Ending AIDS as a Public Health Threat: Faith-Based Organizations (FBOs) as Key Stakeholders
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I. Historical Links of FBOs to HIV and AIDS Response at Local, National, and Global Levels

Particularly in developing countries, FBOs set in place traditions of caring for the poorest and least-served communities. Long before the HIV epidemic began, FBOs had established and operated well-organized health infrastructures and systems to serve local communities not reached by local, public health systems. Long-standing relationships with and commitment to serve local communities have made FBO services indispensable to millions who are unable to access government-run health programmes. The quality of care delivered by such religious-affiliated organizations stems from an ethos of compassion and solidarity motivated by the value of service.

From the earliest experiences with the global HIV epidemic, when Acquired Immune Deficiency Syndrome (AIDS) first began to be identified in 1981, faith-based institutions, hospitals, clinics, and community organizations have been at the forefront of the provision of a high quality, caring and compassionate response. Even before the official identification and recognition of the Human Immunodeficiency Virus (HIV) as the cause of this major public health threat, religious-affiliated hospitals and community groups in Africa, USA, Europe, and elsewhere, were providing basic medical care and treatment, as well as compassionate and non-judgmental support for those living with or affected by HIV.

As the epidemic moved into its third decade, the international public health community made a change, from an “emergency response” to a more systematic and targeted response. This was accompanied by the articulation of the goal to eliminate new HIV infections, AIDS-related deaths, stigma and discrimination by 2030. Just as FBOs were critical players in the early months and years of the epidemic, they are similarly recognized as key stakeholders in a sustained response to reach these global targets to end AIDS as a public health threat by 2030.

The World Health Organization reports that 30-70% of the health infrastructure is operated by faith-based organizations. For example, in Tanzania, approximately 40-60% of health care is assumed by faith-based organizations. In its 2015 report on strengthening partnerships with FBOs, the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) reported, “in high-burden countries, 28 percent of people living with HIV on ARTs receive services from faith-based facilities.” Moreover, in Kenya, “faith-based facilities comprise 11.3 percent of all health facilities, both public and private.” In this country, the major engagement in HIV care from the faith-based sector is represented by the Christian Health Association of Kenya (18.9%), the Kenya Catholic Episcopal Conference (56.9%). The specific data for two key Kenyan cities are particularly impressive, with FBOs covering 52.3% of ART in Mombasa and 47.3% in Nairobi.

This critical involvement of FBOs in the global response to HIV was stressed by UNAIDS Executive Director, Michel Sidibé, when he stated, “My friends, we in the AIDS movement look to the Church for leadership. The Church’s uncompromising position on the need for social justice—to do what is right—and on the inherent dignity of individuals, inspires us to champion for universal access to comprehensive HIV prevention, treatment, care and support as a moral imperative.”

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5 “Building on Firm Foundations: The 2015 Consultation on Strengthening Partnerships between Faith-based Organizations and PEPFAR to Build Capacity for Sustained Response to HIV/AIDS”, 2015, U.S. President’s Emergency Plan for AIDS Relief, Emory University; and Interfaith Program on HIV and Social Justice, St. Paul’s University, 2015, p.13..

6 Ibid.

7 SidibéMichel, Executive Director of UNAIDS, during and address to a Vatican Sponsored Conference held in 2009.
Catholic Church-related organizations engaged in the HIV response are active in at least 114 countries\(^8\). During 2010, ten of the largest member organizations of the Catholic HIV and AIDS Network (CHAN) channeled USD $200 million in support of the global AIDS response\(^9\) by financing and providing technical assistance to community-based and Catholic organizations in low- and middle-income countries.

Many FBOs enjoy global presence and networking. Moreover, at community level, their services are comprehensive, holistic and recognized for their inclusiveness and compassion. Not only do they partner with governments in delivering healthcare, FBOs also serve as “havens of refuge” of people living with HIV, offering welcoming, non-discriminatory and valuable palliative care\(^10\). In addition to reinforcing and complementing national health systems, members of religious organizations contribute tens of thousands of volunteer hours in their local communities in schools, primary health facilities, hospitals and community outreach efforts.

Governments, civil society, and FBOs presently face multiple challenges in maintaining the scope, quality and affordability of comprehensive services for people living with HIV at a time when rapid scale up is needed. The demand for expanded coverage of ART programmes compels all stakeholders to take stock of their services and programmes and determine how “to do less with more,” as has been called for, in particular, by donors. This demand puts extraordinary pressure on community- and faith-based organizations, which

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\(^8\) Catholic HIV and AIDS Network (CHAN). Keeping Commitments for HIV and AIDS: Access for All to Prevention, Treatment, Care and Support. 2011.


already are experiencing “flat-lining” of funding and budget reductions to sustain their current scope and scale. In a 2011 survey conducted by the Catholic HIV and AIDS Network (CHAN)\(^\text{11}\), a number of large organizations providing essential ART services reported that donors had requested them not to enroll new clients for treatment despite the growing need and clinical eligibility\(^\text{12}\).

Dr. Mark Dybul, the Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) recognized that “faith communities play a fundamental role in addressing health challenges around the world. These organizations have been providing life-saving prevention, care and treatment in a holistic way to serve the needs of a person.”\(^\text{13}\)

In countries most affected by the HIV epidemic, spirituality and religion play a central role and oftentimes are important determinants in health-related behaviors of people. Communities look to FBOs not only as providers of health and social services, but also as sources of credible information, motivation, compassion, inspiration, meaning and hope in challenging life moments. Because FBOs frequently serve the poorest of communities and those out of reach of State-run health systems, they contribute significantly to the reduction of health inequalities and are committed to make HIV treatment universally accessible, affordable, and acceptable\(^\text{14}\) in keeping with internationally determined goals and targets. In this respect, FBOs are key stakeholders whose role in the overall AIDS response needs to be better recognized, understood and supported. For this reason, Caritas Internationalis has engaged in research and consultation with several Catholic-inspired and other Christian organizations to examine the breadth and depth of their engagement in HIV prevention, treatment, care, and support, which could be seen as emblematic of a large spectrum of faith-based organizations in general.

\(^{11}\) CHAN is a network of Catholic Church-related partnership and service organizations that offer financial and technical assistance to HIV programmes throughout the world, but give special attention to those operating in low- and middle-income countries.


II. An In-Depth Look at Some Exemplary Models

In-depth interviews were conducted with key implementers in order to discover some of their best practices and to highlight their impact on responses to HIV at local, national, regional, and global levels.

1) Cabrini Ministries: St Philip’s Mission, Lubombo, Swaziland

Cabrini Ministries is rooted in the work and principles of The Missionary Sisters of the Sacred Heart and their founder, Mother Frances Xavier Cabrini, who was declared a saint by the Catholic Church. The Sisters have been working in Swaziland for almost half a century; they arrived in the country in 1971, at the request of King Sobhuza II. For more than ten years, Cabrini Ministries has been providing service to people living with HIV and Tuberculosis who reside in the Lubombo Lowveld, located in the Eastern, rural part of Swaziland. From the beginning of its work in this area, Cabrini has addressed the needs of the whole community. It began its service delivery during a time of overwhelming AIDS–related sickness and death, which also resulted in large numbers of orphaned children. More recently it reports a situation of greater stability, as, with access to ART, HIV infection has become a chronic, but treatable disease.

The Kingdom of Swaziland is in Southern Africa where nearly one third of adults are HIV positive. Cabrini’s work in health care fundamentally promotes a response to local need, which includes addressing issues of health, nutrition, education and protection, as well as ensuring mental and spiritual well-being. The delivery of services by Cabrini Ministries is primarily achieved through
three integrated departments within their overall programme: Health Care, Child Care, and Family Services. Cabrini emphasizes three key methodologies: responses are community and family centric; programmes are assessment based; and service delivery is comprehensive and integrated.

Working with staff and community members, the organization developed the following mission statement: “Cabrini Ministries is a faith-based community care organization serving the Lubombo lowveld with a mission to share the love of Jesus Christ by promoting the well-being of individuals and families through comprehensive integrated health care, child care, education and social services to the most poor and vulnerable.”

These services have grown consistently in depth and excellence. After initially focusing only on HIV and Tuberculosis, from 2015 onward, Cabrini ministries will provide full primary health care, both at a central clinic and through community-based outreach services to traditional Swazi homesteads. This recent development has evolved from crisis management to the provision of chronic care services. Accessible and affordable treatment has made HIV a manageable disease, but the long term effects of a lost generation of Swazis are now just beginning to be understood. As the needs of the community changed, Cabrini’s response followed.

By acknowledging their call to be a “Community Care Organization,” Cabrini Ministries embraced its rich history of service provision to prepare itself for the expanded work required to address a tattered social fabric that resulted from the HIV crisis. A Family Services Department was created to address new community needs that resulted in new initiatives beyond Health Care and Child Care. These include expanded educational support services, community-based health assessments, focused support groups for HIV positive children, and dedicated initiatives to address the unique needs of women and girls affected by the HIV epidemic.

What began ten years ago as a few people doing what they could to help their neighbors has evolved into a full service organization deeply rooted in the community. During 2014, a total of 4,201 individuals received direct care and support services from Cabrini Ministries. A total of 880 orphans and vulnerable children accessed services, including 200 who received a full, comprehensive care package, including food, school fees and supplies, and psychosocial support. The other children received required services depending on initial and on-going assessments; 2,071 HIV-positive clients were served at the health care facility; 96.4% of clients initiated on ART are alive and on treatment, one year

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later; and 1,250 individuals were provided comprehensive health assessments within their local community, at their traditional homesteads.

The organization recognizes that community response must be based on long-term relationships and mutual respect. Religious structures are often in an ideal position to initiate and provide these essential services and, because of their history within a community. They often can develop innovative initiatives to respond to the unique needs within a community.

Cabrini Ministries does not perceive quality HIV care as limited to the provision of medical services. It engages in comprehensive holistic care to address the emotional, social and spiritual aspects of HIV infection. This is especially true for children. Cabrini Ministries, in partnership with USA-based Baylor Children’s Hospital, launched a “Teen Club” to provide care and support for HIV-positive children, 10 to 21 years of age. Meetings provide a safe space to discuss sensitive issues and a time to socialize with peers facing similar challenges. The young people themselves provide leadership for the group of ten to fifteen individuals each.

The introduction of ART has made HIV a manageable chronic illness, but, for treatment to be successful, adherence to medication is essential. In Swaziland, traditional family structures have been ravaged by the HIV epidemic. Caregivers often were overwhelmed and unprepared to support growing numbers of children on ART. Cabrini began a “self-medication” programme for older children and teenagers who struggle with adherence so that they can take responsibility for their own health. Participants are provided with a calendar, pillbox, supportive training and small incentives to support their treatment adherence. The caregivers are also educated and supported to engage in open and direct communication with children regarding their HIV status. Cabrini staff meets with the young people and their guardians on a regular basis until treatment adherence is solidified. The success of this initiative has prompted local government health care providers to seek advice on replicating this programme.

Often the role of Cabrini Ministries is to connect a client to resources beyond those that it can provide. For example, cases of child protection and abuse require the involvement of local authorities. In order to facilitate better coordination between various stakeholders, Cabrini pioneered the formation of a regional child protection stakeholder group. This group brought together government social welfare staff, child protection officers, other NGOs, and Cabrini staff to discuss and strategize methods to improve child protection services. This unique collaboration was presented as a “best practice” example at a UNICEF-sponsored conference.
Easier access to HIV care and treatment can lead to more effective and efficient treatment. With the national Ministry of Health, Cabrini piloted a “community refill” project for people on ART. Individuals with good adherence are grouped together by location, and one of the group members collects the medications for the rest of the group. This limits the amount of clients’ time, travel and resources required for ARV refills. Group members rotate this responsibility, so that a health care provider directly monitors each member during the course of the year. This initiative is particularly important in order to improve health care delivery systems in rural areas where transport remains a significant challenge.

Swaziland has the world’s highest rate for tuberculosis. Because of the high co-morbidity between HIV and TB, care and services must be integrated. Services provided by Cabrini Ministries include TB screening, sputum collection and testing, infection control, initiation of prophylaxis and community education. Additionally, a focused effort has been launched to identify miners and their families since this cohort is particularly at-risk.

In addition to working with traditional leaders and traditional healers, Cabrini launched a dedicated programme for local pastors and church leaders; it encourages the linkage between medical services and spiritual care. This community education programme also provides information and awareness-raising on several key health-related issues, including HIV testing and treatment, tuberculosis prevention and treatment, voluntary male medical circumcision, prevention of gender-based violence, and child protection. Information is provided through dance, drama and music, resulting in increased attendance and engagement by the participants.

The central focus of Cabrini’s HIV and TB programme is effective and accessible treatment in its rural catchment area. Currently, more than 1,200 clients receive this care, with yearly increases of approximately 10%. Cabrini nurses are trained and equipped to initiate clients on ART, as well as on pre ART prophylaxis (co-trimoxazole). Treatment for tuberculosis begins with initial screening and testing for all HIV-positive clients. Those testing positive for TB are provided treatment as well as education to prevent further spread. Clients on treatment receive refills at regular intervals, along with clinical assessment and comprehensive care that addresses, not only physical, but also emotional, social, and spiritual needs of the client.

Cabrini integrates treatment for opportunistic infections and other complications into its regular continuum of care. Additionally, clients who are clinically
malnourished, as determined by body mass index (BMI), receive emergency food support as part of care and support.

Within its catchment area, Cabrini provides a comprehensive education and support programme to guide pregnant women in maximizing the potential for babies to be born healthy and HIV negative. This programme includes counseling, support groups, nutrition and pre-natal education. The women receive ongoing clinical assessment, support and ART.

Cabrini has partnered with two other NGOs in Swaziland to open a local clinic for voluntary male medical circumcision to meet the needs of men who choose to participate in this programme to reduce their risk of HIV infection.

Each Cabrini client, both new and returning, is provided with psychosocial and spiritual support and health education activities, in addition to receiving necessary medical care. This includes adherence counseling, support groups and health and adherence education.

The initiation of treatment only is effective if the individual client remains consistently on treatment. Cabrini employs a very aggressive “missed appointment” and tracking system. While this is very time and resource intensive, it has resulted in adherence rates much higher than the Swazi national average. The process provides insight into the client’s needs and challenges that would not be possible to uncover otherwise. Cabrini partners with other local government and private clinics to provide default tracking and community linkage support.

Provision of health care services is not achieved simply by the availability of such services; it also must be accessible. For this reason, Cabrini sends nurses and staff throughout the catchment area to provide clinical support for the most vulnerable on their homesteads. This catchment area is approximately 250 square kilometers and covers terrain with only rudimentary dirt roads with almost non-existent public transportation. As the number of clients on ART increased, mobile refill stations were introduced.

Cabrini believes that successful prevention, treatment, and impact mitigation strategies must be built from community engagement. Cabrini hosts regular community education sessions in a variety of settings, and targets diverse audiences. This also includes regular dialogue with traditional leaders and area chiefdoms. By reaching the people who have influence in the community, the programme ensures greater impact for education and awareness programmes. Because traditional values and cultural norms are involved, the process must
always be respectful. Change does not come quickly, and time is required to build trust.

Spirituality is an integral part of daily life in Swaziland. Cabrini works closely and regularly with traditional healers and a variety of local pastors providing them with training on effective methods of reaching and working with persons living with and affected by HIV. This approach acknowledges the holistic nature of community wellbeing and the critical role that spirituality plays in the daily lives of the community.

Funding for this highly effective, integrated, holistic programme comes through church-related donors and through a significant grant from PEPFAR (channeled through the PACT). However, the future continuation of this PEPFAR support is now uncertain. Cabrini ministries did receive a small Global Fund grant, but the funds arrived very late, and, subsequently, there was huge pressure to spend the funds in a short period of time. This situation reportedly affected programme quality. Additional efforts to access Global Funds have not been successful.

During its first ten years of programming, Cabrini’s health care services focused solely on HIV and TB. As the global response moved from crisis to sustained care and support, Cabrini was able to assess other community needs. It decided to become a full primary health care provider. This transition means that the high standards of care offered to current HIV and TB clients will be offered to all people requiring health services in their catchment area. This will result in better integration of services, especially those related to antenatal care and chronic health concerns within the local community.

2) The Eastern Deanery AIDS Relief Programme
Operated by the Maryknoll Fathers and Brothers in close collaboration with the Catholic Archdiocese of Nairobi, the Eastern Deanery AIDS Relief Programme (EDARP), began in 1993, with small grants from the Maryknoll Fathers and Brothers and from the German Catholic Development agency, Misereor. During the early years of the epidemic, people diagnosed as living with HIV were discharged from local hospitals and told, “to return home to die.” Due to massive urbanization and migration from rural areas, the Eastern slums of Nairobi grew rapidly with little infrastructure or social services to meet the needs of the expanding population. Compounding other urban social problems in a developing country, HIV infection brought fear, stigma, and often abandonment.

Fr. Edward Philips and Mrs. Alice Njoroge began meeting with local parish priests and church leaders to discuss the ways and means for a compassionate response to this growing epidemic. They asked local church and community leaders to “give us people with a heart” and formed area AIDS committees to respond to the needs of the abandoned and dying. Members of these groups then received training and education about HIV infection as well as the tools and skills to initiate home-based care and support in their neighborhood. From the very beginning, regular supervision and support of community volunteers was built into all programmes for quality and sustainability.

A 40-hour Community Health Care Worker training curriculum was designed and implemented, and volunteers were recruited from local small Christian communities. Currently, over one thousand EDARP volunteers are providing care and support in the Eastern slums of Nairobi on a daily basis and constitute the “backbone” of the programme. While this programme initially focused on care and support for the dying and their families, the community health workers now concentrate on treatment adherence as well as on psychosocial and spiritual support, and refer clients back to health clinics when required.

Additional funding enabled EDARP to provide HIV counseling and testing and to set up a small clinic to treat opportunistic infections and provide psychosocial and spiritual support, offered by local church volunteers, to growing numbers of clients. EDARP offered both clinic-based and community-based services for the constantly increasing numbers of clients and their families.

17 Ibid.
Since 1993, EDARP’s expansion of care services has evolved based on the needs of the clients. Delivery of health care services in non-structured areas has led to innovative initiatives to meet local community needs. One such innovation was the successful early implementation of integrated TB/HIV prevention, testing and care services under a “one-stop shop.” In 1996, the Kenyan National TB Programme supported EDARP to set up and operate a TB diagnostic laboratory. All TB patients seen in EDARP facilities are offered HIV testing and of those that test positive, 96% are on ART.

By 2001, even before the beginning of government-sponsored HIV treatment programmes, EDARP, in collaboration with USA-based nursing organizations, developed a curriculum for a local nurse-driven ART programme and continued its collaboration with the Kenyan Ministry of Health as one of the largest providers of care, support and treatment for people with HIV in the eastern area of Nairobi. EDARP was an early recipient of PEPFAR funding through the Centres for Disease Control of the United States of America (CDC) and, with these resources, began a rapid expansion of HIV treatment and other support services.

Funded by PEPFAR since 2004, the programme has an annual funding envelope of approximately USD $6.5 million. However, recent funding cutbacks have placed strong pressure on the programme to downscale some of its activities, although it retains ART services as a priority in order to avoid treatment disruptions.

EDARP implements TB-HIV care and treatment services in line with the Kenyan National AIDS Strategic Plan and works in close collaboration with the national Ministry of Health. In July 2014, EDARP began implementing the new guideline recommendations for treatment of HIV/TB co-infection that were issued by the Ministry of Health. In order to improve TB case detection among adults and children living with HIV, EDARP offers DNA detection of TB by using the Gene X-pert and LPA machines. Good collaboration with the Ministry of Health has continued so that, at the present time, EDARP programmes complement government efforts to meet the Millennium Development Goals by providing high quality HIV/TB care and treatment, and thus reducing incidence and the burden of disease in five sub-counties of Nairobi county.

18 Eastern Deanery Aids Relief Programme, Annual Progress Report. 2014
The Eastern slums of Nairobi have a population of more than two million people and an estimated adult HIV prevalence of 5.2%. Since 2003, EDARP has supported HIV treatment activities at fourteen sites within the informal settlement area of Eastern Nairobi. The residents of these slum areas often do not have steady employment, and it results in significant challenges to access government health services because of the cost of transport to these facilities.

During 2014, approximately 126,000 individuals received HIV counseling and testing services through EDARP; 12% of those tested were children and 51% were women. EDARP also traces identified male partners of the female client in order to encourage testing. As a strategy to scale up pediatric and adult HIV testing and enrollment in care, EDARP focused on reaching family members of index patients receiving care and 11,340 couples received HIV Testing and Counseling (HTC) during 2014; many reported having chosen EDARP as care provider because of its reputation for compassion. Overall, the HIV positive rate for all individuals tested was 3%, but, with the family-testing programme, the HIV positive rate was 7.1%.

In line with the “Test, Treat and Retain” strategy, EDARP has significantly strengthened the linkage between testing and treatment. 97% of all individuals testing positive in 2014, through EDARP programming, now are receiving treatment. During 2014, 4,006 newly diagnosed adults and children were enrolled into care and 3,923 began ART. By the end of 2014, EDARP reported that 23,035 clients were enrolled in care and support programmes and 21,584 were actively on ART, including 1,349 children. The average one-year retention rate of clients enrolled in ART with EDARP is 82%.

The retention rate of pre-ART clients continues to be a challenge, since, once individuals feel healthy, they often do not see the need to continue with care. EDARP innovatively engaged the community health workers to trace pre-ART defaulters and to resume care and support until such time as the initiation of ART.

Both Mrs. Alice Njoroge and Fr. Edward Philips clearly state that the success of the EDARP programme is rooted, from the beginning, in spiritual values and beliefs that underpin the service delivery promoted by the organization. “Anyone who works with us, you get the values. Caring is a call, and unless you embrace the call, you won’t last in this field. This is beyond being a health professional. We encourage both staff and volunteers to embrace a call to service.”

All staff and volunteers must participate in a mentorship programme that not only provides regular updates and supervision regarding health

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programmes, but also is a time to offer staff the needed emotional and spiritual support to continue in this service.

A young physician currently working in the EDARP programme reported having begun his medical career in a government hospital. He joined the Eastern Deanery programme because he wanted “the connection with the patients”.

For EDARP staff and volunteers, the work means not only the provision of quality health services at the clinic, but also follow-up services in the client’s home to better understand each person’s unique challenges and needs, both those of the client, as well as of their family or support system. This creates an ethos of “we care” throughout the programme. Because of the long-standing relationship between the Catholic Church and the community, there is trust in both the quality of service provided by EDARP and its reputation as a place where all are welcome, accepted and respected.

In addition to care and support for those infected with HIV and their families, EDARP also reached 25,403 individuals through community-based behavior change communication programmes that were implemented by community health workers and people living with HIV. More than 5,000 new clients were referred for HIV Testing and TB screening through the EDARP “Share the Gift of Life” campaign. This initiative involved people living with HIV who, in turn, invite family members and friends to access HIV and TB services from EDARP.

Common social problems in high-density slum areas challenge many of the efforts undertaken by EDARP staff and volunteers. These include early sexual debut, chronic alcohol and drug abuse, and fractured family structures. The staff addresses these obstacles by constantly going into the community and into homes in order to develop relationships of trust and confidence so that services can be provided to those with greatest risk and greatest need.

During 2014, EDARP provided services for 3,132 pregnant women. 1,047 of these women previously had received care and support from the programme, while 2,085 received counseling and testing in antenatal clinics. 205 (9.8%) were HIV positive and eligible for ART. 706 HIV-exposed infants were tested in the EDARP PMTCT programme, with only 7 (1%) receiving PCR positive results. This success can be attributed to the comprehensive health education during ANC visits, home visits and support by staff and volunteers, and the reputation of EDARP to treat each client with compassion, respect and dignity.
EDARP offers a “Positive Health, Dignity, and Prevention (PHDP)” services for its clients. 99.7% of all HIV-positive clients were reached with basic components of education and care in line with the Kenyan national programme. 96% of all such clients received addiction education and information and were screened for alcohol abuse using the WHO AUDIT tool. 1,441 clients received additional support counseling to improve adherence and to lower the risk of HIV transmission.

In 2009, EDARP became the first programme in Nairobi to provide Voluntary Male Medical Circumcision (VMMC) services. During 2014, there was a successful integration of VMMC in 7 of the 14 EDARP clinical sites. Demand creation was intensified through community mobilization campaigns organized by staff, community volunteers, and EDARP clients. 7,107 men received VMMC through EDARP with only 0.7% clients reporting adverse events.

Through a training partnership with the International Council of Nurses (ICN), EDARP strengthened the implementation and community follow-up of its DOTS (Direct-Observed Treatment Short Course) to benefit both TB-HIV co-infected individuals and non HIV-infected TB patients, which also resulted in preventing an increase of multiple drug resistant (MDR) TB among many residents in the area. More than 23,000 HIV positive individuals were routinely screened for Tuberculosis infection. Of these 858 were diagnosed with TB and received treatment according to national guidelines. All TB patients received TB infection prevention education in order to decrease the risk of TB transmission to family and community members. EDARP also serves as a treatment site for MDR-TB. During 2014, a total of 39 MDR-TB patients received treatment; 22 of these successfully completed treatment and thus were cured of the infection.

Because of a significant decrease in available resources for care and support for orphans and other vulnerable children (OVC), EDARP recently has been constrained to markedly scale back this area of service provision. Some children have been referred to other church, government and NGO programmes. Others, however, are now deprived of needed services, including psychosocial support, child protection services, and assistance with school supplies and fees. During 2014, EDARP provided support to 1,759 OVC. This included health care, psychosocial support, nutritional support, child protection services and linkages to education. A total of 452 children received emergency nutritional supplementation.

New laboratory monitoring guidelines for pre-ART and ART patients now have been successfully implemented including viral load testing for ART patients in collaboration with the Kenyan National Reference Laboratory.
The EDARP electronic medical records/point-of-care system (E-Care) was upgraded in 2014 in order to ensure “real-time” entry of client information and inter-facility sharing of information, while, at all times, maintaining maximum safety and confidentiality of such information. The improved electronic medical record, using alerts and triggers for interaction between clinicians and clients, has improved the quality of care and of service provision.

In April 2014, in accord with PEPFAR programme guidance, a process of “right-sizing” began. Programme areas identified as “not core” had to be discontinued. These included: screening for cervical cancer, care and support for OVC, home-based testing for HIV, community-based information, education and communication (IEC) media and print campaigns. EDARP receives the majority of its funding through a cooperative agreement with the CDC that will end in October of 2015. While some discussion has been conducted with PEPFAR with regard to continuing support, there is great uncertainty at this time.

Recent funding cutbacks have placed strong pressure on the programme to downscale some of its activities, although it retains ART as a priority in order to avoid treatment disruptions. At a time when EDARP could and should be expanding its services to help the eastern area of Nairobi reach the UNAIDS Goal of 90-90-90\(^{20}\), its future involvement in the treatment field now is in question.

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\(^{20}\) By 2020, 90% of all people living with HIV will know their HIV status. By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy. By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression. [http://www.unaids.org/en/resources/documents/2014/90-90-90]
3) Churches Health Association of Zambia

The Churches Health Association of Zambia (CHAZ) is an inter-denominational umbrella organization with a mandate to coordinate church-based health services throughout Zambia. The roots of the organization are traced to the early 1930s when various Catholic and Protestant mission health facilities began meeting for mutual support, coordinated advocacy, and planning between themselves and government health structures. A formal structure was created in the early 1970s. This somewhat unique collaboration between both Catholic and Protestant organizations has greatly strengthened the provision of faith-based health services in Zambia, and, in particular, services for people with HIV.

Composed of 151 health member institutions representing 16 Catholic and Protestant denominations that provide 50% of formal healthcare in rural areas and 35% nationally, CHAZ facilitates centralized ART drug procurement, laboratory reagents, and health equipment for its members that contribute toward cost efficiencies. Its membership includes hospitals, health centers, health posts and local community-based organizations. Additionally, 11 faith-
based health-training facilities are members of CHAZ. While its facilities are spread throughout Zambia, a particular focus of CHAZ is placed on the provision of health services in the more rural, remote areas of the country. CHAZ is committed to serving all people without any discrimination but especially the poor and those in underserved communities. They aim to provide holistic, quality and affordable services that reflect Christian values of service, compassion and dignity for all.

CHAZ reports an exceptionally positive relationship with the Government of Zambia. The two parties regularly collaborate and coordinate their services in order to avoid unnecessary duplication of services. In 2013, a Memorandum of Understanding was signed among the Zambian government, bilateral and multilateral health-related partners, and CHAZ. Regular meetings are held among CHAZ, Ministry of Health, and State House staff. This ensures smooth coordination of services, and also allows CHAZ to assume an important advocacy voice, especially for the rural poor in need of services.

CHAZ provides administrative, financial, and clinical support for its member organizations and puts particular emphasis on capacity-building for the smaller faith-based community organizations that provide care and support for people living with HIV where there are often no other available government services. Of the 151 Christian health facilities supervised by CHAZ, 29 are community-based programmes. 69 facilities are providing PMTCT services, 65 are providing ART and 68 are providing tuberculosis diagnosis and treatment services.

Promotion of HIV counseling and testing is one of the key preventive strategies implemented by CHAZ, in line with the Zambian National Health Strategic Framework. During 2014, CHAZ provided HIV counseling and testing for 173,330 individuals. Many of these testing sites were in areas where only faith-based health facilities are operating. There is a strong ethos in the organization, that all people are welcome and accepted at CHAZ facilities. It is well known in local communities that, when individuals approach a CHAZ facility, they will not only receive quality services, and all will be treated with dignity and respect.
The CHAZ ART programme has provided treatment for more than 12 years. At the end of 2014, a total of 86,789 HIV positive individuals, including 6,532 children, were receiving antiretroviral therapy from CHAZ member organizations. Through the provision of high quality, holistic services, which include support for the spiritual needs of clients, there was only 12% loss to follow-up for all patients receiving ART. CHAZ continuously offers training, supervision and mentoring to health workers at these sites to maintain high standards of comprehensive service provision.

CHAZ emphasizes the holistic nature of all its programmes. Successful care, support, and treatment for people living with HIV require not only the highest quality medical services and clinical interventions, but also the equally important understanding of an individual’s unique psychosocial and spiritual issues and how these may impact on treatment and adherence. Community members know and understand that, at CHAZ facilities, there is always someone with whom to talk and someone who will listen. Additionally, each CHAZ hospital has chaplaincy and pastoral care services both for the patients, and for their family members and support system.

In addition to CHAZ member facility staff, more than 4,600 Adherence Support Workers (volunteers who are paid a small stipend) are engaged with the organization. Individual support workers are attached to each facility for community support and follow-up with individuals on ART and with mothers and their babies receiving PMTCT services. This type of personal, community programme is a key driver in CHAZ’s current record of low “loss to follow-up”
rates. However, this programme, currently supported through a grant from the Global Fund, is only able to provide a small incentive for these community workers. Concern was expressed that, without an increase in resources, a higher number of Adherence Support Workers may terminate their service and that such a trend may result in higher default rates.

During 2014, CHAZ worked with 32 member facilities to provide voluntary medical male circumcision for a total of 24,526 clients. Clients were provided the necessary clinical support and education as well as psychosocial and spiritual support when appropriate. Services were provided in both facility-based and outreach locations.

Many of the CHAZ member facilities, as well as the community-based organizations, provide extensive care and support a significant number of orphans and vulnerable children in their service areas. In 2014, a total of 62,415 Orphans and Vulnerable Children (OVC) were provided with a variety of services, depending on the needs of the child. Through a grant from the Global Fund, these children were provided with needed psychosocial support as well as with support to help the child remain in school. The latter includes assistance with school fees, clothing and school uniforms, shoes and school supplies.

All programmes and initiatives implemented through CHAZ member facilities and organizations are based on a foundation of human rights that are inherent in each individual. Its members work to ensure that both women and men have equal access to high quality services in all activities and programmes.

The CHAZ Advocacy Programme is a deliberate, planned, and sustained effort to proactively and reactively seek avenues to advance the creation and sustainability of a policy environment that supports universal access to health care as well as sound governance that enhances transparency and sustainability. Advocacy has been a core mandate of CHAZ since its foundation. In its advocacy efforts, CHAZ devotes particular attention to the poor and vulnerable.

CHAZ recently initiated two innovative programmes with its members. To encourage pregnant women to attend Focused Antenatal Care (which includes testing for HIV and PMTCT), CHAZ members provide each mother with a “Mama Baby Pack” that includes some basic baby supplies and clothing. These items are given only to mothers who attend four antenatal visits, deliver in a health facility, and then bring their babies for postnatal visits. These small incentives have helped to increase safer health facility deliveries and attendance at pre-and post-natal clinics.
A second innovation, aimed to address issues of poverty, is a village banking or Community-Managed Micro-Finance (CMMF) scheme. CMMF is now being implemented in 13 rural sites across six different provinces. CMMF forms groups of 10-30 village members, with women in 50% of the decision-making positions. It includes a process of teaching basic business skills and financial literacy. Members then participate in the process of saving and borrowing funds designated for the creation and expansion of small business enterprises. Early results indicate increased inter-household cooperation, increased participation of women within the community, a new culture of savings, and improved self-confidence among those participating in the scheme.

During the past two years, CHAZ has embarked on a new health systems strengthening initiative through a consortium headed by Catholic Relief Services. The aim is to build the health systems of CHAZ member institutions by using the six WHO health systems strengthening building blocks. This is a long-term project to increase institutional sustainability and improve overall administration among the CHAZ member organizations. The focus is not only to implement various systems of accountability, but also to equip key staff with leadership and management skills.

CHAZ currently receives funding from a variety of bilateral, multilateral and faith-based funding sources as well as some funding for its facilities through the government of Zambia. Concern has been expressed, however, that in conjunction with the current PEPFAR transition process and recent changes in Country Operating Plans, priority is being focused on “high prevalence” and “high impact” sites and locations. Practically, this means that many CHAZ sites, which traditionally have focused on the rural poor, may suddenly be faced with significant financial sustainability issues.

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UCMB serves as the Health Department and implements the HIV response of the Uganda Catholic Bishops’ Conference in 19 dioceses spread throughout the country. The UCMB principally is responsible for ensuring the quality, capacity, and strength of Catholic health centres accredited with the UCMB. Additionally, the UCMB represents Catholic health care and manages linkages, coordination and cooperation with public and private health systems. The focus of UCMB includes both general health clinics as well as specialized programmes including treatment, care and support for people living with HIV, maternal and child health centers, and joint TB/HIV care. There are currently 280 health facilities in Uganda that are accredited to the UCMB.

All facilities accredited with UCMB strive to provide comprehensive, high quality services, as required by the Ugandan Ministry of Health policies and guidelines. As faith-based institutions, these facilities provide clinical care as well as holistic care to address each individual’s unique social, emotional and spiritual needs. This ethos, as well as the Catholic Church’s reputation in Uganda, creates a sense of care, trust, welcome and acceptance at UCMB hospitals and clinics. Among Ugandans, there is a profound sense that health professionals and volunteers in such faith-based programmes, not only “treat” the individuals, but also “accompany” them on their respective health “journeys”.

4) The AIDS Care and Treatment (ACT) Programme – Uganda Catholic Medical Bureau (UCMB) of the Uganda Episcopal Conference (UEC)
Partnering with Cordaid (Caritas organization of the Netherlands), UCMB implements an extensive HIV programme that is supported by an annual budget of USD $6.2 million. ART services constitute 35% of its budget, followed by home-based care for people living with HIV, including programmes for family support groups and for the mobilization of village health teams.

Among UCMB facilities, 142 provide care and support for people living with HIV. Through the ACT programme, UCMB implements a PEPFAR/CDC funded project that currently supports 47,618 HIV positive individuals on treatment through 34 Catholic hospitals and clinics. An additional 22,265 people are supported at other UCMB facilities through a variety of different funding streams for a total of 69,103 HIV positive individuals, including 6,220 children, who are receiving ART.

UCMB sites include Provider Initiated Testing and Counseling (PITC), traditional facility-based Voluntary Testing and Counseling (VCT), mobile and outreach VCT, and special HIV testing programmes to encourage joint counseling and testing among couples. In addition to serving clients who seek services at hospitals and clinics, the UCMB works with key populations, such as transportation workers, sex workers and fishermen. Currently, test kits and consumables are provided from national supply chain mechanisms both through the Ministry of Health and the UCMB. During 2014, a total of 624,632 individuals received HIV testing and counseling and were provided with results. 26,196 individuals tested positive and 16,628 began ART. Due to increased social mobilization efforts, 50,663 individuals were tested as couples. However, because of shifting donor priorities focused on “most-at-risk” populations, there is a risk that this successful programme to decrease HIV transmission within discordant couples may now find itself in jeopardy.

UCMB facilities and sites also support a variety of community-based HIV prevention initiatives. These include basic HIV education and awareness-raising, behavior change communication and life skills education, as well as education and training for children and youth. During the past three years, more than 40,000 men have accessed voluntary male medical circumcision through UCMB accredited clinics.

Antiretroviral treatment for HIV-positive adults and children is provided in line with Uganda’s national treatment guidelines. These services include initial assessment, lifelong treatment preparation, laboratory investigations, provision of medicines, psychosocial and spiritual support, on-going adherence counseling, laboratory monitoring and on-going refills of ARV medications. Under the ACT (Accelerating Children’s HIV Treatment)/PEPFAR funding programme, clients are also are provided with intensive community follow-up,
which includes tracking patients who miss appointments. This has resulted in only 18% loss to follow-up among patients in these programming sites. However, at other UCMB treatment sites, without the needed resources to support compliance and retention, the loss to follow-up is almost double, at 34%. This is a clear indication that comprehensive treatment, including important psychosocial and spiritual support, requires sufficient resources. Currently, the Global Fund is providing resources for needed commodities related to ART treatment; however, the UCMB does not receive Global Fund money for staff and operational expenses.

Each treatment site engages and trains volunteers from local parishes to support its work with HIV positive persons. Some of the larger facilities count more than thirty groups of volunteers, with an average of 20 members in each group. Many of these volunteers, especially in the rural areas, also are members of village health teams that have been mandated by the Ugandan government.

Patients currently receiving ART and pre-ART clients, who are waiting to fulfill eligibility requirements for treatment initiation, receive both education and care at UCMB facilities that include the prevention and management of opportunistic infections, screening for sexually transmitted infections, nutritional assessment and counseling, malaria control and treatment, safe water and sanitation education, testing of sexual partners, and support services designed to promote positive health, dignity, and prevention of the further spread of HIV.

All pregnant women at UCMB facilities are provided the opportunity to participate in a standard B+ protocol implemented by the Ugandan Ministry of Health. All of these women receive antenatal clinical services, and those found HIV positive are initiated on ART. As with all HIV-positive clients, they receive a comprehensive range of clinical, psychosocial, and spiritual resources. During 2014, a total of 204,017 women at UCMB facilities were tested for HIV; 4,646 women began ART; 319 HIV positive infants were then enrolled in care. In some of the UCMB facilities, virtually 100% of the children born to HIV positive mothers were found to be HIV-negative.

All UCMB-related facilities include a dedicated department for pastoral and spiritual care coordination. This is to ensure that all individuals, regardless of their religious beliefs, have access to client-centered spiritual care. Staff members of these departments work with local Catholic pastors, as well as with other Christian and non-Christian leaders, to engage their respective faith communities toward elimination of stigma and discrimination against people living with HIV, which regrettably continues to impede access to care and treatment.
The UCMB supports laboratory operations in its project facilities and at key designated hospitals that work as referral points for lower level units and clinics.

Across all UCMB network facilities, services for people living with HIV are 80-90% dependent on donor funding. The local contribution, which is not well quantified or monetized, includes space, facilities and equipment, and literally thousands and thousands of volunteer hours that daily supply compassion, support and care for people living with HIV and their families. Because of this extensive donor funding and volunteer support, all clients living with HIV are able to receive free services at UCMB sites.

From the beginning of the HIV epidemic, the UCMB has actively engaged in advocacy to ensure universal access to HIV care and treatment, especially for the poor, vulnerable and marginalized. In such efforts, the UCMB collaborates with “sister” offices of the Ugandan Episcopal Conference, including the Justice and Peace Desk, the Women’s Desk, and the Caritas Desk.

As UCMB strives to develop care and support responsive to current needs of people living with HIV, it faces key challenges related to future strategic planning and programme implementation. High donor dependency places significant stress on both staff and programme administration. Some donors include stringent conditions for services to be included in the overall programme package and other criteria that essentially exclude some faith-based health facilities from being considered as potential recipients of funding. Without sustained funding levels or an increase in resources, loss to follow up occurs as the client’s condition improves; such loss could be attributed to lack of available community case-finding and support. Currently 18% of the financial resources for the UCMB is derived from the national governmental budgets. For the expansion of FBO services to meet the goal of “90-90-90”, additional resources will be required.

The Catholic Church’s health care network in Uganda is currently providing more than 12% of Ugandan national ART outputs. This has been made possible through the Church’s investment in and commitment to health care provision and through continued support from international donors and the government of Uganda to sustain the church’s health care activities. However, there are still too many individuals living with HIV in Uganda, especially those living in the most rural and isolated areas, who have not yet been able to access antiretroviral treatment.
5) Christian Health Association of Kenya (CHAK)

The Christian Health Association of Kenya (CHAK) is a national FBO network of health facilities, programmes and Medical Training Colleges and Universities associated with the Protestant churches in Kenya. Its core functions include: advocacy, health service delivery, capacity building, health systems strengthening, partnerships & networking, and HIV and AIDS programmes. CHAK collaborates closely with the Catholic Health Commission of Kenya, which coordinates the Catholic health facilities. Both organizations participate in the Church Health Services Coordinating Committee. The Protestant Churches in Kenya have a Partnership Framework with the national Ministry of Health. This framework guides engagement, support and accountability between the two contracting parties. Partnership is coordinated through the Faith Based Health Services Coordinating Committee. In Kenya, FBOs are recognized as key stakeholders in the health sector, since they provide approximately 30% of the health care coverage there.

The CHAK Secretariat and the member health network engage in a wide range of services to mitigate the impact of HIV and AIDS in Kenya within the framework of the Kenya National AIDS Strategic Plan (KNASP). CHAK is guided by international- and country-level policies, guidelines, strategies, and good practice models.

http://www.chak.or.ke/fin/index.php/component/content/article?id=46
CHAK’s HIV response initiatives are evidence-based and embrace a comprehensive and holistic approach addressing the physical, psychological, social, spiritual and economic well-being. The scope of the response includes: prevention, diagnosis, care and treatment (ART), PMCT and stigma mitigation. The services include VCT, PITC, PMCT, VMMC, TB-HIV co-infection, ART, cervical cancer screening, economic empowerment and promotion of legal and human rights of people living with HIV.

CHAK is the prime partner in a 5-year CDC grant funded by PEPFAR for the implementation of a comprehensive high quality HIV care and treatment project in Faith Based Health Facilities in Eastern, Central, Nairobi and Coast regions of Kenya. The consortium partners include MEDS, the Institute of Human Virology of the University of Maryland (USA), Futures Group and the Catholic Medical Mission Bureau (CMMB).

This initiative, known as CHAP (Christian Health Association of Kenya HIV and AIDS Project), is a sequel to the AIDSRelief project, which implemented high quality comprehensive HIV care in 29 FBO health facilities and 100 satellite sites. The CHAP programme was initiated on 1 October 2011, and has been implemented at 6 hospitals and 17 satellite health centres. These include: Kikuyu, Mater, Mwea, Tumutumu, Chogoria and Maua Hospitals. By the end of June 2012, the project reported having placed 15,046 people on ART; of these, 14,314 were adults and 1,992 (11%) were children.

The response is based on 4 technical approaches:

- Comprehensive HIV clinical mentorship and capacity building;
- Ongoing localized health system strengthening at faith-based health facilities;
- Increased integration of faith-based health system within the District health system;
- Robust strategic information systems.

The programme areas include:

- Adult care and treatment
- PMTCT
- Paediatric care and treatment
- HIV prevention
- TB/HIV co-infection management
- Cervical cancer screening
- Health systems strengthening
A strong multidisciplinary team, with diverse technical skills and competencies drawn from CHAK and the consortium partners, guides the project implementation in the CHAP programme. It trains, mentors, and supports service delivery teams at all implementing sites; local site staff, in turn, is responsible for delivering comprehensive services, each day of the week, to a steadily growing number of clients. In this project, CHAK collaborates with 15 Faith-Based Hospitals and 40 satellite health centres.

CHAK also implements a human rights approach to HIV response. The programme was started, in 2007, through funding from the Open Society Institute (OSI) Foundation of USA. CHAK has developed an effective HIV-related stigma mitigation strategy through capacity building, advocacy, sensitization and legal support for persons living with HIV, since, in many countries of Africa they encounter stigma, discrimination, disempowerment and mistreatment.

This programme works through 16 Faith-Based Hospitals that offer HIV care and treatment with linkages to the community. The purpose of the programme is to strengthen and expand the integration of legal and human rights services into other programmes. The objectives include: creating awareness on legal and human rights, capacity building on the rights based approach, mobilization of key stakeholders and opinion leaders within communities and provision of pro bono legal representation to PLWHA who are subjected to human rights violations.

The programme employs the following technical methodologies:

- Capacity building on legal and human rights: training is provided to health workers, community health workers, PLWHA, community opinion leaders and guardians. Community opinion leaders also are trained on alternative dispute resolution mechanisms.
- Community sensitization forums are held to create awareness of human rights violations to PLWHA and advocate for behavior change.
- Legal aid clinics are provided quarterly in all 16 implementing sites facilitated by CHAK Legal officers and pro bono lawyers through partnership with pro bono legal organizations.
- Economic empowerment training is provided and groups of persons living with HIV are supported to initiate income-generating activities.

This human rights programme has created significant impact in the knowledge and practices within targeted communities. CHAK and its partners have been inspired by the results and decided to document the achievements in a documentary to facilitate sharing best practices and lessons learnt.
6) Transitioning from Catholic Relief Services (CRS) AIDSRelief to local partner responsibility – the LEAD Project, Tanzania

Catholic Relief Services (CRS), the official international humanitarian agency of the Catholic Church in the United States, started its first HIV project in Uganda in 1989. By the end of 2013, it had supported 184 HIV programmes in 35 countries, with a total expenditure of $106 million in 2012. Over the years, working in partnership with other faith-based and non-governmental organizations, CRS served more than eight million people affected by the epidemic. Specifically with regard to treatment, CRS and its partners enrolled more than 400,000 people on ART, trained 30,000 staff during a nine-year period, and pioneered a strategy of early treatment offered through 276 local health facilities in Ethiopia, Guyana, Haiti, Kenya, Nigeria, Rwanda, South Africa, Tanzania, Uganda, South Africa. This comprehensive and far-reaching programme was implemented through AIDSRelief, a consortium with five other organizations, which received financial support through PEPFAR, initiated in 2004, and was implemented in ten countries and

AIDSRelief was built on the extensive reach of faith-based networks (both Christian and Muslim) to provide the most underserved populations with access to HIV care, support and treatment. These networks enabled the programme to leverage community linkages, develop highly effective community support mechanisms and reach clients and families at the household level.

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24 Other organizations participating in the CRS AIDS Relief Consortium: Institute of Human Virology, University of Maryland School of Medicine, Catholic Medical Mission Board, Futures Group, IMA World Health
When the first PEPFAR programmes were launched in 2004, many people did not believe that it was possible to deliver high-quality, sustainable HIV treatment in low-resource settings. Over the next nine-year period, AIDSRelief and other PEPFAR implementing partners transformed HIV care and treatment in low- and under-resourced settings and, in so doing, exceeded all expectations.

AIDSRelief found that the most important variable in successful treatment is the care delivery system. Adherence to treatment, and the support to ensure it, was considered a therapeutic intervention and integrated into the total care for the client. Through intensive treatment preparation, adherence counseling, and highly supported treatment initiation with peer-supported home visits and community involvement, AIDSRelief support networks helped clients to adhere to their treatment plans and reduce treatment failure. As a result of this comprehensive and holistic care, over a nine-year period, AIDSRelief implementing partners attained a combined 88.2% viral suppression and 83% retention with only 7.8% mortality and 10.6% loss to follow up.
AIDSRelief country programmes supported diagnosis, care and treatment services for children and adolescents. This is reflected in the high paediatric enrollment of 8.3% and low paediatric mortality of 2.7% within AIDSRelief. In an effort to facilitate the best care for HIV-positive infants, AIDSRelief was among the first PEPFAR implementing partners to create a comprehensive dosage schedule for paediatric ARVs and to advocate for, and initiate, treatment of HIV-positive infants without being linked to CD4 count or clinical staging.

Each AIDSRelief country programme was designed to transition management to local ownership. Local partners were identified based on their potential to sustain high-quality care and support for people living with HIV. As treatment systems were put into place, different understandings of transition emerged among donor representatives, local partners, and within the consortium. By strengthening all aspects of capacity within these institutions, AIDSRelief supported local partners to assume full clinical and administrative responsibility for their respective sites. Some of these programmes became direct recipients of US government funding; others were transitioned to either local government funding or government public health programmes. In some countries, follow-on grants from Catholic Relief Services continued the support of clients receiving treatment as well as additional capacity building for future functioning as the local partner assumed greater programming responsibility.

The LEAD Project (Local Partners Excel in Comprehensive HIV & AIDS Service Delivery) constitutes a sequel to AIDSRelief, thus supporting quality HIV care and treatment, TB/HIV integration and PMTCT services in the Mara, Manyara and Tanga regions of rural northern Tanzania. The project is
implemented by a consortium of four organizations led by Catholic Relief Services (CRS) and includes Interchurch Medical Assistance—World Health (IMA), University of Maryland School of Medicine—Institute of Human Virology, and Futures Group International. The LEAD project works with the Tanzanian National AIDS Control Programme, government district, regional structures, and FBOs to strengthen local capacities to provide comprehensive HIV care and support including ART as well as support to HIV-affected families. CRS provides technical assistance, supervision and support to government, faith-based, and private treatment sites. The government of Tanzania clearly has recognized that all partners are essential to reach universal treatment goals.

Under the LEAD project, CRS has supported 101 care and treatment clinics and 521 PMTCT sites in three targeted regions of Tanzania, with 53,210 clients enrolled in care, of whom 41,198 (including 3,093 children) already receive ART. The programme supports 84 government facilities, 3 private clinics, and 14 faith-based clinics. Under LEAD, the funding resources are restricted to clinic-based services. Through the Tanzania Interfaith Partnership (TIP), some of the faith-based clinics continue to network with local congregations for the provision of home and community support. Further evidence will need to be collected, however, in order to determine whether or not this “split” between facility-based services and home care ultimately will result in effective or efficient outcomes.

Eleven faith-based clinics under this project have provided care for 10,783 clients with 8,846 currently on ART, including 668 children. Additionally, 7,236 pregnant women were tested for HIV at these clinics. Almost 100% of these clients also were screened for tuberculosis; those testing positive for TB then were initiated on treatment. The adjusted retention rate for these faith-based clinics under LEAD is 75%.

During a two-year period, through intensive staff training, mentorship and tracking mechanisms, the LEAD project achieved a marked improvement in the number of infants who received a virological test for HIV during the first 12 months of life.

LEAD uses a variety of strategies to identify and facilitate the return of clients who have missed appointments. This includes both loss to follow-up clients as well as clients who are eligible, but not yet initiated on ART. Healthcare workers are trained, and continue to receive mentorship to regularly review appointment registers and track eligible clients. This information is then shared with other health facilities when clients transfer out, resulting in a marked decrease in loss to follow-up.
Beneficiaries of service from these faith-based clinics express trust in the quality of services and appreciation for the dedication of the staff. Due to the low administrative costs at the faith-based clinics, more resources can be dedicated to efficiently reaching programme targets.

Given the progressive hand-over by CRS to local partners and overall trend “flat-lining” of foreign support from programming Tanzania and other low-income countries, much concern is being expressed about future sustainability for these high-performance programmes. There has been some discussion about an increase in domestic support by the Tanzanian government but, so far, the local programmes still await concrete commitments in this regard. Without future external funding, it is unlikely that these faith-based clinics will be able to survive and provide the comprehensive services to their rural poor clients.

7) Engagement of Catholic Women with Grassroots HIV programming in South Africa

While many faith-based responses to HIV have been promoted and organized through well-structured health care institutions and community-based programmes, and other initiatives have been undertaken by small groups of dedicated individuals, motivated by their faith and focused on simply trying to accompany and support those living with and affected by HIV and AIDS. These less formal programmes frequently go unnoticed and undocumented at
national and international levels, but their contribution to the global effort is critical.

Sr. Alison Munro, OP, the Director of the Southern African Catholic Bishops Conference (SACBC) AIDS Office recently gathered evidence of the contribution by women of faith responding to HIV at the grassroots level in southern Africa. She surveyed 32 projects from 21 different dioceses and summarized some of the key characteristics of the programmes and services initiated by these highly motivated women of faith.

Most of the initiators and coordinators of these small projects reported having been inspired by their faith and having begun their work as a response to the call of the Christian Gospel to serve. They profess their deep determination to put into action the Social Teachings of the Catholic Church, including the core values of love, respect, compassion, solidarity, justice, hospitality, peace, preferential option for the poor. All these groups and projects offer support and service without any discrimination, irrespective of the religious or spiritual beliefs of the persons needing care. Other partners from non-Catholic backgrounds also participated in these projects, both as volunteers and employees, and claim to have been inspired by a sense of community and the call and dedication to service.

Many of the projects included in this informal survey began under the wider auspices of Catholic Church-related primary health clinics or of parishes and small Christian communities. In some instances, the organizers perceived an unmet need for HIV education and training and understood that community mobilizers and educators could best provide such activities. In the early years of the epidemic, before the availability of antiretroviral treatment, there simply was a need to care for the sick and dying. During that time, too many HIV-positive clients were simply discharged and told, “There is nothing more we can do.” Many of these early volunteers sought training to care for one of their own immediate family members in their own homes but soon learned that their skills and compassion also were needed by other relatives, friends and neighbors.

Such projects were initiated, or at least encouraged, by concerned bishops, priests, and other diocesan level leaders; this necessitated larger area and regional planning for implementation. At the forefront of many early projects in response to HIV and AIDS were communities of Catholic Religious Sisters. The Sisters of Our Lady of Divine Love, the Daughters of St Francis of Assisi, the Augustinian Sisters, the Holy Family Sisters, and several more, initiated

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projects in Southern Africa in order to accompany and support those living with HIV. Other groups of Catholic Sisters, who were involved in work with children, soon responded to the unprecedented numbers of orphans and other vulnerable children as a result of their parents infected with HIV. As one parish-based group caring for children orphaned by AIDS testified, “they gave the community, and especially the children, a sense of belonging, instead of stigmatization.” Moreover, the emerging HIV epidemic offered many of these women of faith the opportunity to put their spiritual and religious values into action.

Many people, especially those living in the informal settlement areas, already were suffering from HIV-related illnesses but did not understand the cause or the dynamics of transmission. Small groups of women soon were developed in order to provide HIV and AIDS awareness-raising and to promote the creation of support groups for people living with HIV and for caregivers, hospice and palliative care. Subsequently, some of the same groups established HIV counseling and testing centres, care for orphans and other vulnerable children, and ART programmes (when treatment became available). Sr. Alison reported that more than 50% of the survey respondents focused their work on home-based care, support for OVC, and TB screening and referral.

Almost one third of the respondent projects reported receiving less than USD $50,000 per year in funding, and this often came from a single source. They reported susceptibility to funding cuts and indicated that they might not survive current funding priorities that discount community-based support services. In some instances, volunteers reported providing hours of service with little or no financial compensation, despite their own personal financial struggles. Some mentioned that they have continued their work in communities even after projects no longer received any outside funding.

A second group of projects reported funding support ranging between USD $50,000 and $100,000 per year and provided by two or more sources of donor funding. These slightly larger projects have the capacity to produce the necessary documentation to maintain their status as non-profit organizations. They also demonstrate basic skills in financial administration and have strong links to larger church-related structures.

A third group of the respondents reported funding support of between USD $100,00 and $600,000 per year. They provide multiple interventions and services for people with HIV and have the skills and capacity to seek out both church and government partners for their work. They frequently originate from

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27 Munro, Alison. *Grassroots Movements, Women and the Fight Against AIDS.* Pretoria, South Africa. 2015
large parish or diocesan projects and are able to support and manage larger groups of volunteers and community workers.

A fourth group of respondents receives between USD $1,000,000 and $1,500,000 and demonstrates strong, effective, and enduring resource mobilization capacity. These projects frequently have a charismatic leader with a background in fundraising and financial management.

Spiritual and pastoral care was identified as an integral component of these projects. They aim to assist individuals as they search for meaning and purpose in their lives in the midst of living with their HIV diagnosis and all its life implications. With regard to the strong role assumed by women in these projects, the respondents noted that, in their respective cultures, women traditionally provide compassion and care for families, children and the sick. Many of these women recognize their own vulnerability and give testimony that their work and actions strengthen their resolve to combat the stigma and discrimination associated with HIV. Their involvement in projects also provides a way to be informed about HIV and share this information within their local communities.

III. Convening FBOs to Encourage Expanded Engagement toward Achieving Universal Access to HIV Care and Treatment

Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive
With the goal of intensifying the engagement of FBOs in the HIV response by effectively aligning them with the strategies and targets of the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive,\textsuperscript{28} UNAIDS, together with the African Christian Health Associations Platform, Caritas Internationalis and the Ecumenical Advocacy Alliance, convened a consultation among faith-based networks, national governments, networks of women living with HIV, and international organizations in Lusaka, Zambia from 28 February—1 March 2013\textsuperscript{29}. This consultation, held in conjunction with the biennial meeting of the Platform of African Christian Health Associations, aimed at informing government officials about the ways in which FBOs serve as key stakeholders in the implementation of the \textit{Global Plan} and in the overall scale-up of antiretroviral treatment.

The Lusaka consultation was held in a spirit of honest dialogue among all the stakeholders, in an effort to identify their respective strengths and weaknesses. Particular emphasis was placed on finding ways to harness the complementarity of each stakeholder’s unique contributions to the prevention of mother-to-child transmission of HIV (PMTCT) and ART scale-up. Government officials affirmed that FBOs were complementing public health care in many countries and acknowledged the need for increased involvement of FBOs in the efforts to end mother-to-child transmission of HIV.

Local FBOs are essential in the national HIV response since they often are closest to those in need of information, support and services. In her remarks during the consultation, Karen Sichinga, the Executive Director of the Christian Health Association of Zambia concluded, “The African Christian Health Association Platform stands by the Global Plan and stands ready to do all it can in partnership with others to meet the Global Plan goals. Indeed, it is only by strengthening our partnerships that we are going to be able to develop holistic and effective ways to overcome the challenges set before us. As FBOs we have been here all along, but why has it taken so long for the international community to recognize our contribution to health service delivery and engage us?”\textsuperscript{30}

The FBOs present at the Lusaka Consultation confirmed that they were ready and able to partner with national responses by:

\textsuperscript{28} UNAIDS. Countdown to Zero. Geneva, 2011.
\textsuperscript{29} Consultation Report, \textit{Scaling-up the engagement of faith-based organizations in the implementation of the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive and scaling up access to anti-retroviral treatment for HIV infection}, Lusaka, 2013.
\textsuperscript{30} Ibid..
• Promoting HIV testing, reducing stigma in the community and in health care settings, strengthening community support and referral networks for people living with HIV, and enhancing human rights literacy;
• Increasing enrolment in HIV care by expanding community-centered service delivery which reduces overall treatment cost and transport barriers;
• Supporting people to start treatment by enhancing peer-support programmes, ensuring adequate nutrition, and reducing stigma in health care settings;
• Strengthening treatment adherence by increasing adherence support programmes, reducing gender inequalities and fear of disclosure, and ensuring referral and support programmes for migrants.

Subsequently, when UNAIDS intensified its push toward the achievement of the 2015 global target of “15 million people living with HIV on ART,” it was clear that all stakeholders needed to invigorate their ART programmes in order to reach this ambitious target. In collaboration with WHO, GFATM and the President’s Emergency Plan for AIDS Relief (PEPFAR), UNAIDS launched Treatment 2015, which put forward a framework for advancing ART by underpinning treatment access on strategies that were more effective and efficient, as well as broader in reach. Treatment 2015 sought to scale up ART programmes to levels that outpace the spread of the epidemic\(^{31}\).

\(^{31}\) cf., UNAIDS Treatment 2015 Initiative.
In this context, UNAIDS reached out to FBOs, recognizing that their inherent strengths, already evidenced by their participation in efforts to prevent transmission of HIV to children, could be further harnessed for scaling up ART services. These strengths include deep reach into rural areas, and often neglected communities, service provision that recognizes the holistic and comprehensive needs of clients, a long history in providing services for people with HIV, and an extensive track record to provide these services with great efficiency.

In partnership with Caritas Internationalis, UNAIDS convened a consultation in February 2014, in Rome, Italy, which gathered more than 100 representatives of diverse Christian faith traditions, the international donor and diplomatic community, and medical and scientific organizations engaged in work with people with HIV and AIDS. Its specific aim was to explore the best ways to strengthen the involvement of FBOs as active partners in scaling up ART programming.

**IV. Examining Faith-based Responses to HIV in order to refine strategies and alliances**

As co-organizer of the Rome Consultation, Caritas Internationalis undertook a survey among Catholic organizations participating in this meeting in order to highlight the current scope of their HIV programmes and elicit practical strategies as a roadmap for addressing challenges in scaling up ART services.

Twenty-two organizations provided responses to this survey and represented a diverse profile in terms of geographical breadth, as well as HIV programming focus, structure, and level of operations. The respondent organizations were of three types: a) programme implementers, which are directly involved in managing and delivering services through an organized infrastructure, b) coordinating organizations with operations focusing on management of, or financial and technical assistance to service delivery and implementing organizations, and c) a hybrid of joint implementers which coordinate services provided by other partners as well as implement their own activities.

The majority of the organizations in this survey were linked with to a broader church-related structure. As such, their programmes and services function, for the most part, under the authority of an ecclesiastical structure at local, national or regional levels. National religious bodies provide important links among local, national, regional, and global levels. These structures help to create and
sustain support networks that provide targeted, population-specific services and that reach some of the most rural, vulnerable and marginalized members of local communities.

91% of the respondents, a large proportion of which are based in Africa, operate their programmes within their respective regions or countries. These organizations provide different types of services. Some offer programmes in targeted or specific areas, for example, in a particular slum in Nairobi. Others provide programming at multiple sites within a specific country, others within multiple countries within a specific region, and others on a global basis across several regions.

**Figure 1: Typology of Respondent Organizations**

<table>
<thead>
<tr>
<th>Types of Respondent Organizations</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV programme organization</td>
<td></td>
</tr>
<tr>
<td>• Implementing</td>
<td>14 (64%)</td>
</tr>
<tr>
<td>• Coordinating</td>
<td>5 (23%)</td>
</tr>
<tr>
<td>• Implementing/coordinating</td>
<td>3 (13%)</td>
</tr>
<tr>
<td>2. Organizational structure</td>
<td></td>
</tr>
<tr>
<td>• Under broader Church-related structure</td>
<td>18</td>
</tr>
<tr>
<td>• Programme/project structure</td>
<td>4</td>
</tr>
<tr>
<td>3. Regional base</td>
<td></td>
</tr>
<tr>
<td>• Africa</td>
<td>8 (36%)</td>
</tr>
<tr>
<td>• Asia</td>
<td>4 (19%)</td>
</tr>
<tr>
<td>• Europe</td>
<td>8 (36%)</td>
</tr>
<tr>
<td>• Americas</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>4. Level of HIV programme coverage</td>
<td></td>
</tr>
<tr>
<td>• Global</td>
<td>4 (18%)</td>
</tr>
<tr>
<td>• Regional</td>
<td>2 (9%)</td>
</tr>
<tr>
<td>• National</td>
<td>13 (59%)</td>
</tr>
<tr>
<td>• Local</td>
<td>3 (14%)</td>
</tr>
</tbody>
</table>

Despite the diversity of the respondent organizations, there was a general consensus on the challenging context of HIV programmes under which all stakeholders function, at all levels, and in the different parts of the world. The major challenge cited by the respondents (91%) was the pressure to *scale back*
both HIV prevention and treatment services, despite increasing need and demand for services in their programme area. Unreliable long-term funding and increasing budget cutbacks have resulted in staff shortfalls, diminished numbers of clients served, and reductions in capacity-building activities vital to ensuring competent ART service delivery. All these organizations operate HIV programmes in developing countries, for example, in Africa, Asia, and Eastern Europe, where the need for expanded access is most urgent.

The respondents were in agreement with regard to the strengths that FBOs bring to the overall HIV response. A unique combination of positive factors provides them with solid foundations to further expand their engagement. Such a package includes strong community ties due to longstanding relationships and commitment, fairly durable health infrastructure and systems in place.

A. Significant Findings that Emerged from this Survey:

1. The HIV programmes and services provided by the respondents cover a wide range of activities along the prevention and care continuum.

2. All the implementing organizations and the combined implementing/coordinating organizations are engaged in a wide range of prevention and treatment activities. 60% reported offering a package of at least eight services for people affected by HIV, including: HIV prevention education, counseling and testing for HIV, home-based care, programmes to reduce stigma and discrimination, tuberculosis case finding, and treatment, and local, national and international advocacy.

3. A total of 75% of respondents identified home-based care as their primary service. Over 50% reported being engaged in general HIV education and awareness within local communities. This was followed by the provision of ART, treatment for opportunistic infections, palliative care, counseling and testing, and advocacy work. 25% reported offering programmes that target and focus on the unique needs of HIV positive women.

4. The faith-based implementing organizations provide technical and financial support to local organizations and groups as well as direct implementation activities and service delivery. 50% of these organizations provide technical support for ART and indicated this activity as an essential area of strength and a priority in institutional capacity building.
5. Among the organizations that provided budget-related information, programmes for ART provision, care and support for orphans and vulnerable children and palliative care represented at least 50% of total budget allocations. The respondents with HIV programmes in Africa reported an even larger percentage of investment in support to HIV initiatives and services.

6. Figure 3 shows the range of HIV annual budgets of FBO national implementing organizations that responded to the survey. Programmes implemented in Africa have larger budgets to address the need for broader coverage and larger numbers of individuals eligible for ART. Many of these financial resources and percentages were reported as dependent on donor priorities and funding levels, and thus are subject to previously unplanned changes in available resources for activities that may be vital to efficient and effective service delivery, as well as to the overall quality of life and ultimate survival of the people receiving services.
B. “Snapshot” Information about a few respondent organizations:

1. The Mai Tam Centre works at the local community level and is located in the Catholic Archdiocese of Ho Chi Minh City, Viet Nam. It is supported by a mix of local and international donors, has a small number of clinics and centers, and serves people living with HIV, orphans and vulnerable children, people who inject drugs, and pregnant women. Its current operational costs are estimated at USD $700,000 annually, which are expended for delivery of HIV services, including ART for clients who are not covered by government programming. Despite community and government recognition of the contributions by the programme to the community, and a willingness and desire to expand coverage, the organization is constrained by the lack of additional funding.

2. The Grupo AAVE, a nonprofit NGO in Goiania, Brazil is supported by the local Catholic Archdiocese and the National Conference of Brazilian Bishops. It provides HIV services to people living with HIV in the Goainian community. Initially established as a home and hospital visitation organization, it has evolved into a home for people living with HIV. Its annual operational budget of USD $50,000 is not only
dedicated to housing and HIV prevention, but also to a holistic programme of social and skills-building services for people living with HIV.

3. The Catholic HIV/AIDS Services Incorporated in Papua New Guinea (PNG) provides HIV services through its vast national network of hospitals and health centers. Its Director is a permanent member of the Global Fund Country Coordinating Mechanism (CCM), a unique status for a representative from an FBO. The organization operates 24 ART sites in 2013 and invests 25% of its annual budget of USD $4 million to ART services and another 25% for PMTCT. Its PMTCT services are highly effective, and all its clinics offer Option B+ to all pregnant women.
4. In Malawi, the **Drug Resource Enhancement against AIDS and Malnutrition (DREAM)** has made significant contributions to the country’s HIV response. Since its establishment in 2004, DREAM Malawi has reached 58,000 people living with HIV who receive ART in six provinces. In 2013, the programme served 13,000 people living with HIV on ART, including 1,600 children. DREAM’s high-quality molecular biology laboratories serve a large number of government and non-government programmes by providing CD4 and viral load tests for their respective clients. In Malawi, DREAM has an annual budget of USD $2.2 million. Under the umbrella of the Italian-based Comunità di Sant’Egidio, DREAM programmes also have been established in nine other Eastern and Southern African countries.

C. **Reported challenges currently faced by FBOs as they attempt to scale up services**

Despite the wide variations among these above-mentioned organizations, they report having reached the maximum range and coverage of services, given the limitations in available funding. While UNAIDS is calling for FBOs to scale-up service provision to meet the targets of 2030, the funding cutbacks or flat-lined funding by most FBOs present serious challenges to achievement of expanded engagement.

Due to a decrease in PEPFAR support in Namibia, for example, Catholic AIDS Action found it necessary to close six of its regional offices that provided home-based care for almost 2,500 adults and support for over 3,000 orphans and other vulnerable children. The organization also had to change its strategy of home-
based care to home assessments and referrals to government services; however, government structures often are unable to meet the increased demand.

Other faith-related donors in fact, provide much funding for FBO activities in this field. Reported funding sources included Misereor (Germany), Trocaire (Ireland), Catholic Relief Services (USA), Episcopal Conferences in some regions, and other Catholic organizations in developed countries. On the other hand, it should be further noted that several of these faith-related donor organizations themselves receive bilateral support from the governments of countries in which they are headquartered. Thus the donor partners serve as intermediary channels for public support to which they add the private donations from the faithful people in their respective denominations.

About half of the respondents claimed to have successfully secured direct financial support, as implementing partners or sub-recipients, from GFATM and the US Government (44% and 43% respectively). 46% of the respondents mentioned unsuccessful approaches to GFATM through their country coordinating mechanisms (CCMs). Almost a third (27%) reported a lack of adequate information and understanding about the application processes.

The respondents mentioned little contact with multilateral organizations such as UNAIDS, the World Bank, and other UN organizations, in terms of resource mobilization. Only a fourth of the respondents had approached any of the UN organizations, and among those that did, only 8% reported a successful application for resources. The limited resource mobilization contacts with UNAIDS and multilateral organizations may be rooted largely in a lack of knowledge about opportunities for collaboration with UNAIDS, which is not a funding organization, or about available financial or technical support resources provided by other multi-lateral structures.
Another major challenge reported by the respondents involved the lack of access to a consistent supply of anti-retroviral medications (ARVs). Approximately one-half of the respondents reported such problems, particularly with regard to lack of available and child-friendly ARV formulations for children. Stockouts for adult ARVs were mentioned by one-third of the respondents.

Other relevant findings from the survey included the following:

**D. Networking and collaborative mechanisms among FBOs and others**

The respondent organizations implementing programmes at local and national levels maintain strong ties with structures that have similar mandates, foundational values, and mission. As shown in Figure 5, more than two-thirds of respondents reported being closely linked to local or national religious bodies and mechanisms and reported playing important roles for capacity building and experience sharing across different implementers and ensuring overall accountability in programme quality and expenditures. Local diocesan structures are particularly important for strengthening connections among implementers at the community level and for providing a way of channeling community perspectives.

Again, more than half of the respondents reported limited relationships with other FBOs engaged in the provision of services in their region. At a time when financial resources are stretched, there may be a strategic advantage to establish and maintain collaborative links among a wider range of FBOs engaged in HIV
programming. Sharing experiences, expertise, resources and advocacy strategies is critical to efficient use of limited resources.

As indicated in Figure 6, respondents reported the need for improvement in networking relationships with the UN organizations, in particular with UNAIDS and WHO. Less than one-fourth indicated that they enjoyed well-developed relationships with multilateral organizations. This indicates the need for mutual outreach in order to harness the comparative advantages that community-based organizations (including FBOs), as well as governmental and multi-lateral organizations bring to the HIV response. The extensive network of healthcare services and infrastructure operated by FBOs offers vast untapped opportunities to expand ART services. Since UNAIDS and WHO are critical stakeholders, linkages with these organizations can provide information and build capacity among FBOs with regard to current HIV policies, issues, and approaches to HIV prevention, treatment, and support. Moreover, the convening role of UNAIDS is essential in bringing to the table all stakeholders possessing skills, assets, experience, and outreach that can be tapped for expanding access to antiretroviral treatment.
E. What Comparative Advantages are offered by FBOs?

1. Broader networking facilitates contacts for increased funding and capacity building. Through their linkages and collaboration with mechanisms outside the religious sector, FBOs strengthen the impact of their contributions to HIV infection prevention and HIV treatment and care. In terms of collaboration with local, provincial, and national AIDS programmes, all respondents reported being linked with respective governmental HIV policies and programmes. In fact, a large majority (87%) of respondents described such relationships as well developed. Alignment with the national AIDS programmes and strategies provides opportunities for some of the respondents to assume significant roles either as direct implementing partners or sub-recipients in larger funding and/or technical assistance mechanisms. It also ensures that HIV prevention, treatment, and care services are in line with national guidelines, thus maintaining common standards of care within the community.

Two of the respondent organizations, Caritas Democratic Republic of Congo and Catholic HIV/AIDS Services Incorporated (CHASI) in Papua New Guinea, act as Principal Recipient and Sub-recipient respectively for GFATM supported national programmes. These opportunities provide strong evidence of the capacities of faith-based organizations to act as implementing partners on a national level and to conform to the standards of performance-based accounting systems.
Almost half of the respondents reported enjoying well-developed relationships with the CCMs in their respective countries. This current situation represents a significant evolution from the past when FBO work in HIV was perceived as isolated from national HIV strategies and programmes.

2. FBOs have strong health infrastructure systems; these often facilitate effective service outcomes and provide a necessary foundation for expansion. The quality of health services offered by FBOs is recognized both by the communities and by governments where they serve. Several organizations reported service provision to significant numbers of people living with or affected by HIV in the local populations, for example, 19% in Ho Chi Minh City and 50% in 5 surrounding districts; 50% in Nairobi; and 70% in Papua New Guinea.

In addition to noting the large numbers of people served by FBOs, respondents also reported significant levels of adherence to antiretroviral treatment. Nine organizations reported ART adherence between 70% and 95%. These impressive outcomes were traced to several reported strategies being implemented by FBOs, including adherence counseling and follow-up visits by community volunteers. The community volunteer system employed by most FBOs represents a vital component in their service delivery system. These volunteers systematically and personally monitor ART clients, offer continuing and updated HIV prevention education, and provide psychosocial and spiritual support, the latter of which completes the circle of holistic care for which FBO-delivered services are so well known. The personalized, community outreach and interaction also furnish timely, valuable, and first-hand feedback to the implementing organization with regard to the ART needs of people living with HIV.

This follow-up and monitoring system constitutes a critical “game changer”, especially in the context of low ART literacy in many of the communities where respondents reported that they were engaged. Ten respondent organizations indicated that treatment literacy is often weak and thus reported the need for consistent education on the consequences of non-adherence and medication-sharing.

Routine monitoring of patients on antiretroviral therapy is crucial for measuring programme success and accurate forecasting of medication supply needs. Almost 90% of the respondents reported using a cohort approach for monitoring ART adherence, as recommended by WHO. Although this is a labor-intensive approach, the organizations maintained
that personalized monitoring is highly effective to observe, not only adherence, but also drug resistance and risky sexual behavior.

CRS maintained that its impressive contributions to the national responses to HIV in the countries where it was engaged were due to the establishment and maintenance of professional systems, such as strategic information and supply chain management, and to the long-standing health care involvement of its programme partners on the ground. Other respondents, such as the Eastern Deanery AIDS Relief Programme, the Uganda Catholic Medical Bureau and the Catholic Health Association of India, also reported having established highly developed programme management systems and ongoing capacity building, or technical support, in order to adequately respond to community and national needs and to maintain the desired standards of quality.

V. Toward New and Expanding Partnerships – a Roadmap for Treatment Expansion

In their efforts to expand access to antiretroviral treatment services, FBOs have attained some exceptional results. They offer a significant contribution to achievement of national and global aims to end HIV as a public health threat. However, challenges remain, particularly since access to HIV services continues to be limited among the most vulnerable populations. A logical step to further accelerate this progress is to build on the assets of the health services and systems that FBOs already put in place.

The past and current performance of FBO-delivered health services clearly indicates the potential of this sector to more vigorously engage in the treatment expansion strategies developed by UNAIDS and other key stakeholders. FBOs could provide a tremendous boost to such initiatives by leveraging their unique contributions and roles in the community, strengthening their capacities, and increasing their participation in political and financing fora.

On the basis of evidence demonstrated through the survey and in-depth analysis of seven projects, the following specific actions are recommended:

• **Increase collaboration and working relationships between FBOs and the multilateral community.** Strategies to improve mutual understanding by the international community, especially by the United
Nations agencies and structures, of the role and contributions of the faith community at the national and local levels, can result in mutual benefits.

• **Explore opportunities for increased ecumenical and inter-faith collaboration**, especially to amplify advocacy for non-discriminatory and expanded access to services for people living with and affected by HIV.

• **Strengthen programme management capacities of FBOs**, particularly in management information systems and supply chain management, so that they will be better positioned as programme implementers and considered as appropriate partners of major financing mechanisms, such as the Global Fund and other bilateral donors. Upgrading management capacities may attract increased financial support.

• **Advocate for the participation of FBOs in the national CCMs and in other policy and decision-making structures related to national response efforts for HIV and other health challenges.** Given the broad coverage of their health care systems, FBOs should be considered as major stakeholders in national HIV programmes.

• **Promote closer coordination between religious and public health systems.** Linking faith community health systems with government-run health facilities at all levels may result in cost efficiencies and increased quality of care. Such linkages have the potential to maximize use and coverage of existing FBO health infrastructures, on one hand, and help infuse the public health system, on the other hand, with the values and quality-driven service outcomes of faith-delivered services.

• **Strengthen partnerships with networks or associations of people living with HIV.** These collaborations could broaden the reach of treatment literacy services and could complement the more personalized home and outreach visits.

• **Explore integration of two key services into the overall ART “package”: TB case management and treatment and care for children.** These services require similar staff competencies and clinical resources and expertise.

**VI. Conclusion**

The story of service and accompaniment of persons living with and affected by HIV and AIDS, offered by organizations that have religious roots, has been clearly demonstrated and articulated in this document. They give witness of
being exemplary, faith-based, and selfless; efficient, effective, and evidenced-based; loving, caring, and non-judgmental. The yet unrealized goal, however, is to more fully engage faith-based organizations in solidarity and partnership with multi-lateral organizations, governments, and wider civil society. By realizing this aim, both global and local communities will be able to bring a quicker end to HIV as a public health crisis and more effectively and efficiently achieve universal access to early diagnosis and treatment of HIV. Perhaps the best concluding challenge, therefore was given by Dr Luiz Loures, UNAIDS Deputy Executive Director for Programmes, at the consultation in Rome: "We are entering a new phase where we can see the beginning of the end of AIDS. The faith communities have the scale, and the means to move us forward. You care about the dignity of the person and it is only this unique combination of access to drugs and dignity that can provide the necessary drive to reach the end of the AIDS epidemic."

Faith-motivated initiatives could assess their efforts in this regard by their engagement in achieving the Road Map developed by the co-organizers (UNAIDS and Caritas Internationalis) and the participants in the Consultation on Expansion of HIV Treatment by FBOs, held in Rome, during February 2014:

- **Drugs, dignity and decentralization**
  - FBO service providers will promote a holistic approach to health care, by prioritizing access to services and provision of care to the most marginalized, remote and vulnerable populations, protecting service delivery, confidentiality, client and staff safety in situations of conflict and difficulty.

- **Data, document and disseminate**
  - UNAIDS will partner with faith-based partners to gather accurate data, through more systematic methods, document and disseminate and showcase good practice to support applications for funding.

- **Coordinate, collaborate and communicate**
  - UNAIDS will convene meetings at national and regional level between UNAIDS staff, churches, and other counterparts to discuss concrete areas for collaboration.

- **Community of practice**
  - Faith-based partners will convene ecumenical collaboration at national level to facilitate a broad partnership base for national Governments in the HIV response
  - UNAIDS will send quarterly updates/or hold webinars with FBO technical partners on key technical issues
In closing this study and reflection, we once again acknowledge the key stakeholder role of FBOs in working toward universal access to HIV diagnosis, treatment, and care for all persons in need.

Let us also keep in mind the message sent by Pope Francis to the six thousand participants in the Opening Session of the International AIDS Society’s Eighth Conference on HIV Pathogenesis, Treatment and Prevention, held during July 2015, in Vancouver, British Columbia, Canada. The Pope expressed his “esteem for the work and the dedication required” of the scientists, clinicians, and members of civil society engaged in the global AIDS response. He gave thanks for the lives saved by Highly Active Anti-Retroviral Treatment (HAART) and for the use of “Treatment as Prevention” and noted that such efforts “give witness to the possibilities for beneficial outcome when all sectors of society unite in common purpose.” Finally, he assured the participants of his prayers “that all advances in pharmacology, treatment, and research will be matched by a firm commitment to promote the integral development of each person as a beloved child of God.”

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32 Message of Pope Francis sent to participants in International AIDS Society Conference, July 2015, sent through Holy See Secretary of State, Cardinal Pietro Parolin, 05 June 2015.
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Ms. Ruth Foley, Ms. Sara Speicher, Ms. Sally Smith, and Rev. Msgr. Robert J. Vitillo, authors of Consultation Report Scaling-up the engagement of faith-based organizations in the implementation of the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive and scaling-up access to anti-retroviral treatment for HIV infection. Lusaka, Zambia. 2013


Mr. Ron Kamara, Coordinator of the AIDS Care and Treatment Programme of the Uganda Catholic Medical Bureau.


Dr. Samuel Mwenda, Director of the Christian Health Association of Kenya (CHAK).