the collective response to the pandemic.

What Faith in Action Doesn't Do. The study is based on the opinions of individuals. It is neither an evaluation of the role that FBOs have played, nor is it a comparison of the effectiveness of services provided by FBOs with those of non-faith-based groups. It is formative research based on qualitative data and is not designed to provide statistical information on FBO activities. Furthermore, the sample does not represent the universe of informants from FBO or non-FBO sectors involved in HIV/AIDS programming.

It is not possible in a report of this length to present all of the findings from our study, nor has all data been analyzed. In light of the vastness of data generated by the study, we focus on issues that have limited exposure in the available literature. For example, because UNICEF issued a report in 2004 on FBO care and support for orphans and vulnerable children,¹⁷ this report does not include a section on that topic.

METHODOLOGY

In collaboration with host-country researchers based in six countries representing a range of HIV prevalence rates, cultures and socio-political structures, we conducted 201 semi-structured interviews^{iv} with 206 key

informants based in Haiti, India, Kenya, South Africa, Thailand and Uganda, or who work for international organizations. The study commenced in September 2003 and interviews concluded in June 2004.

Key Informants

Interviewees were selected using the “snowball technique,”^v beginning with a list of potential interviewees identified from a background information search including the World Bank Multi-Country Program on HIV/AIDS (MAP), relevant country proposals to the Global Fund, and a variety of individual and agency recommendations. From a database of nearly 800 potential key informants representing 11 different sectors, 25 to 30 senior-level interviewees who are actively engaged in HIV/AIDS work were carefully selected in each of the six countries. Those surveyed included representatives from non-governmental organizations (NGOs), government officials, researchers, health-service providers, national AIDS control program officers, pharmaceutical representatives and leaders from major FBOs in each country. In addition,

30 key individuals representing international organizations involved in HIV programming were interviewed. (See pages 74-78 for a breakdown of numbers in each sector and a listing of individuals interviewed)

In the FBO sector, we interviewed at least one representative from each of the major religions in each country. That two-thirds of our FBO respondents were Christian is attributable to Christianity being the predominant religion in four of the six study countries, as well as to the preponderance of Christian-affiliated health services in most of the study countries.

Sectors Represented in <i>Faith in Action</i>		
<i>Businesses/ Pharmaceuticals</i>	<i>Health Care Facilities</i>	<i>Non-Governmental Organizations</i>
<i>Donors</i>	<i>HIV/AIDS Researchers</i>	<i>Organizations Representing People Living with HIV/AIDS</i>
<i>Faith-Based Organizations</i>	<i>International Governmental Organizations</i>	<i>Organizations Representing High Risk/ Vulnerable Groups</i>
<i>Governmental Ministries</i>	<i>National AIDS Control Programs</i>	

^{iv} Semi-structured interviews use open ended questions to serve as a guide to the interviewer. New questions are allowed to be explored as a result of the discussion (unlike other more structured interview techniques).

^v A technique for finding research subjects in which an informant gives the researcher the name of another, who in turn provides the name of a third, and so on.

Interview Framework and Procedures

By basing the interview questions on *The Global Strategy Framework on HIV/AIDS*, we highlight and explore the “guiding principles and leadership commitments that together form the basis for a successful response to the epidemic,” as they relate to faith-based organizations (see Box page 21).

Face-to-face interviews lasting on average 60 minutes examined key informants' perceptions of the extent of FBOs' leadership, collaboration and contribution to strategies to reduce risk, decrease vulnerability and mitigate impact of HIV/AIDS. Interviews were conducted in the preferred language of the interviewee and taped after permission was obtained. Tapes were transcribed verbatim and translated, if necessary, into English. Local researchers forwarded transcripts for central analysis by the Global Health Council. All key informants were asked for permission to list their names in the report.

Data Analysis

We aimed to reduce bias when analyzing transcripts by “blinding” ourselves to the identity of the informant through the assignment of a number to each informant. Using a qualitative

Research Methodology Highlights

Methods: 201 semi-structured interviews

Countries: Haiti, India, Kenya, South Africa, Thailand and Uganda, as well as representatives in the international arena

Key informants: 206 senior-level respondents representing 11 sectors

Analysis: Verbatim transcripts coded according to a consistent framework, analyzed using qualitative software (Atlas.ti)

analysis software, *Atlas.ti*, we coded all electronic transcripts with predetermined categories that referred to the general topic(s) that informants discussed (e.g., “condoms,” “legal/policy issues,” “Islam,” etc.). We then divided transcripts into sub-groups according to the sector (FBO and Non-FBO) within each study country.

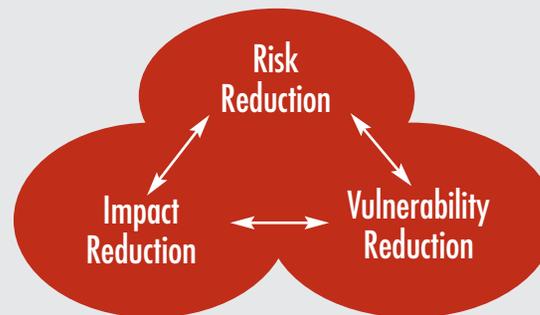
Using a combination of codes to compile quotations that addressed a particular question within *The Global Strategy Framework*, we studied our informants' responses in terms of FBO contributions (or lack thereof), the conditions that define their participation (including facilitators and barriers) and the consequences (both positive and negative) of their involvement. We determined dominant emerging themes through categorizing, indexing and counting key informant quotations. Themes that resonated among a critical mass (assessed by the number of times a theme was mentioned) were further systematically analyzed for commonalities, variations and disagreements. Lastly, we contrasted and compared these themes across all countries and sectors to synthesize our findings. The analysis is limited to what our key informants perceive and does not aim to validate the objectivity of these perceptions.

BREAKING THE CYCLE OF RISK, VULNERABILITY AND IMPACT: *THE GLOBAL STRATEGY FRAMEWORK ON HIV/AIDS*

The HIV/AIDS epidemic is fueled by interactions between the risk of contracting the disease, vulnerability to the virus, and the impact of AIDS on the affected individual and family. For example, AIDS increases a family's economic vulnerability by affecting the ability of parents to care for their children and keep them in school. Unless the parents receive treatment, their children are likely to become orphaned, unschooled and desperately poor. Or they may be forced to drop out of school to help care for ill parents and to help support the family. Out-of-school children not only fail to develop skills necessary to earn a living, but also miss out on school-based AIDS education and may not learn how to protect themselves. Desperate poverty increases vulnerability to contracting HIV, for example, by increasing the likelihood of risky behavior such as exchanging sex for money. The self-perpetuating cycle must be broken through simultaneous actions to prevent new infections, reduce vulnerability and mitigate impact on those who are infected or affected by the disease.

In response to the epidemic's evolution and major scientific and policy advances, *The Global Strategy Framework on HIV/AIDS* was formulated by consensus

by United Nations (UN) Member States as a common strategy for achieving global HIV reduction targets they had agreed to at the 21st Special Session of the UN General Assembly in July 1999.



Global Strategy Framework on
HIV/AIDS

The Global Strategy Framework puts forth a strategic approach to respond to the growing epidemic. It recognizes that the risk of contracting the virus is accentuated by underlying vulnerability, especially poverty, and that the impact the disease has on individuals and families only heightens their risk and vulnerability.

Thus, the Framework stresses the need for an "expanded response" including programs to address both "what places individuals at risk and why they are at risk." A key component of the expanded response is to change harmful social norms, lessen stigma, and address the deep-seated gender inequities that heighten the vulnerability of girls and women to the disease. For these changes to occur, it is essential that local communities and key groups mobilize to promote positive change.

While recognizing the centrality of national leadership and political will, dramatically increased efforts at the community level are essential in order to contain and reverse the spread of the epidemic. The *Framework* stresses the need to recognize, support and strengthen local capacity for prevention, care and support efforts. Civil society, including religious institutions, is well-positioned to assist these efforts.

To download *The Global Strategy Framework on HIV/AIDS*, visit www.unaids.org/html/pub/publications/irc-pub02/jc637-globalframew_en_pdf.htm

STUDY COUNTRIES

To achieve a manageable scope, we limited the study to six countries (see map). In selecting the countries, we recognize that the global AIDS epidemic has different faces in different regions of the world, “varying from city to city, village to village, community to community. The differences often may be subtle but they can be important enough to require a different, and sometimes entirely novel, approach.”²⁶ In each region, solutions to changing the course of the epidemic will also vary according to the cultural, economic and political context. We aimed for representation of countries at different stages of the epidemic, in different regions, and with different religious traditions. We selected countries based on pre-established criteria, including those that fell into one or more of the following categories:

- Countries in which the HIV prevalence is already high.
- Countries in which the HIV epidemic is growing rapidly.
- Countries in which mature HIV/AIDS programs have had demonstrable effect on reducing HIV prevalence.

Based on the above criteria, the following countries were selected for study:

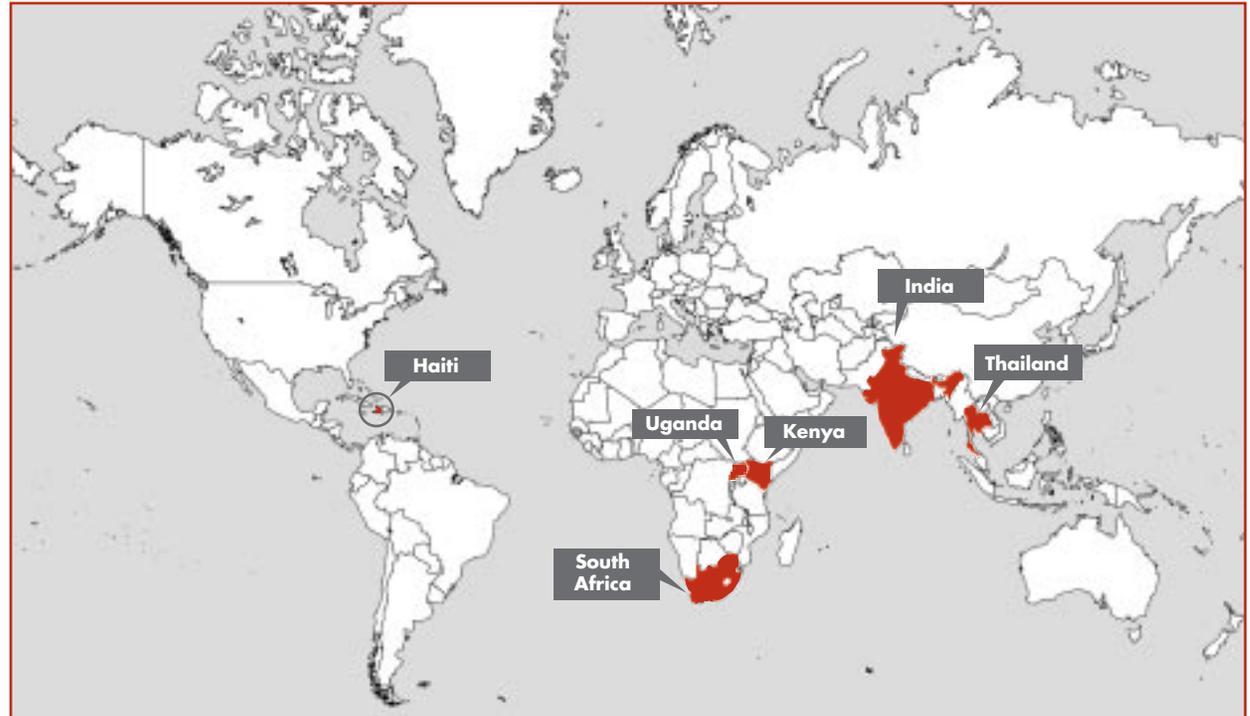


Table 1: Demographic, HIV/AIDS Indicators	Haiti	India	Kenya	South Africa	Thailand	Uganda
Population (2002), millions ⁴⁸	8	1050	31	44	62	23
GNI per capita (2002) ⁴⁸	USD 440	USD 480	USD 360	USD 2600	USD 1980	USD 250
Percent living under national poverty line (year) ³⁷	65% (1987)	29% (1999-2000)	52% (1997)	48% (2002)	13% (1992)	44% (1997)
Rate of HIV/AIDS infection among adults ages 15-49 (2003) ²⁸	5.6	0.9	6.7	21.5	1.5	4.1
Number of women ages 15-49 living with HIV/AIDS (2003) ²⁸	150,000	1,900,000	720,000	2,900,000	200,000	270,000

Haiti

Haiti is home to 8 million people who practice a distinct blend of Christianity and Voodoo. Two hundred years after gaining independence, Haitians continue to suffer from an unrelenting mix of civil strife and poverty. Seventy-five percent of the population is poor, while 56 percent of the population lives in “extreme poverty,” defined as less than USD 1 per day.²⁷ After the civil unrest, riots and violence of 2004, Haiti is being run by a transitional government with new elections planned for 2005.

With more than a quarter of a million people living with the virus, Haiti has the highest adult HIV prevalence rate in the Western Hemisphere and accounts for 90 percent of AIDS cases in the Caribbean.²⁸ Since the first cases of HIV infection were detected in 1979,²⁹ the epidemic has now spread throughout the country, especially among its most deprived citizens. The death of roughly 30,000 each year has left nearly 200,000 children orphaned by AIDS.³⁰

Public and visible activities of religious organizations involved in the fight against HIV/AIDS have been relatively recent. Although a meeting on HIV/AIDS was held with Roman Catholic, Protestant and Voodoo

leaders in 1992, it was not until 10 years later that representatives of the main branches of Christianity launched the Forum of Christian Churches. Subsequently, the major faith groups, including Voodoo leaders, met in a series of conferences to discuss their participation in this fight. Since 1999, a Haitian NGO, *Promoteurs de l'Objectif Zerosida (POZ)*, in collaboration with leading religious faiths, has also organized an annual Candlelight Memorial as a day of mobilization and awareness-raising about the disease.

India

With more than a billion people, India is the second most populous country in the world after China. It is exceptionally diverse in terms of religion, culture and standard of living. More than 80 percent of the population identifies with Hinduism, which has an important impact on the public and personal lives of most Indians, while the significant minority who practice Islam also exert a strong political force. The promises of living in the largest democracy in the world have not filtered down to the nearly 80 percent of all Indians who live on USD 2 or less per day.³¹ The anticipated intensification of the HIV/AIDS pandemic will add to the burdens of a population already suffering from the many problems of poverty.

Since its first reported case of AIDS in 1986, the estimated number of PLWAs in India has increased sharply to 5 million at the end of 2003.²⁸ While current prevalence rates are relatively low, the potential magnitude of an unchecked HIV epidemic in a country that has a larger population than the whole of Africa is staggering; today, India is second only to South Africa in the number of people living with the infection. In 2002, more than 80 percent of all persons infected with HIV in South and Southeast Asia were in India.³² The epidemic is greatest in a few southern states, with injected drug use being the predominant mode of transmission in some regions, while in others the epidemic is spreading to the general population through heterosexual relations.³³

Soon after 1986, the National AIDS Committee was set up, and a National AIDS Control Programme (NACP) was launched a year later.³⁴ Today, a multi-sectoral strategy for the prevention and control of HIV/AIDS is in place, but India faces an uphill battle complicated by limited health funding and a lack of strong political commitment to mobilize the population around this key issue.^{35, 36} Faith-based organizations are involved in service delivery, but are reportedly not prominent in the national policy scene.

Kenya

Kenya is a diverse country with multiple ethnic groups. Most Kenyans are Christians, but Islam also plays a significant public role in Kenyan society. Kenya is seen as the gateway to East Africa and the region's financial and trade center. However, with nearly one-quarter of the population living on less than USD 1 a day, it is a low-income country by all standards.³⁷ Nearly 60 percent of the residents of its capital, Nairobi, live in squatter settlements that have little or no infrastructure.³⁸

The first case of HIV was reported in Kenya in 1984, and now 2.5 million Kenyans live with HIV/AIDS. The country is ill-prepared to care for such numbers. By 2000, more than 50 percent of the hospital beds were occupied by AIDS patients.³⁹ At present, there are nearly a million HIV/AIDS orphans, and 1.4 million women are infected with the virus. The government has not yet managed to make generic drugs available to the public on a large scale, and when they are available, a constant supply is not guaranteed.

With a change in government, Kenya is now taking a more proactive approach to tackling its growing AIDS epidemic. It is implementing a national strategic plan that calls for HIV/AIDS prevention programs in all ministries. Kenya has a number of international, national and regional organizations and networks that are

	Haiti	India	Kenya	South Africa	Thailand	Uganda
Buddhist	—	—	—	—	95%	—
Christian	96%	2.3%	78%	68%	0.5%	66%
Hindu	—	81%	—	1.5%	0.1%	—
Indigenous beliefs	—	—	10%	28.5%	—	18%
Muslim	—	12%	10%	2%	3.8%	16%
Sikh	—	1.9%	—	—	—	—
Voodoo	50%	—	—	—	—	—
Other	3%	2.5%	2%	—	0.6%	—

Percentages in each country may not add up to 100% as an individual may identify with two religions/faiths

faith-based. These groups serve millions of the Kenyan population¹⁹ and may be able to contribute to this national plan. For instance, the Nazareth Hospital, located close to Nairobi, has proposed a collaboration with 20 other faith-based hospitals in central and western Kenya to address HIV/AIDS.² However, lack of financing and a weak economy are hampering progress.⁴⁰

South Africa

Emerging from nearly 50 years of apartheid rule in the early 1990s, South Africa is rapidly building a robust democratic political system and free-market economy. The rich array of ethnic backgrounds that make up present-day South Africa is reflected in the 12 official languages including Zulu, Xhosa, Afrikaans and English. Most South Africans regard themselves as Christians, and a significant number also hold indigenous African beliefs.

While South Africa is significantly wealthier than most sub-Saharan nations, poverty and inequity are still widespread. With more than 5 million people infected, South Africa has the greatest number of people living with the virus of any country worldwide.²⁸ South Africa's development efforts have been significantly affected by the HIV/AIDS epidemic. AIDS-stricken households spend approximately 34 percent of their income on health care.⁴¹

Until quite recently, the South African government was criticized by a number of national-level advocacy groups and members of the international community for its approach to addressing the epidemic. In a major shift in policy in 2003, the government announced a plan to make antiretroviral drugs available to treat 1.2 million people by 2008. The government has also formulated a multi-sectoral national strategic framework for 2000-2005

that covers 17 sectors, and involves persons living with HIV/AIDS, faith-based groups and traditional healers.⁴⁰

Thailand

Predominantly Buddhist, Thailand is a middle-income Southeast Asian country that is doing relatively well according to the United Nations human development index (HDI), which combines measurements of life expectancy, school enrollment, literacy and income.⁴² A favorite tourist destination, Thailand is also known for its booming commercial sex industry, which has significantly contributed to its AIDS burden. At the end of 2003, more than half a million people were infected with the virus.²⁸

The first case of AIDS in Thailand was reported in 1984.⁴³ Poised on the brink of an HIV/AIDS disaster in the early 1990s, the country has been credited with implementing a successful national campaign focused on, among other things, a “100 percent condom use program” for the close to 100,000 sex workers in Thailand.⁴⁴ Since 1988, the country has spent approximately USD 400 million on Thailand’s National AIDS program.⁴⁵ The focus is now to quadruple access to low-cost antiretroviral treatments. The shifting interest of the Ministry of Public Health (MOPH) has reportedly led to severe cuts in the budgets for free condoms and prevention efforts.

Buddhist faith-based institutions have been involved for some time in care for the sick and dying. More recently, Buddhist nuns and monks have become actively involved in HIV/AIDS prevention work.^{46, 47}

Uganda

Uganda is one of the fastest growing economies on the continent. Yet, despite a healthy GDP growth rate (6.2 percent in 2001)⁴⁸, Uganda continues to experience very high poverty levels, ranking 150 out of 176 countries on the United Nations HDI. School enrollment is only 45 percent; population growth remains extremely rapid.⁴²

Uganda has been widely recognized as an “HIV/AIDS success story.” It has received international attention and accolades for having taken effective action in the early days of its HIV epidemic. President Museveni demonstrated commendable leadership by making HIV/AIDS his nation’s priority. Prevalence rates

among antenatal clinic attendees were reduced from 25 percent in 1992 to 11 percent in 2000.⁴⁹

Its successes notwithstanding, Uganda still faces a large AIDS problem that will affect its social and economic development for decades. Life expectancy at birth is now only 44 years (compared to a developing country average of 64.7 years).⁵⁰ The country requires significantly more resources to mitigate the impact of HIV/AIDS; 82 percent of the AIDS population is in need of treatment.²⁸ In response, the government is pursuing public-private partnerships as well as community-based responses to the epidemic.⁴⁰

Although Uganda is predominantly Christian, nearly all of its major religious institutions, both Islamic and Christian, have been actively engaged in the country’s struggle with HIV/AIDS.^{51, 20} Religious groups, in collaboration with the government, are providing AIDS services including peer education, home-care programs and counseling.⁵²

Table 3: Health Expenditure Indicators ²	Haiti	India	Kenya	South Africa	Thailand	Uganda
General government expenditure on health as percentage of total expenditure on health (2001)	53.4%	17.9%	21.4%	41.4%	57.1%	57.5%
Private expenditure ^{vi} on health as percentage of total expenditure on health (2001)	46.6%	82.1%	78.6%	58.6%	42.9%	42.5%

^{vi} Includes the following: non-profit institutions serving mainly households, household out-of-pocket spending (prepaid plans and risk-pooling arrangements), and firms’ expenditure on health.



We have defined “faith-based organization” broadly to include the range from places of worship to development organizations with a mission of faith (See Box). This decision was taken for practical reasons in that separating out the activities of the diversity of faith-based actors in a particular country would be difficult, if not impossible. For example, religiously-affiliated hospitals are not typically run by local parishes. Hospitals and parishes may collaborate with and receive funding from religious-based development organizations. *The Global Strategy Framework* refers to the “religious sphere” of life, a phrase that seems to incorporate the full spectrum of institutions we have defined as “faith-based.”

As we began this research, “faith-based,” “religious” and “interfaith” were used interchangeably in each country. But since it is impractical to define “faith-based” or “religious” across regions with different cultural contexts and political environments (for example, church-state relationships and the legality of religious institutions vary), we were guided by our in-country collaborators and by key informants both within and outside each country in an effort to assure that we had objectively defined the universe of FBOs and were consistent in investigating an organization’s role in its particular context.

Faith-Based Organization: A general term used to refer to religious and religious-based organizations, places of religious worship or congregations, specialized religious institutions, and registered and unregistered non-profit institutions that have religious character or missions.⁵⁴

While our interviewees generally understood the rationale for this broad definition, in practice, numbers of them found it problematic not to differentiate. Several distinct issues emerged in defining FBOs as we progressed with the study.

FBOs as Places of Worship vs. Services/ Development Organizations. Our key informants used “faith-based organization” to refer both to places of worship such as temples, churches and mosques and also to service organizations that have a mission that is inspired by faith.

In my own way of looking at the world, I think there is major distinction between the church and faith-based organizations. The church is really there for the spiritual. They need the people, whereas the faith-based organization needs the business. It’s very different, the way they organize and budget.

— International Key Informant (Non-FBO)

In defining faith-based organizations, it’s easy to name the mainline churches and Islamic organizations because they are religious institutions with identity, but we have lots of gray area in terms of agencies like World Vision or Catholic Relief Services, which are development agencies with a faith mission and so where do they fit in?... But at the micro-level, a lot of the women’s organizations that are active in HIV/AIDS work since the early ‘90s many of them are faith-based women’s groups that came together to create an NGO to address HIV/AIDS in their communities and their lives. So they don’t call themselves an FBO until now, when it becomes a funding source for them, but if you look at the membership, all those members happen to be people belonging to a church and that piece of their faith is very much imbedded in their activities and in what they say and what they do in their work, the kinds of messages they give.

— International Key Informant (Non-FBO)

FBOs as Institutions vs. Individuals. Our informants also speak of individual religious leaders as distinct from the institutions themselves when talking about FBOs.

On supporting a treatment plan, they were very, very supportive. They did support us on civil disobedience. Some did... Again, it was a minority of the outspoken recognized church leaders who did it rather than the church as a body.

— South Africa Key Informant (Non-FBO)

How visible [have FBOs been]? Is it one of those instances where you can say FBOs in general? I'm not sure. Can you say the individuals within that group? Definitely. I know there is a rabbi who is very visible on issues around HIV and AIDS. There are a couple of Imams as well, and obviously some ministers on varying levels of their churches' hierarchies. But as a whole and collaboratively and sort of in a planned and forceful way, I suppose they do as best as we all do.

— South Africa Key Informant (Non-FBO)

Personal Convictions Influencing One's Work and Actions. The fact that the majority of people have a faith, whether or not they belong to or work for an institution with an explicit faith mission, has blurred the boundaries of our initial sector definitions. Should a priest working in a secular institution be classified as a non-FBO representative? Clearly, a person's faith can have as much influence on perceptions as the organization's mission. For a study that is primarily about perceptions, this presents a clear problem in categorization.

Many people who work for Ministries of Health in whatever country are religious people. They're Christian or Muslim or some other tradition and so they bring with them their faith tradition in terms of what they think they should be doing and what they think the national policy should be. So many of the debates in countries from the early stage with the Ministries of Health personnel were that 'We shouldn't be promoting condoms because we're promoting promiscuity,' and those are messages from the physician or the MD who heads the

National AIDS Control program, and he's saying that coming again out of his faith tradition, but he's not representing a church or Islamic group when he says that. He's representing his own opinion as a person of faith who happens to be head of the National AIDS Control program.

— International Key Informant (Non-FBO)

I think the description of faith- and non-faith-based also trouble me a little bit, because if I'm working for [my organization], or my friends are working for CARE or Family Health International, it doesn't mean they don't have faith. It doesn't mean they don't have some religious or spiritual or other kind of, if you will, 'higher calling' for doing this work. In fact, I think no matter where they're working...they're doing God's work, and whether they characterize themselves as a faith-based organization, which they do not, or they reverence God, it's their business. So the little concern — when it says, "not faith-based" it sounds like somehow there's no faith involved in that group or that organization and it isn't officially that way, but many people are driven to this work in general because they have some kind of deep spiritual commitment.

— International Key Informant (FBO)

Country/Sector Variations. In the different countries and within different sectors, our key informants have defaulted to certain terms when talking about FBOs: church, FBOs, gurus, faith communities, monks, religious leaders, imams and temple. These terms tend to reflect all the

issues raised above and give insight into our key informants' perceptions of what FBOs are.

As with our key informants, we have used various terms (e.g., FBO, church, temple, monk, etc.) as appropriate in the analysis and writing of this report. At times our informants make distinctions between what different denominations and types of FBOs are doing. At others, our informants have not specified a particular faith and so we also have used the generic "FBO." Our study has included all of the groups and individuals mentioned above, and thus has the strength of addressing issues that are of significance to many and the weakness of lack of depth that necessarily accompanies such a broad project.

There is so much complexity inside this term 'faith-based organization' and that's probably lacking from the interview. When you say FBOs, you mean Voodoo priests, and you mean very conservative Protestant sects, and you mean big institutional religions. So, I think that it's hard to talk about FBOs, they are so complex. I think you notice this in your own work. And I think it's great when you think about FBOs, you should be thinking about Voodoo priestesses, Voodoo followers, bishops and the pope and all that, but imagine, it's all the complexity of humanity. So, how do you make that come out in a questionnaire? I don't know. But I don't believe there is such a thing like FBOs. I really don't believe it. The whole thing is sort of a recent construct.

— Haiti Key Informant (Non-FBO)





Photo by Annmarie Christensen

We begin our analysis at the entry point that many FBOs have taken in response to HIV/AIDS – mitigating impact of the disease through care, support and treatment. We then consider how FBO behavior-change communication (BCC) efforts aiming to decrease risk of contracting HIV are perceived. Next, we explore views on FBO efforts that specifically address the vulnerability of women to HIV. And lastly, we review opinions surrounding FBO accountability and participation in public policy at the national level. We conclude the report with some considerations for the dialogue that we hope this report will generate.

MITIGATING THE IMPACT OF HIV/AIDS: PROVIDING CARE, TREATMENT AND SUPPORT

Care, treatment and support for persons living with HIV/AIDS form a critical component for all stages of the infection. Management of the disease requires a comprehensive approach including the treatment of infections, both sexually transmitted (STIs) and opportunistic; counseling and spiritual and social support; adequate nutrition; and, when the viral load reaches a critical point, antiretroviral drugs. Through a complete continuum of care, PLWAs and their families can live healthier and more productive lives. Stigma and

discrimination against those living with the virus can also be reduced through strong community-based care and support systems.

Providing health and social services in many of the countries hit hardest by HIV even before the pandemic, FBOs' health personnel and infrastructures have also been utilized for the care and support of those living with the virus. The following sections highlight some of the key areas of care and support in which FBOs have been active.

Our sense would certainly be that among faith-based organizations, probably their strongest area of engagement with HIV is around care and support work, certainly among Catholic-Church-based organizations. And that would cover a wide gambit from home-based care for adults and children who are sick with AIDS-related illnesses, providing pastoral care, psycho-social care, looking to the material needs, providing social visits and emotional support through peer-to-peer visits. A lot of these models of care will have been developed within local communities, mobilizing a large volunteer base led by skilled individuals.

— International Key Informant (FBO)

Providing Health Care in Hospitals, Clinics and the Home

Clinical services, both in-patient and out, and home-based care are important points on the

care continuum that aim to improve and prolong the lives of PLWAs. Whether monitoring asymptomatic infections, treating opportunistic infections and malignancies, providing STI care and family planning or offering counseling, it is chronic and palliative care that is the focus of most health-care services offered in low-income countries where access to treatment remains very limited.

Services Reflect Religious Mission and Values. A large proportion of our key informants feel that faith-based organizations play a significant role in providing health care to persons living with HIV/AIDS. Many respondents discuss how providing health care to those with HIV fits naturally within the overall mission of almost all faith-based groups – “to help our neighbors” in time of need.

[F]aith gives them more courage to go where public servants may not be able to go.

— Uganda Key Informant (Non-FBO)

Ours is a health organization that is interested in the health of the sick; it is normal that we are interested in the fight against AIDS. From the religious viewpoint, it is a matter of religious consciousness and ethics to help our neighbors to get rid of problems that can lead to the loss of lives such as AIDS.

— Haiti Key Informant (FBO)

Strong Presence of FBO Health Infrastructure, Especially in Poorer Countries. Faith-based health facilities have often been strongest where government programs are weak. Unlike South Africa with its fairly well developed public health infrastructure, respondents from Uganda and Kenya note that FBOs have a long and significant history supplementing the public health system as care providers in their countries. A number of informants estimate that FBOs provide nearly 50 percent of all health care to infected people, especially the poor, at low or highly subsidized rates. Secular and faith-based informants in Kenya state that many hospitals are faith-based, with mission hospitals being on the frontline of care for PLWAs. Furthermore, Kenyan and Ugandan interviewees often consider the quality of care offered by FBO-run hospitals and clinics to be better than that offered by the government.

I think that about half of the health facilities out there belong to faith-based organizations... If [people] have no money they choose to go to the faith-based facilities because it's subsidized, and yet very good services...

— Kenya Key Informant (Non-FBO)

At mission hospitals, you find it's clean, it's affordable, and you feel more welcomed. Where you know they try their level best to ensure that essential drugs are there. Unlike where you are treated (at a government clinic), where you arrive in the morning and then the doctor comes in at midday, sees a few patients and walks away. So that is the difference, it's like now the community has lost hope on anything related to government.

— Kenya Key Informants (Non-FBO)

The quality of services received from a faith-based medical institution still remains much higher than our public health-care system.

— Uganda Key Informant (Non-FBO)

A number of secular key informants from India also believe that the provision of health care to PLWAs is the leading role for FBOs, with Protestant and Catholic groups cited most often. Although Christianity is a distinctly minority religion in India, Christian-affiliated medical institutions are disproportionately represented among faith-based institutions. Indian FBO respondents state that the existing infrastructure of hospitals, clinics and medical training schools facilitates their work in treating PLWAs.

According to respondents in Haiti, FBO medical services primarily aim to reach the poorest and to avoid isolating those with HIV through stand-alone clinics.

The services are provided to anyone. If there is privilege, it only belongs to the deprived.

— Haiti Key Informant (FBO)

We take care of patients by treating the opportunistic infections but we try not to isolate them... HIV patients are treated as all other patients and I think that is something that we should encourage.

— Haiti Key Informant (FBO)

South African respondents refer to the prominence of the government in providing clinical services through state-run hospitals in South Africa.

The government...has not really asked religious organizations to run clinics. The main infrastructure is provided by government in this area.

— South Africa Key Informant (Non-FBO)

You know in some countries mission churches are very key players into the big health services, but that's not the case where we are. It's more in the community-based care, home-based care, hospice care.

— South Africa Key Informant (Non-FBO)

Faith-based medical services are not a major theme among Thai informants, although some do mention the role of FBOs in providing health-care services in Thailand.

For example, this hospital that we are doing this interview in was not built by the government, it was built by the church...they built it for the people so that they can take care of them.

— Thailand Key Informant (Non-FBO)

Home-Based Care. Home-based care, offered both in lieu of and in addition to clinical care, is seen by African respondents as one of the strongest program areas of FBOs. Both the non-FBO and FBO sectors in Kenya, South Africa and Uganda cite the significant provision of care for opportunistic infections, palliative care and counseling at the home.

An area that I have found that FBOs are absolutely first class is in the area of home-based care. Whenever we ask the local community to identify a particular intervention that they can say is a good practicing case study, almost always it is a faith-based institution and, most often than not, it is in the area of home-based care.

— Kenya Key Informant (Non-FBO)

A number of informants state that FBOs are “pioneers” in this arena, serving as a model for both the government and NGOs. Their success in this area is viewed as a natural extension of their strong role in community health care and their mission of compassion.

I think in this country FBOs have developed some of the best models for home-care services.

— Uganda Key Informant (Non-FBO)

Home-based services are seen as a way to expand services to those who cannot afford clinical care or have difficulty reaching medical centers.

If there is a family which has a sick person, a son or daughter who is 25 or 30, who has two or three or more children in his aging mother's house...in later stages when he or she gets sick, they cannot even walk to the nearest center which may be 10 kilometers away. But if this woman hopes that once in two weeks the diocese will come, then you know this person will get some care. This is very relieving.

— Uganda Key Informant (Non-FBO)

FBOs' home care provides for people who can't afford hospital fees, and at the same time is helping to reduce the load to the hospital.

— Kenya Key Informant (FBO)

FBOs are perceived to sustain and even increase their capacity to provide home-based care effectively by training volunteers.

They [FBOs] train women who are unemployed ... and give them support so that they can do this home-based care effectively.

— South Africa Key Informant (Non-FBO)

In areas where we have pulled out because of limited funding, the volunteers are trying to sustain the home-care program without us. We have a very strong network on the ground.

— Uganda Key Informant (FBO)

Health Sector Collaboration and Coordination. Kenyan, Ugandan and Thai respondents cite considerable collaboration between the non-FBO and FBO health sectors. In Kenya and Uganda, collaboration between mission hospitals and non-medical FBOs, as well as among FBOs, donors, the government and educational institutions, is seen to increase capacity to care for and treat opportunistic infections of those with HIV/AIDS. However, a warning was expressed about competing with or carrying out parallel development with governmental/national health systems.

Government has agreed to provide them [FBOs] with grants so that they can provide high quality care.

— Uganda Key Informant (Non-FBO)

Where the national health system has been ineffective, the church is trying to strengthen the system or work parallel to it. There are certain examples where FBOs ...weaken the national health system. I would say that faith-based organizations should not do work in competition with the national health system.

— Kenya Key Informant (FBO)

Thai informants discuss collaboration between FBOs and community hospitals to provide direct support in the form of physicians and volunteers. Collaboration between FBOs and PLWAs is also noted.

Both Buddhist and Christian priests work closely with the community hospitals. For instance, a medical development organization or the community hospital would provide support to them by sending physicians or volunteers to help the project. Sometimes monks send their clients to the hospitals or sometimes there are networks of PLWAs working together with them.

— Thailand Key Informant (Non-FBO)

In Haiti, Thailand and South Africa, interviewees discuss the collaboration of FBOs with traditional healers—ranging from education on safe practices to encouraging the use of traditional herbal remedies.

In our strategic plan, we want to encourage traditional medicine.

— Haiti Key Informant (FBO)

We also work very strongly there with traditional doctors or healers, 80 of them, who are actively involved with the community clinic and collaborate in terms of HIV/AIDS there.

— Thailand Key Informant (FBO)

Offering Spiritual and Social Support through Communities of Faith

While clinical care is vital, social and spiritual support are equally critical for the health and well-being of infected persons and their families. Views and thoughts on the comparative advantage of FBOs in providing spiritual support to those infected and affected, as well as their shortcomings, are illustrated below.

Restoring Hope through Faith. Nearly all interviewees feel that spiritual and social support is a key component of FBOs' work. The provision of hope, compassion and acceptance is considered by most as a first level of care that must be offered by FBOs and underlies all other services. Many informants state that the goal of FBOs is to support patients and their families with care and love.

We need someone whom we can tell that we are infected and whom we can ask if they are willing to help us. One day I went to meditate on my own. One monk walked to me and ask me if there's anything he could do to help. I felt so good. I immediately had faith in him. I had a very nice conversation with him afterwards. He taught me several Buddhist teachings. It's pretty rare to find a monk like this. One who offers help.

— Thailand Key Informant (Non-FBO)

Well, the first thing really is to restore hope among these people, among the infected and the affected to help them rediscover their self-esteem, rebuild their self-confidence and promote positive living...

— Uganda Key Informant (FBO)

Whether they are providing spiritual guidance, moral support or counseling, FBO respondents feel strongly about the role they play in this aspect of care.

[If] you are to take a holistic approach to any issue that people are wrestling with, you can't leave the spiritual dimension out. We can respond to needs but if the spiritual need is not met, and if one's wrestling with the nature of God — I think there are a number of things that government cannot respond to, that churches need to deal with.

— South Africa Key Informant (FBO)

We use psychology to show that the person who has AIDS suffers not only in his body, but also suffers in his soul and his spirit.

— Haiti Key Informant (FBO)

Secular respondents share the view that providing compassion, strength and hope is an important role that an FBO can provide.

At the level of care and counseling, the churches very often are the only support people have.

— South Africa Key Informant (Non-FBO)

Well, faith-based organizations in this country have been very pertinent in the fight against HIV/AIDS. They're particularly instrumental in the area of psychosocial support. That's providing counseling and hope, so they may not be supporting us materially... Living with AIDS is a difficult thing and so people require spiritual support.

— Kenya Key Informant (Non-FBO)

So one of the largest components of care and support is the will to live and knowing how you can live a rich life that is full of quality and where every day is full of wonderful things. And religious-based organizations can make it so.

— India Key Informant (Non-FBO)

Spiritual counseling is also noted to be an important adjunct to treatment.

The faith-based organizations have proved to be very supportive, especially spiritual counseling, because you will agree with me that treatment is a recent thing but in the past, people had lost hope. People knew that if you have HIV what you should wait for is to die. In fact, if somebody got HIV in the past then the relatives would forget about him and even begin sharing his property or her property when this person is still living, and this is very traumatizing. So now the faith-based organizations here are very useful. They give a lot of hope, and that is very good because stigma alone is very detrimental in the process of HIV and coming up to AIDS. So sickness begins attacking them because of that psychological torture and they don't live longer. So that spiritual counseling tended to support people a great deal until when the treatment has come but even with treatment I think care is a whole range of all those things. Because even with treatment, without counseling, reassuring the patient, then even the treatment does not work.

— Uganda Key Informant (Non-FBO)

Spiritual Counseling in Preparation for Death. A number of informants discuss the fact that FBOs aim not only to improve the quality of life but also to help those afflicted with AIDS to be able to die in peace and with dignity. While this issue is discussed in most countries, the theme was most dominant in conversations with key informants from Thailand.

We use dharma^{vii} to encourage people who are infected... We visit them and encourage them to accept the truth about the circle of life. We explain to them how to die happily with consciousness. Then we would go visit them and encourage their relatives to change their attitude and behavior, to be happy living with AIDS people, since if they were not happy, those infected people would be less happy. And we try to show them how to prepare for death, which is an important role of Buddhism.

— Thailand Key Informant (FBO)

In care also there is spiritual counseling. When people are sick, they wonder about the meaning of their lives, and the only guidance is provided through their faiths, why they have become sick and when they are going. Otherwise people never question themselves until they become sick. That is where the faith comes in to give guidance, to be able to endure the problems of sickness. So, counseling or pastoral counseling or social counseling as they call it. Yes, they are playing a big role, even in the end, the time of death.

— Uganda Key Informant (FBO)

Spiritual Guidance and Stigma. A number of FBO informants mention the important role of FBOs in demystifying AIDS and overcoming common beliefs that PLWAs are “cursed” or “contaminated.” Whether by talking to the congregation at large about keeping those who are infected integrated within the religious and social communities or counseling families to

accept and care for their members who are living with HIV/AIDS, FBO informants feel they are playing a vital role in actively discouraging stigma.

Sometimes people come to us saying, ‘Look we want this person out of the house.’ Ah, we don’t take that responsibility. We go out, talk to them and spend some time. We say, ‘All right, he is the youngest son in the family. He may be on drugs. He may have been a troubled person in the past. He is still your son.’ And so we try to work with the family to see their responsibility. Not to pass this or to push them away.

— Thailand Key Informant (FBO)

Today we try to look at the models of what we call support ministries about how to visit people in their houses, how to fight this idea of rejecting the AIDS sufferers, how we can show them the compassion of Jesus Christ today. The person who has AIDS is not a cursed person; AIDS has nothing to do with a curse from heaven. An AIDS sufferer is a person who is struck by a disease and we have to accompany him, we have to support him, we have to love him, we have to have some compassion for this person.

— Haiti Key Informant (FBO)

Conversely, some secular South African key informants express concern that FBOs can perpetuate stigma through their spiritual guidance.

I remember going to a funeral of my colleague... and the priest spent more than two-thirds of the ceremony explaining how women are too loose today... [H]alf of

the church members walked out and you know better than I do, for African people to walk out of a church is very hurtful to them... And so the quality of the counseling and the quality of care is very often mixed with being judgmental, and that doesn’t set a good example for the community, and when I say this, I recognize that there are great religious leaders... to local religious people, they’re great people, but as a body, faith-based organizations have not done enough.

— South Africa Key Informant (Non-FBO)

Proselytizing. While the role of FBOs in providing care and support has been supported by a majority of key informants, concerns over the use of spiritual support to promote religious conversion is also voiced. Proselytizing to persons living with AIDS is mentioned by a number of key informants, especially among Haitian and African informants.

One of the coping mechanisms of people living with HIV/AIDS is actually getting saved. So the Pentecostal community is absorbing most of the people who are HIV positive. So being saved, getting saved, is one of the coping mechanisms of those guys.

— Uganda Key Informant (Non-FBO)

On several occasions, there were Voodoo followers who converted to Protestantism. When I asked them why, they answered that the Protestants tell them that you are contaminated because you are Voodoo followers. Once converted to Christ, they are told you will be miraculously cured.

— Haiti Key Informant (FBO)

Propagating Disinformation. Tensions between Christians and Voodoo followers in Haiti are mentioned, with informants discussing how a number of religious leaders promote the idea that HIV/AIDS is the result of sin or practicing Voodoo. A number of informants mention that a minority of FBOs dissuade the use of drug therapies or promote stigma – a theme with the strongest resonance in Haiti, Uganda and South Africa.

Increasingly in the born-again churches...people are claiming that their status has changed. You people call it sero-reversal. People are standing up to claim that 'you know last year I was tested and I was positive but I have been tested three times and I am negative.'

— Uganda Key Informant (Non-FBO)

There is also concern among several African informants that some churches are convincing infected congregation members to “put all their faith in healing through prayer,” and stop taking medicines.

There are some shortcomings of a few [FBOs], just a few of them. Religious fanatics who have misled HIV-positive people and ask them not to take any treatment for opportunistic infections and to just have faith.

— Uganda Key Informant (Non-FBO)

Some are telling people they should stop their treatment because only God can provide for their future.

— South Africa Key Informant (Non-FBO)

Antiretroviral Treatment in Resource-Constrained Settings

Nearly 6 million, or more than 90 percent of those who need antiretroviral (ARV) treatment, do not have access to these lifesaving drugs.¹ Of these, nearly all live in developing countries, with the treatment gap widest in Africa. Until recently, palliative services were often all that was available for caregivers to offer those infected with HIV. However, with expanded funding and technical support, there are new opportunities for FBOs and others to introduce and scale up antiretroviral treatment. Along with these opportunities come a host of challenges.

Expanding Access. Nearly all respondents state that while ARV treatment is still extremely limited in their nations, FBOs have been or are becoming involved in providing, distributing and/or advocating for ARVs at some level.

I think FBOs are doing a great job here in Kenya, particularly in terms of expanding the access to ARVs at a cheaper cost.

— Kenya Key Informant (Non-FBO)

Most of the religious organizations work in the field of prevention. Now for some months they have started to widen access to treatment for persons infected by HIV.

— Haiti Key Informant (Non-FBO)

Much of the work of FBOs in providing ARVs is cited as a collaborative effort, involving government, donors or other FBOs.

From the latest report from the Ministry of Health, the mission hospitals are stepping up to their relationship with the Ministry so that when it comes to ARVs, there is a harmonized approach to the management of ARV therapy.

— Kenya Key Informant (Non-FBO)

I would probably say that FBOs are beginning to expand the avenues of treatment in the sense of increasing the number of service delivery points that are under the control of FBOs. For example, if you look at the network of mission hospitals across the country, they are now beginning to run programs that are helping to dispense antiretroviral medicines. For example, in Kenya, we have the experience of [this faith-based network]—and they are using their network to distribute antiretroviral drugs and therapies to all their clients who are mission hospitals. So that is one way in which the faith community is being used to make sure that different segments of the population can access treatment.

— Kenya Key Informant (FBO)

Among African key informants, discussion of FBO advocacy for increased access to ARV therapy was significant, with many informants specifically mentioning FBOs who lobby the government, influence policy and collaborate with donors.

We actually are very committed to campaigning for the availability of treatment and also doing something to make sure that treatment is available.

— South Africa Key Informant (FBO)

Through advocacy, we are trying to talk—to be the mouthpiece—to talk to donors. Seeing who else can help us, writing proposals here and there because now we are thinking we want to get ARVs because everybody is getting them. We want to have them so we are trying to lobby for such drugs.

— Uganda Key Informant (FBO)

Infrastructure and Networks. In a number of countries, FBOs’ existing infrastructure and networks are often viewed by informants as having better capacity to effectively deliver ARVs than governmental alternatives.

Take the issue of ARVs, and when the government was piloting and saying we want institutions that have the capacity to provide ARVs, most of them were church related.

— Uganda Key Informant (FBO)

In Kenya, there’s a good example where the mission hospitals were in fact the first to expand comprehensive HIV clinical care with ARV...to get the experience, to train people in the use of antiretroviral therapy, they have been pioneers.

— International Key Informant (Non-FBO)

Supporting Roles. Some key informants, especially in South Africa and India, state that the role of FBOs should be one of supporting access and proper administration, not of providing treatment.

I would say their role in terms of treatment has been more in terms of advocacy and lobbying, and less in terms of actually administering or setting up facilities that actually provide treatment... [I]t’s not realistic for faith-based organizations to set up treatment sites, per se.

— South Africa Key Informant (Non-FBO)

Some South African respondents discuss how FBOs provide support by training volunteers to help PLWAs adhere to treatment and providing nutritional support. An Indian informant states that while some FBOs provide ARVs, FBOs are primarily helping to expand India’s distribution capacity because they recognize this is the “next big thing” for key international donors.

Need for Long-term Sustainability/Adherence. Nearly all who discussed ARVs mention the importance of sustainability, as antiretrovirals must be taken for life. And the ability of FBOs to ensure long-term viability of their programs is dependent on the financial and logistical support of others.

It has to be sustainable. It’s not just to give supply for two months and then not. We would be doing harm to the patient. Therefore, if there is a guarantee from the government, we would be happy to collaborate and do whatever is possible.

— India Key Informant (FBO)

The issue of drugs is a very complex issue for non-medical staff to facilitate the number of people who are living with HIV/AIDS. One small FBO cannot afford to help, because if you help five people, what about the other 20 who are also in need of drugs?

— South Africa Key Informant (FBO)

We don’t do antiretrovirals. Our big concern with antiretrovirals at this point is that if you’re working in an environment where people are poverty-stricken, they will not have nutritional support to deal with the impact of antiretrovirals on their bodies. We have not yet been convinced that people can take antiretrovirals who don’t have access to the nutrition and also the supplementary vitamins and things that need to go with that.

— South Africa Key Informant (FBO)



Photo by CMMB

COMMUNICATION TO CHANGE RISKY BEHAVIORS

Encouraging behaviors that decrease the likelihood of exposure to HIV is a key strategy for curbing the pandemic. However, helping individuals to make changes in behavior, especially in an environment of extreme poverty and deprivation, is a great challenge to FBOs and non-FBOs alike. The field of behavior-change communication (BCC) is grounded in the recognition that knowledge alone is not enough to change unhealthful behavior.⁵⁵ Many strategies are employed to encourage people to take responsibility for their own health, recognize that healthful behavior is in their own self-interest and provide skills that will enable them to make the desired changes in behavior. Where knowledge is inadequate, however, access to accurate information is clearly a first step.

In this section, we analyze the perceptions of our faith-based and non-faith-based respondents about whether and how FBOs have contributed to actions to reduce the risk of acquiring the virus.

General HIV/AIDS Awareness and Education

Our key informants are in consensus that FBOs are actively involved in raising awareness and providing education about HIV. Most key informants state that FBOs are educating people

about HIV/AIDS, including modes of transmission, and are working to “demystify” and “destigmatize” AIDS as a disease.

Sometimes we [monks] would educate children about life skills for teenagers, such as occupation, so they could earn money and not have to move to work at other places. Not only would we prevent AIDS, but also economic and social problems. In addition, when we educate people about AIDS, it is not only the prevention message for themselves, but also changing other people's attitudes to infected people. So infected people could live in the community/society happily.

— Thailand Key Informant (FBO)

Who, What and Where. Our respondents provide examples of activities in each country where faith-based organizations bring clergy, doctors and counselors into communities, school, and social gatherings to provide health and sex education and prevention information about HIV/AIDS. The FBOs that are providing these awareness programs range from small rural churches in Haiti, Islamic village heads in Kenya, monks in Thailand, Hindu gurus and nuns in India, and faith-based development organizations in all the study countries. FBOs provide programs in community centers, churches, temples, mosques, “on the streets” (e.g., outreach to commercial sex workers or street children), schools, and health institutions. Thailand offers an example of different faiths, providing prevention education in a variety of arenas.

Normally we will tell Islamic priests that tomorrow after worship we would like to talk to villagers for about 20 minutes. We would tell them the current news from district level of public health, for instance, there was an outbreak of AIDS. We would briefly explain that the disease could be transmitted through sexual intercourse or by using the same needle for injection. Although our religion does not permit these kinds of risk behaviors, AIDS still takes place anyway. We encourage parents to give their children time to take care. We have volunteers for when there is any question or problem, villagers could ask from volunteers. In case volunteers cannot give them answers, we would ask the local health centers.

— Thailand Key Informant (FBO)

Formats of Awareness Education. FBOs use a variety of formats to deliver prevention education. One of the most often cited formats is preaching or teaching in places of worship where people are essentially a ‘ready’ audience.

Where the faith leaders have come up themselves, it is part of their preaching - whether Protestants, whether Catholics, whether Orthodox, whether Muslims... Church leaders have come up to these AIDS messages, the dangers of AIDS, how AIDS comes into their preaching.

— Uganda Key Informant (Non-FBO)

We invite doctors and priests and counselors to come and sit down on Sunday with our youth, our family meeting, our secondary class to talk to them very openly about HIV and what is the risk.

— Kenya Key Informant (FBO)

While awareness messages are often delivered through sermons, FBOs in South Africa, Uganda and Thailand are using the mass media to promote prevention. In several countries, faith-based institutions are developing school curricula as well as other written materials for distribution. In other places, FBOs organize training workshops, collaborate with other NGOs and government and host community-wide conscious-raising activities, such as World AIDS Day, to mobilize people around HIV/AIDS. Some FBOs are actively using all available means to mobilize and educate people on HIV/AIDS.

We've used radio, we've used the local newspaper. We've spoken on a number of issues. We don't miss forums that are organized on HIV and AIDS because we feel it is something that must be talked about. So we do a lot of mobilizing of communities around HIV and AIDS. We've never missed World AIDS day celebrations and also always once in three months we'll have a candle-light memorial service in church here for people that have died of HIV and AIDS.

— South Africa Key Informant (FBO)

PLWA Involvement in Message Delivery.

Some FBOs involve people living with HIV/AIDS to deliver their messages. In Haiti, an FBO representative states that PLWAs “become missionaries of AIDS” while another says that they help humanize the face of the disease. In Kenya, FBO representatives talk about involving PLWAs.

Sometimes they used to give experiences, testimonies in church of what happened to them...they use themselves as a tool to teach others and it helps them to have faith and hope in the future.

— Kenya Key Informant (FBO)

In South Africa, several FBOs talk of involving PLWAs in a variety of activities, including peer education for youth, hiring and using HIV-positive staff as spokespersons, and providing information in training events. However, a few FBO key informants state that they are not using PLWAs as much as they would like for a variety of reasons, including stigma, which is perceived to be prevalent.

Targets of FBO Prevention Messages. The intended recipients of FBO prevention messages are often youth, who are viewed as key to turning the tide against the epidemic.

There's enormous emphasis on youth sexuality at the moment, every church group that comes here, says, 'come and deal with young people as the next generation.' It's almost like the realization: we won't be able to change this generation of 40-odd year olds, they've grown up, they've adopted a lifestyle that we can't change, but we can change the lives of the young people in our society. And that is where the purpose of faith-based organizations is now.

— South Africa Key Informant (Non-FBO)

FBOs also provide prevention education to other groups: women's groups, medical personnel, commercial sex workers and other adults. While a Christian development organization in India supports prevention programs with men who have sex with men (MSM), another FBO representative talks of educating families of people living with HIV/AIDS.

We tell the family members what preventive measures that they need to take care of. Not that they should keep them in isolation, but then when it comes to wounds or any bleeding or those kinds of things, and we also tell them about the toilet and treating. We give them gloves.

— India Key Informant (FBO)

Training the Trainers. Some faith-based development agencies have recognized the need for clergy to have more information in order to address the issues and answer the questions their sermons may raise.

On World AIDS day, Father...sent out an [announcement] that 'your sermon will be on HIV/AIDS' [but] 68 percent did not speak on AIDS. One of the excuses was, 'I would have spoken about HIV/AIDS but my knowledge is to give one sermon and if communities ask after that for some details, how would I know and how would I be telling people that I don't know?' So that started a series of workshops we are doing in Haiti and many of the countries, using the UNICEF toolkit and other toolkits to do religious clergy training for

HIV/AIDS. It is not sermons but a set of facts, bullet points on PMTCT, VCT, OVC^{viii} and palliative care of the dying.

— International Key Informant (FBO)

Several FBOs in Uganda, Thailand and Kenya are training those among their ranks so that they are better community educators.

We came up with a book that is actually being used by religious leaders to take messages out, and it gives guidance to religious leaders on what they can say on certain issues. So that if you are talking about the youth, what kind of messages are you talking about? If you are talking about sexually transmitted diseases, what are you talking about? How do you go about it as a religious leader? Also who the message goes to is very important. So you have to look at all those issues when you are developing messages.

— Kenya Key Informant (FBO)

Content of Prevention Messages

By the mid-1990s, the dominant HIV-prevention paradigm for changing behavior was known as the 'ABCs' – Abstain, Be Faithful, Use Condoms.⁵⁵ The premise of the strategy was that these were clear actions that the individual could take – healthy behaviors that could greatly diminish the risk of contracting HIV. While many organizations viewed the 'A', 'B' and 'C' as equivalent choices to be made based on the individual's situation in life, others saw them as a hierarchy of behavior, with a clear ordering of

preference for 'A' and 'B' over 'C.'⁵⁶ This controversy continues to this day and has been a major source of strain between faith-based and non-faith-based actors in many parts of the world. While the fact of FBOs involvement in awareness-raising activities may not be in dispute, the content of their education is a matter of much discussion.

Focus on Morality and Values. Faith-based organizations naturally use religious philosophy to frame their teachings about prevention. While Christian FBOs use the Bible as their resource, Buddhists use dharma and Muslims use the Holy Qur'an to frame messaging. As such, morality or ethical and 'clean' living are the foundations of most FBOs messages regarding risk reduction.

If you are to look at AIDS especially from a fairly narrow perspective, AIDS is largely caused through sexual contact. Now this is an area where the faith groups have a role in especially shaping the moral fiber and moral character of our society and this is where the churches, the mosques, the temples need to come in and strengthen the moral fibers of our society by helping the individuals in our communities to better manage their sexuality, to uphold their religious convictions to which they adhere to and to live within what is accepted socially in terms of our sexual conduct.

— Kenya Key Informant (FBO)

^{viii} Prevention of mother to child transmission, voluntary counseling and testing, and orphans and vulnerable children.

And those who are not infected [with HIV] should not take up this improper path. Keep in mind the religious ideals, keep in mind the basic necessities of the family, keep in mind the pride of the nation, and keep in mind the importance of an individual. Protect him/herself from any kind of lustful behavior, because when this [lustful] desire reaches the intellectual horizons, it serves as the nest of various ailments. Therefore, our temple [body] in which God resides and in which indriyas/chakras [senses/energy points] are active, such a temple should be protected from disaster.

— India Key Informant (FBO)

All men and women turn up for religious learning on Friday. A religious leader teaches them about Islamic principles. About AIDS, if people really follow the Islamic principles, there would not be any problems.

—Thailand Key Informant (FBO)

To Thai Buddhists, the concept of “self-control” is central to communications on AIDS-prevention. Overcoming the self and its desires is seen as important to spiritual growth, whether or not one is trying to reduce the risk of acquiring HIV.

The importance of self-control, to which now society does not pay attention, is significant, but people think that safe sex is more important. When talking in religion, we always bring up self-control. Whenever people have self-control, there is no need to talk about other things. Everything is safe since you can control yourself. The understanding in the level of self-control is different from that of safe sex...one of the five precepts states clearly that we should not be unfaithful. If we talk about not violat-

ing other women, there is a belief in Buddha teaching - single wife, single husband. There is no problem about sex since it is a natural thing whenever we have self-control in some extent.

— Thailand Key Informant (FBO)

Abstinence and faithfulness within the framework of morality are the primary pillars of faith-based organizations’ work in prevention.

The strongest message we provide is a value-based kind of message. We promote strongly abstinence around people so that they prevent HIV/AIDS infection so we promote as much as possible positive values in marriage between partners and also abstinence.

— Uganda Key Informant (FBO)

Perceptions of Non-FBOs on Moral Teachings. Some secular informants happily yield the role of moral arbiter to FBOs and find that they are in the best position to credibly relay value-based messages.

In the area of abstinence and faithfulness, we think the churches are more competent than anybody because that is the first line of defense. In ‘ABC,’ it is abstinence first and they are best at that. Actually a lot of money we pump into them is for them to promote that strategy first and foremost. Faithfulness and abstinence — they are very good in that area.

— Uganda Key Informant (Non-FBO)

Other non-FBO key informants, while understanding and even valuing FBOs’ use of religious teachings to frame prevention messages, find the messages ineffective.

They told people to follow the five precepts. Once there was a slogan, ‘If you keep the five precepts, you would not get AIDS.’ About the five precepts, we have been trying to urge people to follow them since we were young, however, it is still not working.

— Thailand Key Informant (Non-FBO)

The Condom Debate. When it comes to faith-based organizations’ involvement in HIV/AIDS, sexuality and condoms are the key issues of contention across the broad spectrum of countries. The controversy lies not only in the opinions of secular organizations regarding FBOs’ stance on these issues, but in fact, in the wide range of positions that FBOs themselves have taken. Non-FBO representatives fall in a continuum regarding their opinion of FBOs’ stance on condoms. Several key informants in Haiti, Kenya and India believe that FBOs are doing their best to preach a holistic message.

Now that everybody in Kenya knows that more than 90 percent of the infections are through sexual transmission and the only way is to abstain, and if you can’t abstain from sex and can’t be with one partner...you use the condom if you have to do it without your faithful partner. So the church is now opening up. They have allowed us now to talk about sex in church also, but for special groups - the older people. For the younger people we talk about ‘AAA’ [Abstain in order to Avoid AIDS], which is also related to sex.

— Kenya Key Informant (Non-FBO)

Other non-FBO key informants acknowledge that issues of sexuality and condoms complicate the role of FBOs in prevention activities. In Thailand, despite claiming that monks could use Buddha's teachings to advocate for prevention, key informants think that involving monks is problematic, since many in the community consider it inappropriate for them to discuss sex.

In people's opinion, they would think about AIDS as a sexual transmitted disease, and some people consider that monks should not get involved with this sort of problem.

—Thailand Key Informant (Non-FBO)

On the other hand, several key informants in the African study countries have been critical of FBOs' messages around condoms as being misleading, unrealistic, confusing and sometimes stigmatizing.

It actually was untruths, I almost want to say lies, but untruths given out about the condom use and message by [a] particular religious organization which were completely untrue, and they went against everything that the sort of medico- bio- psycho- social model was trying to achieve. It just undid all of that.

— South Africa Key Informant (Non-FBO)

Basically what faith-based organizations have done is to sit on the judgment throne and they keep on saying, 'You have to abstain,' with nothing else... 'You have to be faithful, you cannot use condoms.' ... The only time in this country, or the first time in this country that the Christians and Muslims came together was to burn the condoms. And all the two items were doing was addressing HIV/AIDS.

— Kenya Key Informant (Non-FBO)

The position of faith-based organizations on condoms, even within the same country, extends from rejection of the condom as a valid form of protection to active promotion. In Haiti, while key informants state that Voodoo leaders strongly promote condoms, some Christian churches quietly collaborate with others to promote their use.

At Church level, we do not recommend the use of condoms and the prevention methods the Church is committed to are abstinence and faithfulness. Despite that, we do work pretty hard with the organizations that promote the use of condoms.

— Haiti Key Informant (FBO)

Differences between Official Religious Policy and Local Practice. Even where the official institutional policy does not recognize condoms, some FBO key informants note that they see on-the-ground realities in a different light, which leads them to promote or even distribute condoms as they see necessary.

Although in the high hierarchy of the Catholic Church there is really no commitment that it makes to encourage the use of condoms — it favors abstinence, which it encourages, and it is the position of the [Roman Catholic] Pope — but within church communities there is a certain participation, and it goes even beyond the official position of the Church. For example, sometimes we meet [in] chapels of the Roman Catholic Church where young people give condom demonstrations inside the church. That is to say what happens at the base may differ from the message from the summit.

— Haiti Key Informant (FBO)

In 1990 when I was working here before, there were a couple of nuns who were out there distributing condoms to people of the slum areas in this town. I don't think it really mattered to them whether people were categorized as vulnerable to HIV or not, but I think they were targeting everyone — all the people.

— Kenya Key Informant (Non-FBO)

Some FBOs acknowledge that not all people may live up to the moral code of a particular religious order and they make allowances for the use of condoms by special populations, including sero-discordant couples or commercial sex workers.

Causes of the Condom Debate. The reasoning behind the reluctance of some FBOs to promote condoms is related to the morality and values issue discussed above and is articulated by two key informants.

The church is not opposed to the use of condoms per se. The church is opposed to the underlying habit and thinking and logic behind condom use, that it is okay for you to go and have sex with as many men and women as you want as long as you are protected. That is the mentality that the church is against, not the use of condoms per se.

— Uganda Key Informant (FBO)

Condom promotion campaigns promote sexual intercourse.

— Thailand Key Informant (FBO)

Other FBOs think that they cannot promote condoms and still retain their moral authority.

There are other Protestants who will say no, but I believe this is going to create a problem for us when we participate in the distribution of condoms. This is going to limit our message on abstinence. For my part, I say this: it is necessary to leave to each organization its specificity and its specialty. I do not criticize such an organization because it distributes condoms; it is its specificity, it is its work. Let me distribute the message of abstinence and faithfulness because I am very strong in this message. But I believe by distributing condoms that is going to affect the completeness of the message in a certain sense, because people are going to say, there are two waters coming out of your faucet.

— Haiti Key Informant (FBO)

Resolution to the Debate. Some key informants, while insisting that FBOs should not interfere with access to accurate information and services, find a middle ground to the condom controversy by agreeing that FBOs can promote only abstinence and condoms in a way that is complementary to others supporting condom use.

They say, 'If I have been preaching abstinence and faithfulness and know they can prevent HIV, why should I add a component that I don't believe in and that might dilute my message?' And my approach is — if I'm selling apples in the market, and someone asks me what is the best fruit to buy, and asks me about your bananas,

I would say, 'I know that apples are the best for you, but if you want to find out about bananas, go to the banana person over there.' So, what we usually ask them is not to deny that condoms can protect, but we do agree that you cannot easily talk about condoms [when] you don't believe in them.

— International Key Informant (Non-FBO)

We must recognize their (FBOs') comparative advantage. So do not, as I said, expect the bishop to go and start demonstrating how to use a condom if you know it is against his whatever. Use him for what he is best able to deliver.

—Uganda Key Informant (Non-FBO)

Others have seemingly grown weary of trying to convert FBOs to support condom use and would just as soon have FBOs stay out of condom promotion altogether and stick to what they know best.

Stay away from issues that are not within their mandate. Do not create bogus science. Deal with the most important issue that they know about which is protecting, reminding us of the norms and values of the land related to whatever religion you subscribe to, and prevent more new infections. That is their primary role. Don't tell people that condoms kill. They do not. If you do not use a condom, you are 98 percent unprotected.

— Uganda Key Informant (Non-FBO)

Customizing the 'ABC' Message. The 'ABCs' as a general message of prevention seem to be understood and acknowledged by most interviewees. However, some of our informants also adapt this message as they see fit for their local context:

In my Christian community 'A' is accepted, and 'B' is accepted and then 'C', 'condomize' is met with some resistance. And we have changed it to say we encourage abstinence for those who are not married. And we encourage 'B' for those who are in relationships, then if you are not going to do this, then you have to make correct choices. So our 'C' now is for 'choices'.

— South Africa Key Informant (FBO)

The abstinence and being faithful have been the strong messages but the 'C' which has been condom use has been changed by the Catholic Church to mean 'courage.' 'Courage to say No.'

— Kenya Key Informant (FBO)

Well, the 'ABCs' of prevention — we say, 'abstinence, be faithful, and chastity'.

— South Africa Key Informant (FBO)

A few key informants, however, criticize the whole concept of 'ABC' on the grounds that it is at best unrealistic and at worst stigmatizing (see Box on page 44).

DECONSTRUCTING 'ABC'

Many are comfortable with abstinence, with faithfulness; they are very uncomfortable with condoms. Me, I am uncomfortable with all of them. In an effort to make the message simple for people to understand, you make it too simple, too dilute, confusing. I [want it said] when I die that [What] this man really wanted [was] Johns Hopkins University and others who designed it to re-visit the ['ABC'] message'. It had its role at some point, but where we are at the second or third decade of fighting HIV/AIDS, we need to go back to the 'ABC'...and say, 'Wait a minute, what's wrong with this message?'

It's not accurate. You know faithfulness alone cannot protect you from infection because your partner may be already positive or you may be infected through another source when you get it passed on through sex. It's not only inaccurate but also stigmatizing to people living with HIV/AIDS. So when I say that I am positive, they say, 'This is the man who can't abstain, this is a man who can't be faithful.' Namibia has added a 'D.' If a person can't abstain, can't be faithful and can't use condoms, then he dies. A minister said it recently, and I was embarrassed. If you can't do the 'ABC,' there is a 'D' for you. That's what he said: 'Die.' That type of stigmatizing thing.

And because of that ordering hierarchy of values — if you can't do 'A', do 'B', if you can't do 'B' do 'C' — it is like me who is using condoms, I am less spiritual, I am less moral than the one who is doing the 'B'. And I find that very distasteful, because it is only people who are committed, people who have a deep concern for their sexual activity that use condoms. If you are not committed you can't use condoms...You call that person less moral who says, 'Wait a minute, I should not infect my wife, I should not infect my husband.' So when [I] present [myself] in Mengo shops and say, 'Give me two packets,' you see people look at me and say 'Eeee...ensi eyononese [Eh the world is terrible], even these priests no longer care. They just ask [for] condoms in broad daylight. They fornicate.' Because people are thinking that these are people who can't abstain, these are people who can't be faithful, and that's why they are asking for condoms. And you have to explain and say, 'Look, even the faithful people need condoms, because some of us are already positive or some of us are worried of infection.'

Another point on the inaccuracy is that it leaves out something that has been demonstrated in Uganda to work, [and] that is voluntary testing and counseling.

Many people have changed their behavior because they have tested for HIV. 'ABC' - it is very silent on testing. Where is 'T'? Where is VCT [voluntary counseling and treatment] in the message? It has also been demonstrated that if you take care of ARVs, you reduce infections. Where is treatment in 'ABC'? That's the criticism I have on 'ABC.'

In the rural community, AIDS is as simple as 'ABC', that's what they say. AIDS is as simple as 'ABC'! And that leads to my last criticism. Thinking that you can win AIDS by focusing on the individual only, all those messages are targeting him: abstain, be faithful where is the message for the family? Where is the message for the local community leaders? Where is the message for the nation? Where is the message for worship communities, which have these people everyday or every Sunday? Where is the message for international communities, where the terms of trade are terrible [and] agricultural subsidies are causing famine and distress everywhere? Where is the message? So the 'ABC' had its role at that time. I feel it's time we re-designed it.

— Uganda Key Informant (FBO)

Challenges to Individual Behavioral Change

Almost all key informants acknowledge challenges that FBOs and others face in reducing behavioral risks to HIV/AIDS.

Belief Systems and Harmful Social Norms.

Key informants in several countries mention social norms that FBOs as well as others need to address in order to reduce risk of HIV. In Haiti, some individuals view AIDS superstitiously as “bad fate,” or something that is transmitted through zombies, limiting the effectiveness of prevention messages. Key informants note that current social trends such as early sexual debut, acceptance of multiple partners by Voodoo followers as well as by society, also present barriers to reducing risk.

In South Africa, informants point to pervasive media images that glamorize sex and promiscuity. In Thailand, key informants state that pre- and extra-marital sex are accepted social norms for men. These norms challenge the effectiveness of FBOs that may choose to promote only abstinence and faithfulness, especially among youth who are already sexually active.

Certain churches admit that prevention of AIDS can occur if we ask young people especially to refrain from sex until marriage. Others say it is nonsense, and I, for my part, am of those who say that it does not make sense. A small study conducted two or three years ago at the level of the Protestant churches, proved that

more than 60 percent of young people in the Protestant churches have sex before marriage. Even if within the churches we say to the young people, ‘You do not resort to sex before marriage, it is a matter of religion,’ the reality of life says another thing.

— Haiti Key Informant (FBO)

Cultural and Religious Discomfort with Sexuality.

Key informants elaborate on the barrier that dealing with sexuality presents to HIV/AIDS awareness and prevention. In Haiti, informants note that some religious leaders find the topic of sex taboo or even sinful to discuss. Thai monks are considered removed from everyday life and some informants do not think it is appropriate, realistic or comfortable for monks to talk about sex and confront harmful social norms. In India, key informants note the reluctance of religious leaders, who generally avoid any mention of sex.

In contrast, while some key informants say that the discussion of sex is still taboo in South African churches, others report that the churches are now in fact more open.

I think faith-based organizations have undergone transformation in recent years. Previously, the issues around sexuality and sex were never addressed in the context of church. It was something that happens out there; we deny it, it’s not part of the church, it’s not spiritual. Faith-based organizations, due to the pandemic, had to realize that the church needs to wake up and start looking at the parishioners who attend faith-

based organizations as people who engage in sexual intercourse. And that is when you found the turnaround of ministers becoming very vocal around the issues of sex and sexuality.

— South Africa Key Informant (Non-FBO)

THE IMPORTANCE OF TRADITIONAL RELIGIOUS PRACTITIONERS

Since one year ago, I have created an organization which fights HIV at the level of prevention and supports STD/AIDS clients. Our objective generally consists in training Voodoo followers on issues such as, inter alia, human rights, civil rights, politics and law, and about sexually transmitted diseases. . . We try to set up pre-test stations, because the Voodoo structure is made up of various groups which meet periodically. Afterward, one does not see them anymore; therefore, we try to use the drum as an instrument to rally people and there, instead of hailing Voodoo spirits, organizing the rituals, ceremonies, we show films and slides, we distribute newspapers, we educate on sexually transmitted diseases and we also distribute condoms. When one Voodoo follower has a STD problem, we help him, we accompany him, we direct him towards hospital centers.

— Haiti Key Informant (FBO)

FBOs HAVE ALSO PROMOTED SECULAR EDUCATION ON HIV PREVENTION, RESPECTING THE CULTURAL CONTEXT AND SOCIETAL VALUES

With regard to HIV/AIDS, one of the areas we are concentrating on [is] education for prevention. So we brought out a textbook for schools, both in English and Hindi. It is called... Prevention of HIV. We set a memorandum of understanding with Indira Gandhi National Open University to endow a chair for health and social welfare that is to concentrate mainly on research and serious studies mainly for youth, paramedical teachers and those who are social activists. So those who are involved in the field could have a true serious course on HIV. Therefore, the first course offered by this chair is on HIV and Family Education. Since this is offered by a secular university, which offers also a certificate or a diploma, anybody could join. Our concern was mainly to educate people at different levels. This HIV and Family Education was prepared by experts from the field, from the best resource persons available in our country. And this is not something which is just imported from the West, but something that evolved respecting our culture, respecting our family values, our society and so on.

— India Key Informant (FBO)

Poverty and Societal Inequities. Key informants also note that factors that contribute to ingrained societal inequities present challenges to behavioral change.

We would want to say that prevention is about tackling factors that influence behavior at many levels. One of the key factors for the majority of people with the virus is the impact of poverty, gender inequality, [and] political and legislative inequalities that constrain people's realm of choice. And so we would argue as a development agency that unless these deeper causes...are also addressed, that any quick fix sort of message, whether its about abstaining or using a condom, is never going to work.

—International Key Informant (FBO)

In India, Kenya and South Africa, key informants note that poverty presents a barrier to risk reduction that is difficult to overcome without addressing the root causes of poverty. Lacking legitimate alternatives to earning money, transactional sex may be seen as an inevitable response to extreme poverty.

So I think there might be initiatives by faith-based organizations to preach the various gospels of 'ABC:' Abstain, be faithful, not even condomize. But I'm not sure if they succeeded...[W]hile we talk to them, [they] say... 'If we need 50 Rand [currency] and we haven't got a job, the only way we get it is to have sex with other men.'

— South Africa Key Informant (FBO)



EMPOWERING VULNERABLE GROUPS: WOMEN

The 2004 World AIDS Day Campaign was dedicated to raising global awareness of the special vulnerability of women and girls to HIV/AIDS.⁵⁷ Women aged 15 to 24 are now up to six times as likely to contract HIV as young men of the same age.⁵⁸ There are biological as well as social and economic reasons for women's greater vulnerability to HIV. Vulnerability, described in *The Global Strategy Framework* as “a measure of an individual's or community's inability to control their risk of infection,” is strongly associated with poverty, lack of livelihoods and skills, limited access to information and services and an inability to control the circumstances under which sex takes place. Addressing the vulnerability of women, who now make up 50 percent of those infected,⁵⁹ is a key focal point of the *Framework*. In this section, we focus on the observations of both faith- and non-faith-based respondents about whether and how FBOs have addressed the special vulnerability of women to HIV/AIDS.

Gender Inequity

Among international FBOs interviewed, there is a sense that the AIDS crisis has spurred increasing recognition and concern among FBOs regarding gender inequity and women's greater vulnerability to HIV. FBOs describe their

gender-focused efforts as “cross-cutting,” “multi-faceted” and “core” parts of their general training. In fact, several international key informants are of the opinion that the work of FBOs in addressing gender equity and social norms has helped countries with the promotion and advancement of women.

Our international key informants also identify several challenges in the work of FBOs with women. While FBOs are leading initiatives and programs to support, educate and empower women and girls, respondents note that the status of women and their vulnerability has not significantly changed. According to a number of key informants, widespread existence of gender inequality within their own ranks presents an impediment to promoting gender equity within the community.

Whilst all of that work is extremely important, on the whole, I haven't got the impression that faith-based organizations have necessarily very much sort of challenged the status quo with regard to how things work.

—International Key Informant (Non-FBO)

Focus of FBOs' Work with Women

Both FBO and non-FBO informants in some study countries feel that FBOs are addressing women's vulnerability to HIV/AIDS in a variety of ways.

Beginning with this year, we have tried hard in trying to see that we mainstream gender in all program areas, and we have started small by raising gender awareness at community level to different cadres of people; to the AIDS patients themselves, to the care-givers, to the community leaders, to the community volunteers, to the women's groups, and to the youth groups. We go and try to raise awareness about gender as an issue or gender itself and the importance of males involving themselves in HIV/AIDS activities, for example in terms of prevention, in terms of care and in terms of supporting all the interventions towards HIV/AIDS prevention, care and mitigation.

—Uganda Key Informant (FBO)

On the other hand, in South Africa, there is a divergence of opinion among key informants about FBO actions to reduce women's vulnerability to HIV/AIDS. While FBO key informants believe that they reach out to women, secular interviewees think FBOs have not done enough to reduce women's vulnerability through efforts to improve the status of women or challenge traditional gender roles.

Women are in the majority, and those are the people really who are struggling very badly; they have been not privileged from the past. And you find them trying to make ends meet to provide their families with food and resources. So really it's inevitable that our target group is women and young people, women and the youth.

— South Africa Key Informant (FBO)

Around the issue [of] gender, I think that's a particular challenge for the sector. The problem of vulnerability of women to HIV infection, I think it hasn't been taken up strongly enough as an issue.

—South Africa Key Informant (Non-FBO)

Economic Empowerment. Both FBO and non-FBO key informants from almost all the study countries state that some FBOs are providing income-generating, skills-building and/or micro-credit programs to encourage the economic empowerment of women in general, and particularly for vulnerable groups, such as HIV-positive women.

In Kenya and South Africa, according to non-FBO key informants, FBOs lead income-generating activities, including those for widows and commercial sex workers. In Haiti, an FBO-based women's rights program addresses empowerment of women within the household and the community, stressing responsible sexuality and financial security.

However, these informants note some drawbacks to these efforts. For example, strict programming within traditional gender roles is seen to perpetuate women's current economic and social status within the society.

Someone needs to write a book or make a poster that says, "Beyond Sewing," because it seems to be that's all people think that women can do, sew and bead. Sewing and beading is important but that's not the only thing that women can do.

— South Africa Key Informant (Non-FBO)

In Uganda, key informants cite another challenge facing all income-generating programs: securing a market for goods produced. Sustaining the circulation of funds for micro-credit loans has also been a problem when a large number of participants die or leave the area without repaying loans.

Awareness of Behavioral Risks. Key informants note that FBOs are involved in prevention activities that specifically focus on women. In Haiti, FBOs, including a Voodoo priestess, speak of providing reproductive health education and training for young women. Non-FBO key informants are in general agreement that there is education for women church members on condom use and negotiation, although this is framed within the "Christian vision" of morality and protection of the family. In Uganda, the limitation of prevention messages for monogamous women, whether or not originating from an FBO, is noted.

Lots of our women, who are infected in Africa, have never had sex with more than one man, they are faithful but infected. So to say be faithful, therefore you don't get AIDS, is not a very good message.

—Uganda Key Informant (FBO)

Several key informants challenge the emphasis of religious organizations on the institution of marriage itself as offering protection against AIDS.

To say, "Come to marriage," you know that's the message sometimes the church leaders give: 'If you want to escape AIDS please come to Jesus and get married in church and things will be fine,' and you shake your head. How will Jesus protect you from infection? Actually, getting married increases risk. So the churches are trying to publicize and make people aware of AIDS but the way they are doing it needs improvement; needs support from communicators who have done research on what works on prevention and what doesn't work, especially on behavior-change messages.

—Uganda Key Informant (FBO)

In contrast to these countries, a different gender dynamic acts as a barrier to the work of FBOs with women in Thailand. Here FBO key informants only speak about women in relation to the inappropriateness of interactions between men and women, such as that Buddhist monks should not interact with women.

Outreach to Commercial Sex Workers.

Religious organizations often face challenges to their moral and ethical framework in working with those in the commercial sex industry. According to informants, FBOs' engagement with commercial sex workers (CSWs) ranges from outright condemnation to efforts aimed at improving the lives of those engaged in sex work. A Muslim key informant from Kenya states that his organization does not work with the commercial sex industry because "these are some of the taboos which the religion does not recognize." In South Africa and Uganda, according to informants, stigma and condemnation surround CSWs within the church community. South African FBO key informants say they do not see any organized work to reach CSWs. In Uganda, non-FBO key informants are in general agreement that FBOs have condemned sex work, while the FBOs interviewed say that although they do not provide direct programming for CSWs, some of them tailor their messages around condom use to 'special' circumstances such as sex work.

FBO representatives from several different countries, while acknowledging an historic lack of effort, are now beginning outreach to CSWs. Some of the few efforts in South Africa are made by individual faith-based leaders or pastors. In Kenya, FBO key informants say that

CSW outreach programs include income-generating activities, condom distribution and counseling. In India, two FBO key informants state that they provide prevention awareness as well as financial and food support to commercial sex workers.

The oldest [FBO] here is working with sex-workers. It is a Gandhian organization; Gandhi used to teach Brahmacharya [abstinence] but now the organization is motivated towards the sex workers, which is a complete U-turn. There are a large number of Gandhian organizations working with sex workers. Say, for example, [this organization] basically started with Gandhian philosophy. Their role used to be [that] wherever sex work was going on, they would inform the police, go with the police to arrest the sex workers. But now they have motivated them, they are working with sex workers. Such type of changes have taken place. Many good examples we can take.

—India Key Informant (Non-FBO)

While some key informants in Haiti were unaware that FBOs engaged with the commercial sex industry, pointing out that Catholic organizations do not promote condoms, a commercial sex worker disputed this assessment based on direct experience.

I know people working with the Church who sometimes distribute condoms...they tell us what precaution we should take to avoid AIDS even if we are prostitutes. They have always told us that we must use condoms every time we have sexual relation with someone... I think the end-result will be a reduction of AIDS cases because of their work...I cannot tell you 100 percent; but as far as I am concerned, all the prostitutes that I know are now using condoms.

—Haiti Key Informant (Non-FBO)

In a reversal of roles, Thai commercial sex workers are training a new and more progressive school of monks involved in development work including HIV/AIDS education. A representative from a commercial sex workers' organization says her group regularly gives talks to monks-in-training at the university and interacts with them on other AIDS-related activities.

Increasing Women's Access to Health Care/Social Services. Key informants in a few countries give examples of FBO collaborations with other groups as well as their own efforts to encourage vulnerable women to seek medical attention. Both in Kenya and South Africa, non-FBO key informants state that FBOs provide community-based health care as well as medical, social, spiritual and financial support to affected women and their families.

Although the element first was education, we are also going into health care now. First, we started with a clinic; now it is a hospital especially for women.

— Kenya Key Informant (FBO)

The FBOs that I'm aware of ... have volunteers or people that they employ that look after mothers and children. They keep them from minor ailments, so it's like community health workers treating babies and mothers...They also give home-based care. So if somebody requires a dressing in a home, they actually do the dressing, they do practical things, they would help the person to keep the medications. They do social support and give spiritual support. They give financial support for families that are in need. They give them food vouchers...and all those kind of things.

— South Africa Key Informant (Non-FBO)

Where FBOs themselves may not be able to offer services to women, informants say that FBOs refer them to organizations that can.

They encourage women to go to the services, especially in Haiti where the vast majority of live births take place outside the health system. Thus, [although these] services are neglected by FBOs presently, they give information, sensitization and advice.

— Haiti Key Informant (Non-FBO)

Facilitators and Challenges in FBOs' Involvement with Women

Several significant issues are brought up by our key informants as they consider the role of FBOs in reducing women's vulnerability to HIV.

Churches are Women and their Children.

Several key informants in Kenya and South Africa state that FBOs reach out to women not only because they are the most vulnerable but also because women play a comparatively larger role in churches and are easier to approach. Among Christian groups, women (and youth) constitute the majority of parishioners and are the primary beneficiaries of their services. FBOs can easily reach women during church services and group meetings. FBOs also have unique access to women in rural areas.

Women are cited by interviewees as organized and active within their faith institutions, presenting an opportunity for FBOs to consult and collaborate with them on HIV-related issues that relate directly to them. For instance in Kenya, key informants note that women's support groups have been an active force within the church and should be engaged in FBOs' efforts to reach women.

Some of [the FBOs] have existing opportunity to address women's issues...There is the Mothers' Union in the Anglican Church, the various Sisterhoods in the Catholic Church. I think those are existing opportunities for discussing the details of how to scale up the PMTCT.

— Kenya Key Informant (Non-FBO)

At the same time, FBOs can rely too heavily on women to carry out their volunteer work. Because of the role that women have historically played as agents of compassion as well as agents of change for their communities, respondents point out that women bear the burden of FBO outreach to persons affected by AIDS.

The men tend to become involved in the leadership, but actually, people doing the donkey-work tend to be more women.

— International Key Informant (Non-FBO)

Positive Male Involvement. Unanimous across all the countries is the recommendation that FBOs need to encourage positive male involvement if they are to affect real changes in gender equity. For instance, Kenya key informants think that messages from the pulpit do not carry any weight once they are brought home by those who attend church – the women – to the patriarchal household head. Due to the basic inequities within Kenyan society, these

informants believe men need to also be targeted for HIV/AIDS education. In South Africa and Uganda, key informants agree that men as well as women must be reached if gender relations are to be influenced. In South Africa, all FBOs providing gender-equity awareness training and social-norms workshops state that they urge men to participate in the trainings and workshops. Indian informants note that an HIV-positive woman can be thrown out of the household and that efforts to improve the status of women cannot disregard the power and control that men have over women.

This problem of gender — poor women, in the Indian context — it cuts across the board, not just HIV/AIDS. We cannot just address the women, we also have to look at the man, the images that men have. So gender inequality cuts across any health and development issue that we may have to address.

— India Key Informant (FBO)

Activities Only within FBOs. While several key informants believe that some FBOs are working to change social norms, empower women and girls, support their financial security through income-generating activities and challenge harmful traditions such as female genital cutting, they state that these activities occur only within their faith communities, calling into question the effectiveness of FBOs to address these issues in the wider community.

Gender Inequity within Religious Doctrine and Institutions. While FBOs may sometimes address the issue of women's vulnerability, they are also seen to contribute to the injustices that increase women's vulnerability. Many international respondents, both faith-based and non-faith-based, view religious institutions as intrinsically gender-inequitable. The prominence of male leadership and entrenched gender inequity within faith-based organizations stands in the way of FBOs actively and successfully challenging gender inequity in the community and the household. Furthermore, religious teaching often reinforces submissiveness for women.

In all of the African study countries and Haiti, despite the work that FBOs are doing with women, key informants see the gender inequity within communities reflected within the FBOs themselves. For instance, in Haiti, while Protestant churches actively bring in educators to talk with women's groups, women are not allowed to lead assembly in church.

FBOs are very strict when it comes to gender issues. It is a male-dominated kind of leadership in faith-based organizations, and in fact I was talking to the lady who is heading the Gender, Women and Conflict department. I was saying that I find it a paradox that women are most affected, women and children...they are also the majority when you go to church or to all these religious gatherings, but they are the least vocal when it comes to making decisions or getting involved. Leadership is basically men, but the actors are women. If their decisions are made by these men, how will they adequately and effectively articulate the issues of women? We are not saying women should take over. We are not even saying that they need to be everywhere, but they need to be involved when it comes to decisions that will also affect them. So I feel the FBOs are weak in that — very weak.

— Kenya Key Informant (FBO)

Some informants feel that FBOs need to more actively support legal rights for women and advocate for policies that protect women. One FBO key informant admits that FBOs do some good gender-equity work, but they also risk instilling more judgment than compassion and need to address doctrine that supports women's subservience to their husbands. A key informant in India discusses the gender inequity and discrimination that is reflected within the church, where HIV-positive women are far more stigmatized than men.

Of course women have a lot of issues. It has happened in our churches. Once they discover that a woman is HIV-positive, she is thrown out of her family. She is thrown out of the congregation in a church, though it is the person's son who was actually the initial person who was HIV-positive.

— India Key Informant (FBO)



Photo by Annmarie Christensen

ACCOUNTABILITY: EVIDENCE-BASED FOUNDATIONS

In calling for the accountability of those involved in HIV/AIDS programming, *The Global Strategy Framework* states that “there is a profound and widening gap between what is needed to contain the epidemic and what is being done. If this gap is to be closed and the epidemic is to be contained...[leaders] within governments and civil society, legislators and community, religious groups, media, youth and private sector have an opportunity and responsibility to assure success by creating an environment of...accountability, where responses to the epidemic are underpinned by learning from experience through periodic situation assessments, analysis and performance monitoring.” We explore the views of key informants concerning the scientific foundation of the work of FBOs, as well as their efforts in monitoring and evaluating their performance.

Basis of Programming

Belief Systems and Empiricism. Key informants in all our study countries have varied perspectives regarding the foundation of FBOs’ programs and projects. Most international non-FBO key informants state that FBOs base their programs and actions on a mixture of research and religious beliefs to a varying degree.

It’s a mix, obviously. I’d say the initial response started with theology, followed by research. You know, you start with a theological response and then a few years down the road you use theology and then you add some of the clinical research to your interpretation or your theology. Maybe you change your theology a little bit... once you’ve gotten some scientific underpinnings to support how you are thinking about the problem in the first place.

— International Key Informant (Non-FBO)

Some FBOs in Uganda are said to be naïve about research, but also to be moving towards complementing their work with systematic research. In Haiti, non-FBO key informants perceive that religious beliefs are ever present in the work of FBOs while the level of integration of science varies, with research sometimes being used to justify philosophy.

The programs of the religious organizations are inspired much more by ideology than by research, according to what seems to be obvious to me. Concretely, it is difficult to give a response to this disease which will be compatible with our ideology... Now I can say to you that many religious groups have defined mechanisms to support their choice in a scientific way. Abstinence is promoted. One defines mechanisms to try to explain in a scientific way the interest on the one hand and the advantages of abstinence compared to the other methods.

— Haiti Key Informant (Non-FBO)

FBO key informants overall do not claim to base their programming solely on either science or theology.

I think that we have based our programs on our faith. A faith that tells us we are all created in God’s image and we care for one another. So primarily our programs are based on our faith. And of course scientific factors we cannot ignore, statistics and so on.

— South Africa Key Informant (FBO)

I think they are basing more of their programs on conviction, on mandate. God gave them the mandate to say, ‘Look come, let’s have life and let’s have it abundantly.’ They are using that, but using the experience of burying the dead all the time and being burdened all the time by the sick and orphaned. I am not very much aware that it is research that says, ‘Look, this is happening, please.’ Research is done later on, either to provide justification or to build confidence that what you are doing produces results.

— Uganda Key Informant (FBO)

Limitations of Belief Systems as the Basis for Programming. Theology as an underpinning for programming is seen by some key informants as problematic on a number of fronts. For instance, doctrine is seen to dissuade discussions of condoms within public education, perpetuate “wrong research” or misinformation and limit the hiring practices of FBOs by excluding potential candidates from other faiths.

I would say they base [their programming] a lot on ideologies, because you find that concern in terms of recruiting their staff; one has to be a strong believer of what they believe in. You must be a born-again Christian. My experience with them even as a professional, I would not be able to offer my services to them because of my belief system. The fact that I am not able to share the same way of thinking in terms of religion just blocks me out to offer my skills and services to HIV care and prevention. So I think it also limits them because they do not sort out for skills. The first thing seems to be their ideologies, their beliefs.

— Kenya Key Informant (Non-FBO)

When I have to defend in all the local newspapers and television that condoms do not have holes, I'm very concerned about the research that some of these FBOs consult.

— Uganda Key Informant (Non-FBO)

While one FBO informant points out that the philosophy underlying their programs may have been a barrier to their full participation in HIV/AIDS activities, another raises a concern that funding for FBOs may lead to more theologically based programs.

[Our] primary niche has been home-based care and to a lesser extent, prevention. A major reason for that is that up until this year, major donors were funding prevention projects without the other components. So our

ideology limits us from using various methods of prevention. Donors' ideology limits them from funding prevention projects without the other component.

— Kenya Key Informant (FBO)

And I think what we're going to start to see more of, with this new influx of resources into HIV/AIDS, are some of these sorts of ideologically influential organizations getting involved in work in developing countries, implementing programs that maybe don't make as much sense philosophically.

— International Key Informant (Non-FBO)

Research by FBOs to Assess and Evaluate

Assessing and Responding to Community Needs. In all of the countries, FBOs are seen as responding to community needs for HIV programming. Community needs can be determined either by research or based on a belief system that guides the institution to identify these needs. A number of key informants speak of defining the “needs and realities of the community” and “the human side of the fight against AIDS.”

[We got involved because] people were dying and it was not a question of people getting sick. It was people were already dying and so that could not go unnoticed, because we were losing members and we wanted to respond. We were already involved in burying the people, and sort of knew that they were dying of HIV and AIDS, but not having a direct involvement or

responding to the challenge of HIV and AIDS. And, in 1996, we decided that we should respond and deal specifically with HIV and AIDS-related illness.

— South Africa Key Informant (FBO)

[FBOs] work on AIDS because they face the problem in front of them that people are dying and there are increasing number of people with AIDS so they have to give a hand.

— Thailand Key Informant (Non-FBO)

Such community-based directives may provide an opportunity for a baseline study to identify specific needs. For instance, in Uganda, FBO key informants say they are motivated by the needs they see on the ground, sometimes informed by their research.

Our main goal is to address psychosocial, medical, economic and spiritual needs of people affected and infected with HIV/AIDS in the communities where we work. So when we do address those, we do a lot on participatory rural appraisal before we do our projects and programs. But we are doing that purposely to work with the communities to implement a specific project.

— Uganda Key Informant (FBO)

We also find examples of needs-based research at the community level in India, Haiti, South Africa and Thailand.

In the case of the hospital, there is a baseline [study] which is made at the community level to identify needs. We are there to meet the needs of the community. Generally, the activities are based on research.

— Haiti Key Informant (FBO)

In a survey that we did in October we went to 4,000 homes, we found about 900 people were in need of care. Some of it medical care, some of it social care.

— South Africa Key Informant (FBO)

Evaluating Program Effectiveness. Informants cite instances where FBOs are attempting to evaluate their work in HIV/AIDS. In South Africa, according to key informants, some FBOs are measuring their impact by the number of people willing to talk about their HIV status in church as a sign that stigma is being reduced. In Uganda, several key informants describe FBOs as conducting operations research and surveillance studies, while others focus on evaluating the quality of their services.

We very much emphasize the issue of quality. How do we check on that? We use a feedback mechanism. We have a patient questionnaire which is in both English and Lugandan. We give it out to patients randomly selected every month, and this asks them about the various points where they have been within our systems, and they give us feedback. Then we use that feedback to inform our staff to improve on the care and the services that we provide.

—Uganda Key Informant (FBO)

Some FBO informants acknowledge that evidence of the effectiveness of their efforts is lacking, but also note the difficulty in establishing that their efforts are reducing the impact and spread of HIV/AIDS.

So our goal is no AIDS, basically. Virtually no AIDS. That is what we are aiming at. But how we measure it is not easy. We are depending on proxy measures, government figures. But also we can only count how many people we have reached. Those are easy to count in terms of congregation and so on. So we measure that yes we are reaching many people. But whether we are reducing the incidences and so on again depends on scientists in collaboration with scientific data. And again that is still not adequate. We need to measure the effectiveness of this faith-based approach on reducing the incidence and prevalence of the infection. That is not known yet. It is also an area that we should work on.

— Uganda Key Informant (FBO)

Another challenge faced by many implementing organizations including FBOs is a seeming lack of interest among donors to support research that would enable organizations to evaluate their work and substantiate their impact. Donors are said to be interested in programs and actions rather than data collection.

Our programming principle is that we begin from known. That is not always the case. Research is expensive. You need money. With many donors at the moment, when they see USD 40,000 out of about USD 200,000 in just doing research - forget it. Go and start doing implementation. So we are doing post-evaluation implementation. Post, meaning we have no baseline. At the end, can we convince anyone that we made a difference? No. All we are saying is that we trained 500 people to reach 50,000 people with this kind of information. What change did we create?

— Kenya Key Informant (FBO)

Need for Capacity Development

On the whole, key informants state that most FBOs face limitations in being able to measure and report on outcomes. They are seen to simply address the problem at hand as best as they know how. Interviewees state that activities at the level of the congregation and beyond are often unreported and program effectiveness is not known. FBOs are seen as too busy implementing programs to allocate time for monitoring and evaluating their impact. This leads a number of non-FBO informants to cite a lack of evidence supporting FBO program effectiveness.

[H]ow deep is the capacity that's actually there in the faith communities? Nobody knows that because no one's looked. No one's studied it. The communities don't have systematic evaluation capacity. And so it's actually this entire policy of betting on the large-scale response of faith communities is one that, I believe, there's no evidence for it. It just doesn't exist.

— International Key Informant (Non-FBO)

Shortcomings in Documentation. A central theme of this study among both country-level and international key informants is the neglect on the part of FBOs to document their work. Few FBOs have “facts about their work,” for a variety of reasons. This is perceived to have a negative effect on FBOs themselves, as it makes it difficult to substantiate successful efforts, resulting in an opportunity cost for all stakeholders.

[FBOs should be] sharing their best practice. Some of them are doing good things, but they don't even know how to document...So, if we can get more documentation of what they're doing and share that documentation, it is going to help others build their capacity to do it — to come up with their own programs.

— International Key Informant (Non-FBO)

A lot is not documented since they do it as a way of giving to the community.

— Kenya Key Informant (Non-FBO)

One of the biggest problems that you will notice from other institutions is that we are very poor at documentation and recording of our activities. So most of the religious institutions do not have very good records like the scientific community or other NGOs who perhaps base their work on results so that they document, they take photographs, they do those kind of things.

— Uganda Key Informant (FBO)

Lack of HIV/Program Knowledge Among Staff. Although many FBO health practitioners are cited as having advanced degrees in public health and medicine, key informants also talk of a need to improve general knowledge about HIV/AIDS and access to and use of research. For instance, in Thailand, key informants discuss the general need for better information and education among monks who, except for a minority with some university education, typically have only basic levels of education. A key informant in Kenya also talks about a very similar issue.

FBOs need capacity-building in terms of HIV programs; we always tend to assume they are okay. Unfortunately one thing you must know...when you generalize FBOs is that some of the ministers go to a college, in fact they go to universities and get PhDs. Some are called by God. They pick the Bible and start preaching. So the variations are too major. So you should never assume you are at the same level of understanding and comprehension of these issues,

which happen to be scientific. Now most of FBOs need capacity building. I have realized that churches that have training components can incorporate HIV training in their institutions. But for those who are just called by God and they do their business, they need to be trained in many areas. If you expect them to provide any counseling services, then they must be trained in counseling and specifically pastoral counseling. They also need some refresher course to add in the HIV component. So I think FBOs have not been supported well in terms of capacity building to give them the basic knowledge and skills that they can use to handle HIV programs.

— Kenya Key Informant (Non-FBO)

In Uganda, a key informant describes a basic lack of knowledge by doctors implementing interventions in FBO-run facilities.

I visited their clinic before; doctors had never heard of Cotrimaxazole prophylaxis. They should be kind of on top of the scientific information. But I don't think they are accessing it well in some cases.

— Uganda Key Informant (Non-FBO)

Technical Capacity Development. Informants in nearly all study countries discuss the need for developing the technical capacity of FBOs in a range of areas including data collection, financial management, program design, implementation and administration.

[Measuring their goals/objectives] is one of the greatest weaknesses that I have seen...I have said that their personnel have limited capacity. In fact, they mostly do their activities through volunteers. And the program that comes out of this context is going to be less strong in terms of strategy planning, professional planning and monitoring and evaluation.

— Kenya Key Informant (Non-FBO)

Regarding planning and implementation, they need a lot of capacity-building in order to be able to play a meaningful role in these issues.

— Uganda Key Informant (Non-FBO)

They cannot deal with administration that well because they have not been trained to directly deal with administration, but they are developed towards helping people. Thus, they focus on spiritual health and their work is geared towards that direction more than towards administration.

— Thailand Key Informant (Non-FBO)

Human resource constraints and lack of financial management are also seen to hinder FBOs in getting the resources that they need or implementing programs once funds are available.

There is one capacity especially [lacking] with faith-based organizations: financial procedures and systems. [I]n terms of human resource capacity these are low, and that is a very big problem. That is why they cannot access substantial resources, especially at the com-

munity level, if the financial procedures are stringent enough. Some of them are lacking bank accounts and others are lacking personnel. They have brought in volunteers, but then volunteers must be facilitated for them to do their work.

— Uganda Key Informant (FBO)

Resource Constraints to Capacity

Development. The lack of financial and human resources is perceived as a barrier keeping FBOs from developing their capacities in the areas mentioned above.

In terms of resources, there is a major challenge. The amount of resources required to be consistent and targeted, so that we are able to say, 'We have done this, and this is what we can predict on what to do.' For us to be able to deal with the issue of capacity to deal with the specific issues.

— Kenya Key Informant (Non-FBO)

Quality is certainly inadequate at the moment. It can be made better. All services can be improved on. It is not really systematic yet. People need to be trained to consciously give the services in a systematic manner and even assess the impact of whatever they are doing... [F]rom what I hear from the leaders themselves, they want to do better but they cannot because of, basically, money. All the things require money to be able to do them well. Not only money but also training. Training will depend on the availability of money.

— Uganda Key Informant (Non-FBO)

Lack of funds and capacity create a vicious cycle that institutions find very hard to break. The cited funding shortages affect the ability of FBOs to raise more funds and, thereby, improve their services. Key informants point out that a lack of technical skill, such as proposal writing, prevents FBOs from getting more funding to expand their work.

You will find people living in a really rural setting who have the heart to be involved in HIV/AIDS, but don't have the ability to complete fantastic forms and write out good budget proposals. So people like that will never be funded for instance, but the work that they do there is of such a tremendous amount and of such a high caliber that it obviously has a contribution to that.

— South Africa Key Informant (FBO)

This is further hampered by the lack of documentation of their previous efforts.

Now, there is something that is obvious, that faith groups have not needed to document what they do. Yet they do so much, so much. I think that is one thing where they need to come out, because even now when you look at the proposal they give you, they can give you two sentences. That's their proposal.

—Kenya Key Informant (FBO)

In some cases, FBOs also encounter problems in accessing funding because they are not necessarily speaking the 'language' of funders, or understanding or meeting their expectations.

We also find that overseas organizations engage a horrific amount of paperwork in order to access funds. And I think that is extremely off-putting, because the type of detail that they require is just too ominous to prepare.

— South Africa Key Informant (FBO)

Collaboration for Capacity Building. Key informants state that capacity-building in an environment of limited resources necessarily lies in partnerships.

Capacity-building certainly requires financial outlay and we, being a faith-based organization that is predominantly made up of the poor of society, need financial resources that are necessarily linked to building more partnerships with faith-based groups in other countries.

— South Africa Key Informant (FBO)

Several key informants urge FBOs to collaborate more with each other as well as with more experienced NGOs to share and learn about best practices and to avoid duplicating services. More experienced NGOs are thought to be able to help FBOs gain technical skills to write proposals, increase accountability and manage the large sums of money that are now becoming available from donors.

I think that the reality is that these communities have neither real knowledge nor the competencies that are necessary to manage to develop this competency. And to be able to do it, they must be able to buy the services of qualified technicians. This is unavoidable

and I think that these partners must be able to collaborate with others as equal partners in order to develop common actions together.

— Haiti Key Informant (Non-FBO)

We see several examples of FBO collaboration with others to build their skills.

We're trying to ensure the sustainability of projects that we have at a local level. We train them how to write proposals...how to report to donors...how to do things like basic bookkeeping...we help them to access other sources of funding to make sure that they don't just get dependent on the funding from our office to keep them going. The problem in South Africa is that you have many people who are doing very good work, but they don't actually know how to run an organization or how to write a funding proposal. And we have ongoing training in these aspects all over South Africa to help people do that.

— South Africa Key Informant (FBO)

Briefcase NGOs. Although key informants cite the significant experience of FBOs in implementing the programs and a desire to make a lasting impact, money is seen to inevitably attract those with questionable motivation. While some fear that FBOs could be among them, others urge “credible” FBOs to become part of the planning and implementation process, to assure that the precious resources available to provide support for prevention, care and treatment are wisely used.

It was only in 1998, when faith-based organizations thought it was their duty to start talking...I think it is faith-based groups that broke the silence, not the others. Then suddenly the flood came in and we saw hundreds of CBOs and NGOs get registered just to carry out HIV/AIDS programs. Why the flooding when the donor funding has come? I am very frank. The funding for HIV/AIDS has brought a gold rush for hundreds of NGOs and CBOs to get registered...There are so many people with their briefcases going around saying that they are working with AIDS orphans. When you look at it, there are no programs. They are just developing proposals, one after the other.

— Kenya Key Informant (FBO)

I understand [US] money is going to consider FBOs and they will benefit a lot. But I think before that is done, there should be a needs or situational analysis of these FBOs. Otherwise, we might end up getting the same problems we got of quack or briefcase NGOs.

— Uganda Key Informant (Non-FBO)

The World Bank says 20 percent of this [money] needs to go to the FBOs. My thinking is that the government needs to sit down with credible FBOs, plan programs, agree this is the direction we are going. 'FBOs, we want you to concentrate on this program and we are going to give you sufficient funding to be able to implement programs in this direction.' Sufficient funding for a reasonable period of time, three to five years.

— Kenya Key Informant (FBO)



FBO PARTICIPATION IN PUBLIC POLICY DIALOGUES AND PLANNING

Leadership at all levels is at the heart of the *Global Strategy's* recommendations. We examine the participation of FBOs in national policy dialogues in the six study countries, where we see more marked differences between countries — highlighting the critical role of the socio-political environment. The level of government commitment to provide opportunities for engagement can facilitate or discourage the full participation of various actors, including FBOs, in seeking solutions to a national problem.

Faith-based groups can theoretically participate in a number of different venues for formulating national policies and developing proposals. These include the National AIDS Control Councils (NACCs) and Country Coordinating Mechanisms (CCMs), which can help them apply for funding from the Global Fund or MAP. However, as found by the survey cited earlier,¹⁶ faith-based organizations were generally not aware of these opportunities. Suggested reasons for FBO exclusion in some countries were government attitudes and lack of recognition of the potentially positive impact of NGOs and FBOs on the health of people.

India

Non-Involvement. While there are many Christian missionary hospitals and large programs run by international faith-based organizations throughout India, almost all non-FBO and FBO key informants from India say that despite wide recognition of their importance, FBOs have not been very visible in the public arena of policymaking.

Interviewer: Do they play any role at the central level in influencing policy?

Key Informant: In HIV, I have not seen any of it. But I am optimistic.

I: Do you have any of the religious leaders sitting on the committee?

K: So far I have not seen one. But there might be one that I have missed.

— India Key Informant (Non-FBO)

I can't say we have been able to influence policies. But at least we have a lot of respectability and the state government, the health department, whenever they have a proposal they will first approach us and say, 'Please take this on.' I think I would take a little more precaution before saying that we have influenced policy.

— India Key Informant (FBO)

A Hindu guru attributes the historical lack of engagement of Hindu religious leaders in issues of health to their perceived role within Indian society. Another informant notes that although FBOs have not been active in the policy process at the national level, the effect of religion on policies in the context of India occurs indirectly.

I would say that they [FBOs] are part and the parcel of the landscape in a society. You cannot ignore them either directly or by proxy. If I happen to be in government or in the executive or a policy maker and I am a believer, I am a believer in this faith or that faith. And if my belief in that faith makes me opposed to, say, the condom, then as a policy maker this will impact on my policy-delivery role or policy-formulation role. So either directly or indirectly people usually act based on their belief system. You know we all are product of our belief systems. So that's a way that religion, culture and faith affect policy.

— India Key Informant (Non-FBO)

Whether FBOs have sought a greater role in policy formation, some key informants are critical of FBOs for not always delivering on their plans.

They are very good in putting the things on paper and trying to circulate it. The failure is there in relation to the delivery level. What matters for us is HIV service delivery. Not what is stated on paper, but whether it is being implemented or not. So there is a gap.

— India Key Informant (Non-FBO)

FBOs in India may play a greater role in policy in the future as their programs mature and their contributions are more widely recognized.

No, I think we are not very visible because...it is like women, they started their work under justice and now they have reached the stage of maturity. And now they are able to influence the policy. Whereas our area of work, we are just at the start I should say, and I think it will take some time for us to really be visible at that policy-making and lobbying role.

— India Key Informant (FBO)

Thailand

Absent from National Arena. In Thailand, speaking mostly of Buddhist FBOs, all non-FBO and FBO key informants perceive that FBOs are not involved in public policy making at the national level. While some believe that efforts have been made, roadblocks have been encountered.

As far as I know, national policies are hard to do. Even in the higher levels of Buddhist monks, they do not work on the AIDS problem. As long as I have been working here, for 10 years, there was no support from

the Department of Religious Affairs. But we tried to look into it, if there is any plan about AIDS. There is a plan relating to AIDS, but we have not been successful in reaching out for it.

— Thailand Key Informant (FBO)

Some of the non-FBO key informants in Thailand believe that FBOs have the potential to be more involved and should have been so earlier.

Their attempt to create the FBO network should have occurred long ago. It is good that it is taking place now. I hope that through this network they could be able to handle things more efficiently. They would have some bargaining power to suggest policies or to suggest changes in Thai societies. I feel good about this new direction.

— Thailand Key Informant (Non-FBO)

Recently, FBOs cite some attempts to unite in making a declaration on HIV/AIDS to the government.

One time at the meeting in Chiang Mai, I tried to push the religious organizations to get involved by inviting leaders — Buddhist, Christian, Islamic, Jewish. At the World AIDS meeting, I tried to get Buddhist, Christians, and Muslims to help. We started from last year's National AIDS conference. I led Buddhist monks, nuns, Muslims to make a declaration to the Minister.

— Thailand Key Informant (FBO)

Reasons for Non-Involvement. Key informants offer a variety of reasons for the lack of FBO participation in the national arena in Thailand. Social expectations that Buddhist monks in Thailand should not get involved in worldly matters such as politics, the added burden of having to give special treatment to monks as per social protocol, the minority status of certain faiths in the society and the fact that religious organizations are still new in this arena are all mentioned.

At the national level, the religion would not interfere with politics by nature because they perceive that it is the concern of general people, not them. I am talking about Buddhists here. Muslims and Christians do not get involved in politics at all as they are aware that they are the minorities in Thailand.

— Thailand Key Informant (Non-FBO)

At the national level, there are some movements of the Buddhist monks. But they are not working on this fully because HIV/AIDS issues are related to the ethical consideration. In some dimensions, the monks still think from the angle of sin and good deeds. The religions are not very clear about their view about AIDS. The Vatican still cannot accept something. Our religion is the same. We do not accept promotion of sex education, for example.

— Thailand Key Informant (Non-FBO)

A few FBO key informants state that there may be resistance to FBOs joining the policy dialogue on HIV/AIDS in Thailand, based on a lack of understanding of what they can offer:

They are afraid that religion will influence and bring the beliefs or rules of morality to punish or make rules to control them. So they do not want to see us to take a more active role, particularly by PLWAs. They still do not believe that religion has the power to do anything. At this point, we have to accept that we have not yet shown to them and to the public what we can do and how we can make some change. We have not yet shown them our capability

—Thailand Key Informant (FBO)

Haiti

Lack of Government Facilitation. In Haiti, although FBOs have organized among themselves, both FBO and non-FBO key informants say that they have been absent from the national public policy forum until very recently. While non-FBO key informants see this as reflecting a lack of FBO commitment and a lack of coherence among faith-based organizations (which FBOs also acknowledge), FBO key informants state that their slowness to become engaged reflects a lack of interest by the government.

They are almost invisible. In an individual way, you can find a Pastor, a Voodoo priestess [mambo] with much visibility but they do not speak in the name of the religion...There is not a great visibility...at the level of the Voodoo just because one has got involved in the issue.

— Haiti Key Informant (FBO)

Interviewer: How essential has the contribution of FBOs been to the development of the HIV/AIDS country strategy/policies/programs?

Key Informant: I do not believe that much, because we have just elaborated the strategic plan of the Ministry. To my knowledge, churches were not invited. They made an effort this year, they worked in association with the private sector, but as far as I know, they did not appeal to churches, or at least my church was not contacted.

— Haiti Key Informant (FBO)

The effort is small because a catalyst is missing. This catalyst has to be the state, which in matters of public health policy should intervene to say, 'Here is my program, this is what I expect from faith-based organizations, from churches, this is what I expect from technicians.' Then the interested parties have to get organized.

— Haiti Key Informant (FBO)

A non-FBO key informant says that FBOs have been involved primarily as beneficiaries:

I think that the visibility of the religious organizations is really very low. I often discussed with the leaders or the actors in general of the religious world this responsibility that they have regarding the disease. Not only is it a responsibility on the one hand, it is also an opportunity on the other hand, with respect to a response of these organizations regarding the fight against HIV/AIDS in Haiti. And it is certain that up to now except for the organizations that are specialized in the field, the religious organizations are, in my own opinion, getting progressively involved in the fight against HIV/AIDS as beneficiaries or recipients but not really as actors, not really like partners in the fight.

— Haiti Key Informant (Non-FBO)

Recent Commitments. But, in contrast to Thailand and India, almost all key informants in Haiti say that FBOs have recently started to engage in public policy and show commitment. FBOs have recently participated in various committees and have been consulted for the national AIDS strategy.

More and more, I believe there is a greater visibility, and it dates back to the last two years.

—Haiti Key Informant (Non-FBO)

I participated in many meetings and increasingly we are invited to participate in some actions at national level. The president of my organization was present at last year's conference during which a response was given to the AIDS problems by FBOs and he took an official position on behalf of the Church.

— Haiti Key Informant (FBO)

A sign of this progress is that FBOs of various faiths have recently put together action plans.

Since the organization of that Dec. 17, 2002, Day of Reflection on the AIDS Epidemic, the Christian community gave an encouraging response to the problem. Together, they have determined priority areas for coordinated intervention. They analyzed the situation together. We have seen the churches putting out their plans of action. For instance, the Plan of Action of the Catholic Church extends from 2003 to 2008; the Plan of Action of the Anglican Church extends from 2003 to 2006. The Protestant Church is in the process of designing its Plan of Action, because its forum was held only in July.

—Haiti Key Informant (Non-FBO)

However, to date, this participation has been primarily advisory

Their participation was limited to exchanges of ideas, giving advice for a new orientation of the prevention strategies, concerning especially young people. The religious sector gave their point of view in the design of this strategic plan on the psycho-social aspect, including especially support to AIDS orphans.

—Haiti Key Informant (Non-FBO)

Some FBO and non-FBO key informants consider that FBOs have the capacity to play key roles in public policy and advocacy

[FBOs can best contribute] by sensitization, economic planning and the coordination of the actions, the means, the plans and the treatment, by the commitment of everyone, by the mobilization of resources, by the increase in the pressure on the leaders.

— Haiti Key Informant (Non-FBO)

Kenya

Growing Voice. Key informants from the FBO and non-FBO sectors seem to hold contrasting views with regard to the extent of FBOs' participation in public policy. Most non-FBO key informants say that FBOs from almost all the denominations have been both visible and

vocal in the public domain. A number of key informants say that FBOs have shown leadership in advocating for access to ARVs. Others credit them for taking leadership in influencing public policy in a number of areas including PMTCT, VCT, HIV education in the schools, and workplace discrimination. They have also recently been part of national policy bodies such as NACCs.

One of the things I have been happy with is, first, NACC includes them in our council. They are members—the Muslims and the Christians. And at that level, they are able to guide the process of what really is fair for people who are vulnerable and how best to include them in decision making at policy level. Secondly, of late I have been impressed with FBOs advocating for putting some things in the constitution...Quite a number of sexually related issues were being discussed at the constitutional level and that I think will support the programs that are addressed in HIV interventions. So they are at the forefront.

— Kenya Key Informant (Non-FBO)

While a majority of key informants acknowledge the present involvement of FBOs in public policy discussion and formulation, some do criticize them for their earlier contributions to stigma and discrimination.

At the national level, I would say they are very visible at the moment. Earlier on I would say the churches never played any big role because it was something which was outside the church. It was something that was related to prostitutes and also related to people, dirty people in the slums or people who are not faithful. But now the church and other FBOs have realized that HIV/AIDS is also affecting the church and is also infecting people within the church settings...So I would say the FBOs are now coming up very strongly.

— Kenya Key Informant (Non-FBO)

On the whole, non-FBO key informants see FBOs as powerful and able to lead in the HIV public policy arena. According to these key informants, their power and leadership stems from being perceived as trustworthy and representing the interests of the general public. FBOs are perceived to have both the constituency and the moral authority to pressure the government to draft and implement good policies.

FBOs represent the large population. They are widespread in every part of this country. So if they can strongly push for policies, get more involved in these issues, they are the best positioned in representing all the Kenyans. So they need to be more vocal.

— Kenya Key Informant (Non-FBO)

I think the biggest roles for FBOs in Kenya, particularly the Christian religion, has always been to force the government to develop policy. I mean, we saw what they did with the constitutional review. We have seen what they have done with corruption, with land grabbing. So if they could also do the same for HIV/AIDS, I think we will stand a very good chance of getting good policies passed.

— Kenya Key Informant (Non-FBO)

In contrast to the views of non-FBOs, some FBOs perceive that they have had to struggle to get the recognition they felt they deserved.

I would say for a long time faith-based organizations were looked down [upon] and their contribution was immaterial. What has happened now is that faith-based organizations are actually saying, 'Look we have done a lot, and we have a voice, and we need to be listened to. We are doing a lot without any support from donors, just our support from community level.' What I would say is that at the bigger level, there have been voices here and there of faith-based organizations. They have tried very much to change policy, trying very much to be heard and to air their views in as far as various policies are concerned.

— Kenya Key Informant (FBO)

The potential for FBOs to be engaged in public policy is seen by some to be just beginning:

We have the Kenya Religious Consortia, which include the Muslims who send fairly senior members of their faith groups to participate in issues addressing church policy. Now, as a nation, I think this is one area that is still under development, and other than the Sessional paper we had some years back, we don't have anything yet that has gone through Parliament in regard to this. But in terms of just drafting some of the key areas, we have had significant involvement of FBOs. For the last three years also even the government has begun to significantly recognize the role of FBOs. We are beginning to now see a deliberate effort to invite faith-based groups to the table to discuss their further involvement about their heightened role and visibility in fighting HIV/AIDS.

— Kenya Key Informant (Non-FBO)

South Africa

Monitoring/Influencing Government. Most key informants, both FBO and non-FBO, believe that South African FBOs are present in the public policy process, describing their involvement in various policy bodies and speaking to government on behalf of those in need. Several even say that they have lobbyists that monitor or analyze what goes on in Parliament and that in some instances Parliament has listened.

All the religious groupings definitely have a strong voice in South Africa. I mean, in Parliament and other places, we've certainly listened to all the FBOs. A number of them in fact have Parliamentary offices where they actively participate in all the legislation policies and things around the country.

— South Africa Key Informant (Non-FBO)

We have a public policy liaison officer who is based at Parliament. He monitors all legislation processes, informs the church and then makes submission. So we are continually checking, monitoring and inputting on policies as it affects HIV/AIDS.

— South Africa Key Informant (FBO)

I know that there's a faith-based representative on the South African National AIDS Council and I'm sure that they're influencing policies via the Council. And on our Provincial AIDS Council, we have a faith-based organization representative. We basically determine provincial policy and welfare.

— South Africa Key Informant (Non-FBO)

However, some non-FBO key informants criticize FBOs for using the public policy arena as a platform for lecturing about society's moral degradation or for their failure to advocate for the vulnerable.

It's a drop in the ocean. They can do so much more. They can do so much more politically. At the moment, most of the church leaders pray to [President] Mbeki instead of to God. Sorry, it's what they do. Most of the church leaders condemn their communities instead of understanding their communities.

— South Africa Key Informant (Non-FBO)

Government Watch Dog. Key informants from the FBO sector also imply that HIV/AIDS is primarily the government's job while their own role, which they have not necessarily fulfilled, is to keep pressure on the government.

I think one of the things that we would have done differently is not allow government to make the mistakes that they did in their initial response to HIV/AIDS. We should have been more vocal. We should have also partnered with government much stronger than we did. We unfortunately left the problem to government to solve, and when they made a hash of it... we now want to step in. So, yes, that we should have done differently.

— South Africa Key Informant (FBO)

In fact, underlying a theme of FBOs in opposition to the government, this key informant highlights why FBOs may not have a big impact on policy.

The lack of political will is a tragedy... That is a very great sadness. That's why I say the church plays a large role, but because of the political situation... the government is opposing the initiatives, not joining in support.

— South Africa Key Informant (FBO)

Uncertain Impact. Both FBO and non-FBO key informants seem uncertain of the impact of FBO involvement, with some describing a nebulous "moderation of policy" in which policy makers have "to weigh up the religious viewpoints."

I think the country strategy was not developed with us in mind. When it was first developed it was very much a Health Department thing. No one took the faith-based community seriously, initially. And we ourselves couldn't do much because we never had the background or we never had the strategy ourselves.

— South Africa Key Informant (FBO)

FBO and non-FBO key informants agree that FBOs have had a positive impact on policy by adding their voice in support of the successful lobbying effort by the Treatment Action Campaign (TAC) for expanded access to treatment.

The major FBOs have been very supportive of TAC's work in policy discussions. They also have, independently, done a lot of behind-the-scenes work, which is very important... They give support, give some moral support that is required.

— South Africa Key Informant (Non-FBO)

New Opportunities. Finally, both FBO and non-FBO key informants point to the great potential and opportunities for FBOs to be involved in the political process.

Certainly in post-apartheid South Africa the faith-based sector represents one of the most powerful organized groups in civil society... And they have been involved in policy discussion particularly around government's response to HIV and AIDS, and I think they do have a very powerful role to play in terms of that. It's a challenge in a way because it's part of the broader process. And it's almost like, 'How do you now run a democracy, how do you strengthen the role of civil society?' And faith-based organizations are part of that. To be more actively involved in policy-making, not in opposition in the sense that we were before 1994, but as a key player.

— South Africa Key Informant (Non-FBO)

Yes, I think it's becoming clear, especially in this country with the possibility of influencing the formulation of legislation at Parliament... where faith-based organizations, like us who do research and analysis of particular areas, will actively participate in submissions to the Parliamentary committees - written submissions to influence the determination of policy — and then monitoring implementation of policy, carrying back to the authorities.

— South Africa Key Informant (FBO)

Uganda

Powerful Symbols. In Uganda, more than any other study country, most key informants believe that FBOs have been an effective part of the public policy process. Both FBO and non-FBO key informants describe various powerful symbols and processes that show that FBOs have been engaged in public policy for a long time: the Chair of the Uganda AIDS Commission (UAC) has been and is one of the leaders of the major religions in the country; FBOs are represented in various HIV/AIDS policy bodies and committees, including the implementation mechanism for the Global Fund; FBO representatives have participated in the HIV/AIDS strategic planning processes. They have also contributed to various specific policies including bills that deal with women, orphans and children, ARVs, VCT, home-based care, and condoms.

They are quite visible. There is no area that [they are] not involved in. You know the chairman of the Uganda AIDS commission is a bishop. So they have quite a high level. They are participating in the partnership committee, which is part of Uganda AIDS commission. They have quite a big role they are playing.

— Uganda Key Informant (Non-FBO)

Right now, there are 13 commissioners on the board and I think there are about five religious leaders.

— Uganda Key Informant (FBO)

While most key informants are positive about the involvement of clergy, a few are cynical.

It is one of the biggest problems I think we have. The bureaucrats at the end of the day decide what they want to be decided. Sometimes they [FBOs] have been used as a rubber stamp. They get them to participate but at the end of the day, the bureaucrats and the government take the decision that is the predetermined decision they have come with.

— Uganda Key Informant (FBO)

Despite these key informants, however, others state that the participation of FBOs is part of the multi-sectoral approach designed by the government. In fact, key informants state that all the major religions have to be represented in any policy formulation as a matter of process.

The government of Uganda relies so much on the churches as well as Islam, the Muslim faith. Whatever policy is being passed, the leaders of the three churches will always be consulted. For whatever national policy is being passed, all three leaders must be represented. They have played a big role.

— Uganda Key Informant (Non-FBO)

Some FBO key informants also describe their participation as an invitation from the government that has recognized their strengths, including their grassroots experience, which provides valuable feedback to the policy process.

Nowadays Uganda AIDS Commission has set up a partnership forum where all people from various groups including FBOs get together to develop this strategic planning process for the country. So, right now they are contributing to a review of the strategic plan. I know we have been invited, so have the Catholic and Protestants, to participate in these discussions on strategic planning. The mechanisms are now better than before.

— Uganda Key Informant (FBO)

I think that [the contribution of FBOs to the development of HIV/AIDS country strategy] has been very crucial. For example, when the Uganda AIDS Commission was doing its mid-term review of the strategy, we were involved. So a lot of those FBOs have

been involved in the overall strategy, and I think we should commend government in that most cases when they are looking at either strategy or a policy, they bring us on board, which is a good thing.

— Uganda Key Informant (FBO)

Non-FBO key informants describe several real impacts resulting from FBOs involvement in public policy including a change of language on prevention guidelines for teachers within the Presidential Initiative for Youth and a “recognition of the contributions of moral teachings” within the national AIDS policy. FBO key informants describe other substantive impacts, including their contributions that led to the inclusion of home-based care and OVC in the National HIV/AIDS Plan, and the clear articulation of the ‘ABCs’ of prevention message in the country’s policy.

A few key informants (from both the FBO and non-FBO sectors) question whether FBOs have had an influence not just on policies but on national laws.

I am not so much aware of the specific advocacy that has been started by the church then changed into policy and then changed into law, but one would say that, given the heavy presence of the religious leaders on the Uganda AIDS Commission, then probably that influences many of the policies we have had for the last 10 years.

— Uganda Key Informant (FBO)



A FOUNDATION FOR DIALOGUE

An epidemic without boundaries demands assistance at some level from all of us. The “expanded response” advocated within *The Global Strategy Framework* necessitates that all actors involved in the fight against HIV/AIDS work cooperatively and with a common purpose. While *Faith in Action* illustrates a myriad of views surrounding the optimal role of FBOs in the fight against HIV/AIDS, all 206 interviewees acknowledge that FBOs have an important and often unique contribution to make to this fight.

Faith-based organizations are perceived to have a number of comparative advantages including their roots within communities, the depth of their networks and breadth of their infrastructures, the respect and trust of their constituents and moral and ethical competence to work for positive social change. At the same time, there is a general acknowledgement that the response of FBOs needs to be improved and coordinated, not just expanded. We, therefore, conclude with observations that emerge from the findings.

We offer them as a foundation for dialogue among faith-based and non-faith-based stakeholders on how the best efforts of all can be brought forward.

Engage in Cross-Sectoral Collaboration. FBOs are urged to work in a more coordinated fashion with other sectors, making better use of development partners who aim to meet similar objectives. Informants note that faith-based groups should draw upon the strengths of NGOs and others working in the field, particularly in areas where their own expertise may be lacking or where religious beliefs may stand in the way of providing the full spectrum of information and services. Secular groups are urged to engage in meaningful dialogue with FBOs, appreciating the assets that FBOs offer and exploring the opportunities that cross-sectoral collaboration can bring.

Create and Sustain Global Faith-Based Partnerships. In hardest hit countries, local parishes, temples and mosques are said to be extremely overextended as entire communities are devastated by AIDS. Frontline FBO caregivers are often unable to provide all they are capable of with the resources available to them. Twinning opportunities, North/South collaborations and financial and technical partnerships with FBOs in high-income countries would enable considerable expansion of important FBO interventions at the community level. Strong outreach efforts are needed to raise awareness and giving within communities of faith globally.

Promote Understanding and Dissuade Stigma. Many respondents note that some FBO approaches have perpetuated stigma against those infected with the virus. In addition to harming the most vulnerable members of society, stigma directly interferes with important prevention efforts including use of voluntary counseling and testing. Informants note that FBOs should maximize their strengths, including their underlying philosophy of care, by promoting strategies that are grounded in compassion and inclusion. Efforts initiated by some FBOs to examine and interpret their own religious texts in light of the epidemic can contribute to the dialogue.

Involve Persons Living with HIV/AIDS. The meaningful involvement and leadership of persons living with HIV/AIDS is a key strategy in the expanded response to the pandemic. While some FBOs credit PLWAs with having raised their awareness of the disease, facilitating leadership roles for PLWAs in the design and implementation of FBO programs, through paid employment and other means, can deliver multiple and cross-cutting benefits, including more relevant programs, and the reduction of stigma and economic vulnerability.

Expand Linkages with Non-Medical Programs. The importance of FBO health infrastructure and services is well recognized. FBOs often also have capacity in other areas that are important to a comprehensive response. These include primary and secondary education, care and support of vulnerable children and programs to generate income. These assets should be maximized and better linked to health sector initiatives. Because of their culture of confidentiality, FBOs may also have a comparative advantage in expanding access to voluntary counseling and treatment.

Reduce the Vulnerability of Women and Girls. While numbers of FBOs state that gender equity is a primary goal of their work, FBOs are often perceived to ineffectively focus on individual behavior change as the means to reduce vulnerability. FBOs are urged to address underlying gender inequity within their communities and institutional structures. At the same time, FBOs are very well positioned in many countries to expand educational opportunities for girls through existing schools. Because education is considered by some experts to be the most important strategy for reducing the vulnerability of women and girls to HIV/AIDS, the dialogue should address how FBOs can help extend educational opportunities.

Improve the Evidence-Base of Strategies. While many key informants recognize the ability of FBOs to ground their messages within a moral framework that is widely understood, others criticize them for promoting strategies that are not based on scientific evidence and may be harmful. FBOs are encouraged to seek out and replicate scientifically evaluated interventions. When there is unease with particular essential public health approaches, FBOs are urged to collaborate with others to assure the availability of the full range of effective prevention messages and strategies.

Develop Monitoring and Evaluation Capacities. Shortcomings in evaluation and documentation on FBO HIV/AIDS programs, as well as widespread perception and acknowledgement that FBO activities are influenced as much by belief systems as by science, leave FBOs vulnerable to criticisms that investments in their work are unjustified and possibly harmful. The lack of documentation furthermore hinders the advancement of lessons learned, scaling up of successful strategies by other groups and the ability of FBOs to compete for funds based on an established track record of past activities. The dialogue should consider how the expertise of non-FBOs can help build the capacity of FBOs to monitor and evaluate their efforts.

Engage in Public Policy Discourse. While Uganda and Thailand illustrate the lack of a consistent relationship between FBO engagement in public policy and the success of national programs, FBOs are perceived to have power and influence that could be more widely used to promote justice and social good. Both FBO and non-FBO respondents note that FBOs could speak out much more on behalf of the poor and the vulnerable. FBO constituencies extend well beyond their active practitioners and offer an important vehicle for heightening attention among policymakers to issues that contribute to AIDS' impact, vulnerability and risk. The moral leadership of FBOs could help guard against the politicization that funding can bring and keep the focus on alleviating human suffering.

Earlier, we noted a well-known expression, "Perception is reality." We hope that the perceptions presented in *Faith in Action* become more than just food for thought but also food for action. These findings not only substantiate the significant contributions that faith-based groups have already made, but also serve as a starting point for optimizing their future contributions for the benefit of those infected and affected by HIV/AIDS. To quote another phrase, "When it comes to global health, there is no 'them' - there is only 'us'."

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ABC	Abstain, Be Faithful, Use Condoms	OVC	Orphans and Vulnerable Children
ARV	Antiretroviral Therapy	PEPFAR	(U.S.) President's Emergency Plan for AIDS Relief
BCC	Behavior-Change Communication	PLWA	People Living With HIV/AIDS
CBO	Community-Based Organization	PMTCT	Prevention of Mother-To-Child Transmission
CCM	Country Coordinating Mechanisms	POZ	Promoteurs de l'Objectif Zerosida
CMMB	Catholic Medical Mission Board	RCB	Religious Coordinating Bodies
CSW	Commercial Sex Workers	STD	Sexually Transmitted Diseases
FBO	Faith-Based Organization or Religious Organization	STI	Sexually Transmitted Infection
GDP	Gross Domestic Product	TAC	Treatment Action Campaign
GNI	Gross National Income	UAC	Ugandan AIDS Commission
HDI	Human Development Index	UN	United Nations
MAP	The Multi-Country HIV/AIDS Program for Africa	UNAIDS	United Nations Program on HIV/AIDS
MOPH	Ministry of Public Health	UNICEF	United Nations Children's Fund
MSM	Men Who Have Sex With Men	USAID	United States Agency for International Development
MTCT	Mother-To-Child Transmission	USD	United States Dollar
NACC	National AIDS Control Council	VCT	Voluntary Counseling and Testing
NACP	National AIDS Control Program	WCRP	World Conference of Religions for Peace
NGO	Non-Governmental Organization	WHO	World Health Organization

KEY INFORMANT SECTOR REPRESENTATION

	Haiti	India	Kenya	South Africa	Thailand	Uganda	International	Total
Non-FBO Sector								
Businesses/Pharmaceutical Companies	1	1	1	1	0	1	2	7
Donors	1	1	2	0	2	3	2	11
Government Ministries	2	2	1	3	2	2	0	12
Health Care Facilities	2	2	1	2	2	1	0	10
HIV/AIDS Researchers	0	2	3	1	1	4	4	15
International Governmental Organizations	3	3	1	2	1	1	3	14
National AIDS Control Programs	2	2	1	1	1	2	0	9
Non-Governmental Organizations	4	4	2	4	5	3	7	29
Organizations Representing People Living with HIV/AIDS	1	4	3	4	4	3	2	21
Organizations Representing High Risk/Vulnerable Groups	3	1	2	2	2	2	0	12
Total Non-FBO	19	22	17	20	20	22	20	140

Faith-Based Sector								
Buddhist					4			4
Christian	6	3	7	10	2	7	8	43
Hindu		1						1
Indigenous African				1				1
Interfaith		1	1	1			2	5
Islamic		1	1		2	1		5
Jewish							1	1
Voodoo	1							1
Total FBO	7	6	9	12	8	8	11	61
TOTAL (BOTH SECTORS)	26	28	26	32	28	30	31	201

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