HIV and Maternal Health

Faith groups' activities, contributions and impact

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Report prepared by Ann Smith, PhD and Jo Kaybryn, MSc

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http://www.jliflc.com

Contact:

Jean Duff, JLI F&LC Coordinator

jeanduff@partnershipforfaithanddevelopment.com

Foreword

Unlike other areas of query around faith and development intervention, when it comes to HIV and AIDS, and to some extent also maternal health, there is a wealth of research on faith-inspired engagement. Indeed this report alone has provided a significant reference material thereof. Some entries within this bibliography are themselves tomes and portals to a great deal of collated material. This report therefore, does not aim to provide the penultimate reflection or proof or evaluation of evidence for faith-based engagement. Indeed some these efforts have been undertaken and documented already in some of this reviewed literature.

The Joint Learning Initiative on Faith and Local Communities (JLI F&LC) brings together several schools of thought around human development and international aid. It is also a collation of diverse experiential narratives of service provision and community engagement. The strong common thread binding the various organizations partaking of this learning initiative is an interest in the nexus between faith and sustainable human development.

Many of those involved in the JLI F&LC themselves represent faith-based and/or faith-inspired development organizations, and most of the others are either partnering with faith communities around various development concerns, or have published academic and other forms of research on faith-related issues, or indeed, a combination of the above.

The interest of this particular Learning Hub on maternal health and HIV/AIDS, therefore, went beyond querying the 'why' of faith and development, and instead, queries specific aspects of the 'how'. The audience is intended to be as mixed as those who have partaken of this research – i.e. development practitioners, academic researchers, as well as interested policy-makers in both governmental and non-governmental fora.

In fact, this report is a unique attempt, by a diverse group of development practitioners and researchers, ***to review the available data on the nexus between faith, maternal health and HIV/AIDS development work, with specific and critical questions in mind.*** Questions which may seem obvious to some of the more 'secular' development mainstream, but which had yet to be asked of the faith-based development organizations, working in these two critical health areas.

The questions themselves reflect the common ground of practical, intellectual and policy interest, which emerged from among the diversity of the JLI F&LC's own composition and the Learning Hub Advisory Group set up to oversee the research outcomes .The report is framed along these questions, which include the feasibility of scaling up service provision; the degree of accountability of some of the programming; the extent to which the 'faith' aspect of an organization's identity may interfere or impact on the nature of the services offered; whether these critical health services are complimentary to those offered by governmental or other development actors; whether these two wide areas of health services were integrated at the field level…and many such.

A search was then undertaken by the JLI F&LC for experts to review available information with a view to seeking at least some preliminary answers to these queries. The search was for those with a unique combination of a legacy of related research and publications, as well as practical experience in development field work, in these two health areas.

Another unique feature of this report is the deliberate attempt to bring in the voices of some of the faith-based development practitioners themselves, to complement the existing publications, as well as seek out documents and analysis which, while compiled with some investment of time and effort, for various reasons, is not readily available in the public domain. Otherwise known as "grey literature".

There is a strong recognition that the complexity of the questions posed, as well as the extensive amount of knowledge yet to be harvested, requires much more detailed and in-depth research, preferably at the country level. Thus this report constitutes a first step, to scout, and provide a basic roadmap, of what is already available in terms of preliminary answers to these questions, gleaned from the first such attempt combining two significant health areas.

This report is a testament to the efforts of the selected authors to pool together, in short order, an impressive amount of data, of voices, and of analysis. It is also a testament of the will and commitment of various organizations and individuals, to

undertake a journey of joint learning, around a timely geo-political dynamic framing some critical human development efforts – the question of faith.

The Joint Learning Initiative on Faith and Local Communities team sees this report as a signpost pointing towards more nuanced research questions which would zero-in on different local contexts, more detailed features of maternal health and HIV/AIDS, and specific local faith community interventions. The last section of this Report indeed provides some of these, which now should constitute phase two of the JLI journey we are committed to undertaking.

We invite your comments and contributions to the ongoing work of gathering evidence for faith groups' activities and contributions in the area of HIV AIDS and Maternal Health.

The Joint Learning Inititiative on Faith and Local Communities team

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Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal care
ARHAP	The African Religious Health Assets Programme
ART	Antiretroviral therapy (see also HAART)
BCCI	Buhimba Child Care Initiative
CABSA	Christian AIDS Bureau for Southern Africa
CHAM	Christian Health Association of Malawi
CHAN	Catholic HIV and AIDS Network
CHART	Collaborative for HIV and AIDS, Religion and Theology
cPMTCT	Community-based PMTCT
CRS	Catholic Relief Service
DR Congo	Democratic Republic of Congo
EAA	Ecumenical Advocacy Alliance
FBO	Faith-based organisation
FP	Family planning
GNP+	Global Network of People Living with HIV and AIDS
HAART	Highly active antiretroviral therapy
HIV	Human Immunodeficiency Virus
INERELA+	International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS
LFC	Local faith community
LGBT	Lesbian, gay, bisexual, transgender
MCH	Mother and child health
MDG	Millennium Development Goal
MSM	Men who have sex with men
NEP+	Network of Networks of HIV Positives in Ethiopia
NEPHAK	Network of People Living with HIV/AIDS in Kenya
NGO	Non-governmental organisation
NZP+	Network of Zambian People Living with HIV/AIDS
PEP	Post-exposure prophylaxis
PMTCT	Prevention of Mother to Child Transmission (see also cPMTCT)
RH	Reproductive health
SACBC	Southern Africa Catholic Bishops Conference
SAVE	Safer practices, Access to treatment, Voluntary counselling and testing, Empowerment
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary counselling and testing
WFDD	World Faiths Development Dialogue
WHO	World Health Organisation

Acknowledgements

About the Authors

Ann Smith, PhD has worked in the HIV sector since 1984, first in laboratory-based postdoctoral research on HIV virology and serology, and thence into community-based work both in the UK and internationally. She has 18 years of experience in the HIV and faith-based sector, and until 2011, Ann led CAFOD's global strategy on HIV and AIDS and continues to provide consulting services to NGOs and FBOs.

Jo Kaybryn, MSc is a consultant with 13 years of experience in the HIV and faith-based sector. She has undertaken local, national and regional programmatic research into the involvement of faith communities in response to HIV, sexual and reproductive health, and violence against women, as commissioned by a range of international NGOs, UN agencies and government ministries.

About the Joint Learning Initiative on Faith and Local Communities

This report forms part of a broad programme, the Joint Learning Initiative on Faith and Local Communities (JLI F&LC) which aims to gather and communicate robust, practical evidence on the extensive, and yet under-documented, role of local faith communities (LFCs) in a wide range of development and humanitarian settings. Joint Learning Initiatives (JLI) bring together practitioners, academics, faith leaders, local community members and other stakeholders in a joint-learning approach organised around 'Learning Hubs', each of which has a particular sectoral focus. To date, the JLI on Faith and Local Communities has four Learning Hubs: Resilience in Humanitarian and Disaster Situations, Immunization, Capacity Building for Local Faith Communities, and one on HIV AIDS and Maternal Health, the focus of this report.

The JLI F&LC was formed in 2011, and initially funded in 2012, by a broad collaboration of international development organisations, UN agencies, academic institutions and religious bodies. This group was drawn together by a shared conviction: that there is an urgent need to more fully and effectively partner with the massive, under-used resources of local faith communities to tackle poverty and injustice all over the world, and that robust evidence for activities, and contributions of faith groups, as well as for effective collaborative models, is required by governments and NGOs in order to scale up successful, lasting partnerships.

The initiative is guided by a Steering Group, with day-to-day work supported by its Coordinator, Jean F Duff. Wider international stakeholders are drawn in, both as 'Friends of the JLI F&LC' and as working members of **'Learning Hub Advisory Groups'**.

The overarching goal of the JLI initiatives is to provide practitioners, policy makers and donors with robust evidence and actionable policy and programmatic recommendations which will, in turn, influence policy, praxis and funding decisions, improving the quality, effectiveness and impact of partnerships between LFCs and other development and humanitarian actors. Interested stakeholders work together in joint learning communities to explore the broad question: 'What is the influence and impact, both positive and negative, of Local Faith Communities on community mobilisation and systems?'. More specifically each Learning Hub asks:

- What do we already know—what evidence exists?
- How can we better communicate that evidence to policy makers and practitioners?
- What new research is required to fill key information gaps?

The JLI F&LC has received seed funded from a variety of partner organisations including: CAFOD, McKinsey, Christian Aid, The MacLellan Foundation, Tearfund, World Vision, Samaritan's Purse and UNFPA.

The focus area of the Learning Hub on HIV and Maternal Health is the examination of evidence for the activity and impact of Local Faith Communities on HIV and Maternal Health, with special attention to Prevention of Mother to Child Transmission of HIV (PMTCT) and to the use of skilled birth attendants.

About this Project

Overall Purpose

HIV & AIDS and Maternal Health were identified by the Joint Learning Initiative on Faith & Local Communities Steering Group as deserving of a dedicated learning hub for several reasons, paramount among which are the following:

- The direct relevance of these two issues to the evolving debates around the Millennium Development Goals and the sustainable development goals agendas beyond 2015.
- There is relative availability of existing literature and project writings which identify and indeed attempt to analyse the role and impact of faith-based engagement on these two health domains. Yet in spite of this, the contribution of faith communities to these two critical health areas and Millennium Development Goals, seems to remain largely unknown to international policy makers and organisational counterparts outside of the 'faith-based' realm of development work.
- The two areas (HIV & AIDS and maternal health) are clearly interlinked at the level of service provision, by the realities presented in vertical (parent-to-child) transmission of HIV; and the fact that most clinics and health services responding to people living with HIV within local communities, also deal with the health of young women, pregnant women and the welfare of the newborn.

The findings presented in this report are a first step in a broader trajectory of considerations for further targeted research and/or interventions, aimed at creating a common global platform of knowledge among diverse development actors, deepening the appreciation of specificities of faith-based or faith-inspired service provision; and strengthening related development cooperation efforts around these critical development goals.

Two key questions underpin the current project:

1. What are the contributions to and impact of the work of faith groups in relation to HIV & AIDS and maternal health?
2. What are the challenges to faith groups, at local, national and international levels, in delivering on HIV & AIDS and maternal health?

The work described in this report constitutes stage 1 of a two stage process described by the Terms of Reference agreed by the JLI Learning Hub members:

Stage 1 – mapping existing evidence – The survey aims to collate existing evidence about the range of services, activities and any impact assessments available, of the work of faith-based organisations and local faith communities, in the field of maternal health and HIV & AIDS - including but not limited to - prevention of mother to child transmission (PMTCT), and the training and provision of skilled Birth Attendants.

Stage 2 – setting an agenda for further research and/or programme interventions – This will be determined based on the gaps identified through the evidence mapping exercise, and will set the parameters for focused research to be commissioned to elaborate the contribution of Local Faith Communities in specific contexts.

Overview of the Report

This report has four main sections.

Section 1

Draws mainly on published literature and describes the complexity of issues encountered at the critical intersection point of HIV and maternal health. These set a broader paradigm for this area than is usually encountered, identifying key social, cultural and economic issues that become human rights concerns often lost sight of in more medically focused paradigms.

This section also sets out the rationale for, and a reminder of the history of, engagement of faith-inspired organisations in health care generally and more specifically in HIV and maternal health care.

Section 2

Presents a brief consideration of the benefits of engagement of faith-inspired organisations in responding to HIV, as documented in the literature reviewed and corroborated by responses from participants. It also outlines factors internal and external to faith inspired organisations that can act as barriers to their engagement.

Section 2 further provides a summary of the information received from respondents and that gleaned from publications with regard to the specific questions set by Learning Hub members. It points to evidence for faith-inspired organisations' engagement – or lack thereof– with each of the areas probed, along with examples that typify this engagement.

Section 3

Considers the opportunities and challenges for faith-inspired organisations as determined from the evidence presented in sections 1 and 2 and indicates areas that might particularly engage faith-inspired organisations to take action at the level of policies and practice.

Section 4

Presents the recommendations emerging from this study which the JLI Learning Hub are committed to endorsing

and promoting; These are grouped into those applying to faith-inspired organisations and their organising or overseeing bodies and those applying to the wider sector (governments, policy makers, funders, international agencies and other NGOs etc.). The recommendations also become the basis for identifying further research by JLI and its collaborators in this area.

This research recognises and is indebted to existing extensive research carried out especially by The African Religious Health Assets Programme (ARHAP), World Faiths Development Dialogue (WFDD) and The Collaborative for HIV and AIDS, Religion and Theology (CHART). It is concerned to avoid duplication and seeks to build on that reservoir, using it, along with other contributions collected in the course of the research, to focus more particularly on considerations of the role of faith-inspired organisations in HIV and maternal health.

The documents cited within the main text are listed in the bibliography that follows Section 4. A much fuller bibliography of relevant publications is compiled by CHART, who provided the most up-to-date version. This is cited in the bibliography, though space prevents a listing of all its data.

Finally, it should be noted that the authors have sought to ensure as far as possible that the facts, opinions and insights recorded are evidence-based and verifiable. Three means of validation inform the contents of the report:

a. Published sources of information are referenced against the relevant statements throughout the text
b. Opinions and facts contributed informally and for various reasons not always attributable, are validated by the authors through documenting repetition from various sources or similar cross-comparisons
c. The authors draw on their own considerable experiential knowledge of both HIV and faith sector engagement to support and expand on points validated through points a and b.

Process and Methodology

The two key questions above were pursued following a fairly standardised approach:

A literature survey of published and "grey material": Approximately 200 documents were collected, both through the research endeavours of the report authors and through the published and grey material provided by respondents to the request for information described in step 2 below. These comprised an eclectic mix of publications documenting the range, variety, impact and nature of faith responses to HIV, formal and informal reports from faith groups on some of their programme activities, academic research on various aspects of HIV, health (including maternal health) and faith-linked endeavours, conference papers and reports, and policy documents of governments and international agencies (UN and others). A separate document of extended bibliography, annexed to this report lists all documents received.

A request for further information and documentation, circulated to Learning Hub members and their networks, and to other relevant individuals and networks identified by the consultants. Eight specific questions had been agreed by Learning Hub members and these were modified by the consultants (Appendix 2) for ease of response and analysis. Questions sought input on the following considerations:

- HIV and maternal health activities, contributions and impacts of faith-based organisations (FBOs) and local faith communities (LFCs)
- Whether and how FBOs and LFCs address social determinants of health, and HIV related stigma
- How FBOs and LFCs reach the "most vulnerable"
- How FBOs and LFCs relate to other health services and wider health sector
- How FBOs and LFCs ensure accountability, sustainability and scaling up
- The challenges and barriers to effectiveness and how FBOs and LFCs overcome these

Twenty-one individuals (from 18 organisations) provided written responses to the questions set out in appendix 2. Some of these contributors did not have fuller documentation (grey or published) of their work and their response to the questions provided valuable additional information.

In depth interviews with 10 people: selected Learning Hub Action Group members and others identified by the consultants. Key informants were selected on the basis of implementing faith-based responses to HIV and maternal health or because of their engagement with faith-based organisations. An attempt was made to seek key informants with experience of differing geographical regions. This was achieved with respect to East, West and Southern Africa, South and Southeast Asia. Participation from Latin America, North Africa, Central Asia, the Middle East and the Pacific sub-regions was not achieved. Key informants were also selected in order to obtain a broad range of faith perspectives and this was achieved to the extent that organisations from Christian denominations and Islam participated, and interfaith organisations which work with Buddhist, Christian, Hindu, Muslim, Indian spirituality and indigenous faiths participated. (Appendix 3 lists respondents to the request for information and those contributing to the structured interviews).

Brief Observations on the Methodology

The methodology chosen was that deemed most effective in achieving, within the time and funding constraints specified, the mapping and review required in stage 1 while offering some pointers to an agenda for further research and programme interventions that will be explored more fully in stage 2.

A methodology based on a literature review examining, for the most part, published material or lengthy formal reports held by respondents along with structured questions circulated electronically, limited the extent to which contributions from local faith communities could be gathered directly. The authors recognise this as a limitation of the work presented in these pages. It will be important to give in-depth consideration to processes that more effectively gather the experiences and insights of local faith communities in stage 2. This raises questions as to what constitutes evidence, in real life, how this should be collected and by whom.

One final consideration that is important to include is that this piece of research was intentionally time-limited in order to achieve a snap-shot to use as a starting point for defining the future research and action agenda of the Joint Learning Initiative Learning Hub. The research, including literature review and key informant interviews took approximately 24 working days during October and November 2012. As a rapid assessment rather than a comprehensive study, its findings are indicative rather than definitive. It was a unique opportunity to begin to explore the world of integrated Maternal Health and HIV through the faith-based lens.

The authors and learning hub members recognise that there is more - literature –both grey and published- in existence than is included in this review and that the process was not able to reach more than a few voices of local faith communities at this stage. At the same time, because of the composition of the JLI membership, the researchers were able to access information through some of the best-placed resource people working on these issue based within some of the world's largest development organisations, and straddling both secular and faith-based experience. Although the lack of (financial and time) resources is a key factor any in-depth research and evidence gathering process, this endeavour was made possible precisely because of the increasing interest of both faith-based and secular practitioners to mainstream FBO work into development.

The importance and challenge of mapping faith – based development activity

The JLI operates from the belief that it is not only desirable but necessary to identify and map the activity of faith communities in relation to maternal health and HIV. Such information constitutes valuable evidence for a variety of stakeholders, including the faith communities themselves, governments, donors, and policy-makers. It extends our knowledge-base and promotes informed analysis. Documenting the types and extent of such engagement not only provides knowledge of 'who does what, where'. It also, by implication, indicates where there appear to be gaps in types of activity (i.e., 'what is not being done').

However, some caution is required when interpreting the available data. It would be wholly unrealistic to assume that the enormous scale of faith involvement in HIV and maternal health has been adequately captured in the literature. The JLI can uncover many but not all gaps in faith- related activities. Gaps in evidence in relation to certain parts of the globe, or in relation to certain faith communities, or in relation to certain sorts of activity, should not necessarily be taken to indicate that there is no faith engagement in this area. The research conducted for this report appears to indicate a wide distribution of faith activity across the globe by all the major faiths, though some geographical areas appear to be more extensively mapped than others.

An important future task will be to attend to these gaps in the evidence-base to better understand whether such lacunae are due to a lack of evidence, or due to an underlying lack of activity. Are there failures adequately to record what is happening on the ground, or does the lack of evidence reflect the fact that there is little or nothing happening on the ground?

Julie Clague, Learning Hub Member and Moral Theologian, University of Glasgow

Executive Summary

This report forms part of an overarching programme, the *Joint Learning Initiative on Faith and Local Communities* which aims to develop robust, practical evidence on the extensive, and yet thus far under-documented, role of local faith communities (LFCs) in a wide range of development and humanitarian settings.

The JLI's **HIV and Maternal Health Learning Hub** aims to examine evidence for the activity and impact of Local Faith Communities on HIV and Maternal Health. The findings presented in this report are a first step in a broader trajectory of considerations for further targeted research and/or interventions. The research was underpinned by two key questions:

1. What are the contributions to and impact of the work of faith groups in relation to HIV & AIDS and maternal health?
2. What are the challenges to faith groups, at local, national and international levels, in delivering on HIV & AIDS and maternal health?

The research included a literature review of approximately 200 published and "grey" documents, which included documents received in response to a request for further information and documentation to Learning Hub members and relevant individuals and networks. Eight specific questions had been agreed by Learning Hub members and these were modified by the consultants for ease of response and analysis and distributed with the request for information. Twenty-one individuals (from 18 organisations) provided written responses to the questions. In depth interviews were conducted with ten people selected interviewees -Learning Hub Action Group members and others identified by the consultants. The review including literature review and key informant interviews took approximately 24 working days during October and November 2012.

This report has four main sections.

Section 1: Draws mainly on published literature and describes the complexity of issues encountered at the critical intersection point of HIV and maternal health. These set a broader paradigm for this area than is usually encountered, identifying key social, cultural and economic issues that become human rights concerns often lost sight of in more medically focused paradigms.

This section also sets out the rationale for, and a reminder of the history of, engagement of faith-inspired organisations in health care generally and more specifically in HIV and maternal health care.

Section 2: Presents a brief consideration of the benefits of engagement of faith-inspired organisations in responding to HIV, as documented in the literature reviewed and corroborated by responses from participants. It also outlines factors internal and external to faith inspired organisations that can act as barriers to their engagement. Section 2 further provides a summary of the information received from respondents and that gleaned from publications with regard to the specific questions set by Learning Hub members. It points to evidence for faith-inspired organisations' engagement – or lack thereof– with each of the areas probed, along with examples that typify this engagement

Section 3: Considers the opportunities and challenges for faith-inspired organisations as determined from the evidence presented in sections 1 and 2 and indicates areas that might particularly engage faith-inspired organisations to take action at the level of policies and practice.

Section 4: Presents the recommendations emerging from this study that the JLI Learning Hub are committed to endorsing and promoting; These are grouped into those applying to faith-inspired organisations and their organising or overseeing bodies and those applying to the wider sector (governments, policy makers, funders, international agencies and other NGOs etc.). The recommendations also become the basis for identifying further research by JLI and its collaborators in this area.

1. Setting the Scene

Faith-inspired institutions and initiatives are diverse in their size, forms, structures, outreach and sense of identity. Faith groups often have extensive reach and access throughout many countries, through the services and infrastructure they provide, although estimates of the extent of faith-related involvement in health care vary considerably. Estimates of the degree of involvement of faith-based organisations (FBOs) with HIV (and maternal health) likewise vary. Despite the challenges and flaws in conflated aggregated data sources, it is the case that FBOs are significant actors in health care provision generally and HIV-related services more particularly, in many parts of Africa and in resource-poor countries in other continents.

There is an increasing mutual recognition of the need for constructive engagement between and by faith-based and secular organisations.

More recently, there has been a growing international focus on the responses of faith-based organisations, driven by factors of effectiveness and efficiency. As the recognition increases both of the importance of religion to individual and community decision-making, and the possibility of assets held by religious entities being leveraged in a context of limited resources, the role of FBOs should not be considered in isolation from that of the wider community-based engagement with HIV which in its turn must be set within the overall multi-sectoral response.

There is a resonance between FBO values and rights-based responses to HIV. Tackling the complex social determinants of health requires a global response. Human rights are foundational to human health. This is why a rights-based response to such global health challenges is required. Faith communities can exert powerful leverage to reduce vulnerability to ill-health, since the major world religions express a commitment to respecting the dignity of every person, regardless of age, gender, sexual identity, ethnicity, social position, or political affiliation. Areas of convergence exist, therefore, between the core values informing faith-based and rights-based responses to HIV and there may also be areas for mutual learning.

HIV has thrown the spotlight, over the past 30 years, on violations of a wide range of basic human rights. People continue to face many forms of HIV-related stigma, discrimination and exclusion based on their actual or presumed HIV status. Some elements of rights-based approaches to health are controversial for some faith-based perspectives but the fact remains, that on most questions connecting HIV and maternal health, faith communities of all persuasions, and the many and varied secular agencies share a common purpose in saving lives, promoting health and human flourishing for all.

The relationship between HIV and maternal health was brought into more prominent focus with its recognition in 2001 (at the UNGASS meeting) with a call for a 50% reduction in vertical (mother to child or parent to child) transmission by 2010. At the UNGASS 2011 meeting world leaders launched and ratified their commitment to the Global Plan towards the Elimination of New HIV Infections among Children by 2015 and Keeping Their Mothers Alive. Its goal is to move towards eliminating new HIV infections among children and keeping their mothers alive.

The currently piloted World Health Organisation (WHO) policy Option B+ "a new, third option proposes further evolution—not only providing the same triple antiretrovtal (ARV) drugs to all HIV-infected pregnant women beginning in the antenatal clinic setting but also continuing this therapy for all of these women for life. Important advantages of Option B+ include: further simplification of regimen and service delivery and harmonization with antiretroviral therapy (ART) programmes, protection against mother-to-child transmission in future pregnancies, a continuing prevention benefit against sexual transmission to serodiscordant partners, and avoiding stopping and starting of ARV drugs. While these benefits need to be evaluated in programme settings, and systems and support requirements need careful consideration, this is an appropriate time for countries to start assessing their situation and experience to make optimal programmatic choices."[1] WHO is still assessing this as an option and plans to issue new guidelines for general rollout in 2013. Option B+ proposes to extend the provided triple ART to all pregnant women living with HIV, not just during antenatal care (ANC) but for the rest of their lives, regardless of the CD4 count. The basis for this approach has been challenged by some groups on a number of counts including costing arguments used, concerns about lack of informed consent and subsequent risks of stigmatisation, and the increased risks of resistant strains of HIV, with consequent implications for personal and public health. WHO is currently conducting consultation with a range of partners including women living with HIV to address these concerns and to draw up guidelines on ART treatment and Option B+.

A number of contextual factors are most likely combining at this juncture in the HIV pandemic, to drive what might be termed a "re-medicalisation" of HIV and AIDS. Politically, and at a time of enormous economic constraints and pressures to show results, keeping babies free of HIV becomes not only a hugely laudable aspiration but also a more immediate and tangible outcome that fulfils short-term targets at the risk of de-prioritising the long-term health needs and entitlements of their mothers. Practically, as well, a one-off intervention that produces effective and measureable results is very appealing.

Initially omitted from these overly medicalised and top-down approaches to maternal health and HIV was solid evidence of the influence or even the voice of women living with HIV. Women living with HIV and civil society

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[1]

http://www.who.int/hiv/pub/mtct/programmatic_update2012/en

representatives are now involved in national responses to varying degrees in all 22 focus countries (Smith S. 2012). Missing also was the recognition of the serious social, political, cultural and economic considerations that prevent women accessing HIV and maternal health services including and not limited to:

• Stigmatisation and discrimination
• Abandonment, abuse, violence
• Lack of male involvement
• Poverty and economic dependence
• Access in rural or remote areas
• Cultural influences
• Failure to integrate services
• Meaningful Participation of women living with HIV
• Violence against women *within* health service provision (coerced or even forced sterilisation and being tested for HIV without informed consent or confidentiality

Currently work is beginning around these often-omitted issues (Smith S. 2012). There is a clearly a need for effective programming that requires a variety of initiatives reaching beyond the narrowly medical, and beyond acute-care institutional settings to longer term, sustainable community-based engagement. This agenda can and should engage FBOs responding to HIV and maternal health.

2: Findings from the Research

The following paragraphs present a summary of the findings from the review of published and grey literature, along with those reported by respondents to the request for information and the insights provided in interviews. After considering the benefits and barriers of faith based organisations engaging with HIV, the findings corresponding to the eight questions set by learning Hub members are grouped under the remaining subheadings of this section.

A considerable number of examples of faith-based programmes, and in some cases of training resources and working tools, are given in each of the subheadings. Significantly, the majority of these are documented in grey material only, and thus less easily accessible and less well known across the research and practitioner sectors more generally.

Benefits and Barriers

The numerous benefits and barriers of FBO s need to be honestly acknowledged while cautioning against the risks of reinforcing stereotypes or polarisation. The social capital of FBOs is a strong feature of the benefits, and the advocacy role of FBOs sits alongside that of service provision. FBOs have a transformational role within their own faiths, both through theological discourse and internal advocacy and accountability processes. Respondents to requests for information noted mostly external barriers such as lack of funding, with a smaller number acknowledging some of the internal barriers. An important observation from one interviewee was that despite the significant investment in HIV and maternal health, the contribution of FBOs was not unique compared to secular responses

The benefits identified include: moral motivation and shared values among faith groups; preferential service to the poorest sectors; holistic perspectives; providing pastoral and spiritual care; sustainability of community responses; cultural awareness and relevance; a greater sense of trust and acceptance by communities; infrastructure assets; strong national and international networks; highly committed network of staff and volunteers; facilitation of community mobilisation; women – particularly in rural areas – may have their only form of non-kin association through membership in a faith community; well-placed to gather accurate data over prolonged time periods; religious leaders are numerous, even in remote areas, are well placed to influence both locally and nationally and at family and community levels; and religious leaders and communities can be pivotal in tackling stigma and discrimination.

Identified barriers that are internal to FBOs include: poor documentation of faith-based initiatives especially at local community level; non-conformity by some to the norms of public health strategies and prevention messages that focus on sexuality with uneven effectiveness; slowness to work collaboratively; suspicion regarding the agenda of secular actors; lack of coordination within their own networks; judgmental attitudes of some religious leaders and communities can increase stigma and discrimination; some religious attitudes to sexuality and marriage can be underpinned by a rigid judgmentalism, or an endorsement of power and gender inequality in relationships; teachings and beliefs of some religious traditions (both actual and perceived or misrepresented) on sexuality and on gender may serve as further barriers; harmful gender norms and practices which reinforce cultural isolation of women; religious leadership that is primarily hierarchical and male

can prove to be a barrier; prioritisation of aligned faith tradition in recruitment of senior post-holders rather than expertise in the key requirements of the post; reluctance to engage with some key HIV-affected populations; FBOs can be guilty of interfaith competition, suspicion and misconceptions; historic association between missionary activity and colonialism, especially with Christianity; and a tendency among some FBOs to use programmes as a means to proselytise,

External barriers identified include: the work of FBOs is often little known; poor literacy among donors regarding FBOs and among FBOs regarding donors; heightened emphasis on the need to prove value for money means that the less tangible assets, characteristic of FBO activities, are less attractive as they are harder to measure; potentially different targets between secular agencies and FBOs; preconceptions, prejudices and stereotyping of FBOs; development agencies' desire to maintain the boundaries of Faith/State relations; reduction of funding by multi-lateral and bi-lateral donors.

Range of Services

Published mapping of FBO responses is incomplete, yet shows significant engagement. A strikingly stronger response is recorded for Asia than Africa, reflecting differing capacities or traditions regarding publishing work. Most initiatives are community-based, though stronger than expected proportions are also involved in institutional formal services, mostly health care. Responses are widely diverse, spanning prevention, home-based care, advocacy, treatment, care for children, PMTCT, training of faith leaders and congregations. The scale of initiatives ranges from multi-country (e.g. international networks of religious congregations surveyed reaching circa 40 million with education) to localised one-to-one. Of materials cited, only four are published while 13 are grey material i.e. reports sent by respondents or self-published on their websites. With one exception, all descriptions of training resources came in grey material.

Integration of Services: Maternal Health

There is scant mapping published of the engagement of FBOs in maternal health. Respondents most often cited PMTCT as their programme response to maternal health and HIV. There is little indication of how this specifically addresses the needs of mothers, as the emphasis is more often on unborn or new born babies. A number of respondents train traditional birth attendants. Publications

show these are an important first contact and point of referral for mothers, and that they are only effective if integrated into formal health systems, signalling an important role for FBOs especially in building collaborative linkages to other health care systems.

Other initiatives listed included voluntary counselling and testing (VCT), antenatal screening, mobile patrols to reach rural areas, family planning, ART provision, condom provision, prevention, community PMTCT (cPMTCT) and positive prevention, and training of faith leaders, volunteers, midwives and traditional birth attendants. Initiatives to provide economic opportunity for women, or address intimate partner violence, or give nutritional support to new mothers or pregnant women, were each mentioned just once. One programme stressed the importance of involving men. FBOs reported high awareness of the UNAIDS Global Plan but low involvement or consultation. Roughly 75% of programme information was reported through grey material. A variety of training resources were reported, again in grey material received.

Holistic Approaches to HIV

The publications reviewed, indicate that FBO responses to HIV are holistic, addressing livelihoods, nutrition, stigma, gender equity, psychosocial and spiritual support, and advocacy concerns alongside health needs. Few of the respondents gave examples of holistic responses in their programmes. Additionally, Just two resources were named, one as a training resource and another as mapping tools for and client monitoring of holistic responses in care and prevention

Trends in strategies of international funders and agencies appear to focus more on the medical aspects of HIV, provided in the main from institutional settings, making it more difficult for community-based and more holistically focused initiatives to secure funding.

Reducing HIV-related stigma

Experiences abound both of faith-based groups driving stigma and discrimination and of faith-based initiatives to denounce and remove stigma. The role of faith leaders in addressing stigma is critical, and within these, that of faith leaders living with or affected by HIV who openly identify as such. International FBOs have an important role in raising their voices to condemn stigma and in supporting initiatives to tackle stigmatising attitudes and actions. Local and international FBOs need to address stigma, both within the local communities where they work and within the health, educational, livelihoods and worshipping

services provided by faith entities. A number of transformational (experiential), community-rooted initiatives undertaken by FBOs were reported, most of these documented in grey literature received.

Reaching the Most Vulnerable

Women and the poorest feature prominently in FBO responses while the literature reviewed gave little evidence of outreach to youth and adolescents. The teachings of all major faiths urge preferential attention to the poorest and the most vulnerable, without discrimination or judgment. The teachings or their interpretation can challenge the role of FBOs in working with some key populations e.g. sex workers, men who have sex with men (MSM) and with regard to gender equality. A few programme examples (all grey material or from interviewees) were given of programme responses to key populations, including sex workers and people who use drugs. Some described outreach, support, prevention and advocacy, others reach out to proselytise. Many FBOs define their programmes as broader community-based and not targeted at any specific vulnerable group, unless these fall within the broad base. People living with or affected by HIV were identified as more vulnerable and examples of their involvement in programme planning cited (GIPA). Respondents indicated the importance of having the support of programme decision-makers e.g. trustees, faith leaders etc. FBOS have a local and national advocacy role for and with more vulnerable groups.

Complementarity with Wider Health Services

FBOs reported their adherence to national guidelines, particularly those of National AIDS Programmes, PMTCT and child health guidelines, thus ensuring their integration. A number of respondents gave examples of work to strengthen health systems and Ministry of Health guidelines, and numerous examples of integrating HIV into broader health services existing locally. Vertical programmes need not undermine the broader health system when they make effective referrals, provide peer support and outreach services not otherwise supplied. Vertical and horizontal FBO programmes making few referrals, having limited capacity and low quality, or are discriminatory are of limited effectiveness.

Accountability of Health Services

FBOs' ability to hold national governments and international agencies to account is strengthened through membership of national FBO networks, relevant NGO networks and activist groups and as signatories of international agreements. FBOs accountability regarding their programme standards and practices is monitored through (usually voluntary) subscription to internationally agreed codes of practice and programme standards and through obligatory monitoring and evaluation requirements of donors. Results-based financing can strengthen some FBOs wishing to provide more comprehensive services. Others will choose to maintain the status quo.

Respondents made little reference to community-based monitoring of FBO programmes or of governments or secular NGO initiatives. Gaps between secular and faith-based responses can sometimes be caused by a mutual suspicion, which is a result of a lack of mutual accountability. FBOs need to show the same degree of compliance and regulation conditions as other secular health responses are required to meet.

Sustainability and Ability to Scale Up

Respondents provided little information on sustainability and what information was provided reflected the diverse interpretations of sustainability including in the contexts of impact, organisational capacity, funding, and more. Lack of funding was cited most often as the obstacle to scale up. The concept of scale-up needs to be further explored to take account of the diversity of situations and opportunities of faith based and other community based initiatives. Scale-up may not always be about getting bigger but about effective replication i.e. scaling out.

Volunteerism, Mobilising Communities and Resources

Significant numbers of volunteers are mobilised by faith-based organisations, although estimations of numbers are often difficult to ascertain. Organisations can rely heavily on volunteers which reduces operational costs. Quantifying the contributions of volunteers in monetary terms can be difficult, and FBOs do not seem to routinely calculate or include the contribution of volunteers in the costs of programmes submitted to donors or their efforts to show impact or value for money. However, a lack of professional and paid staff can mean that FBOs increasingly rely on the volunteers to meet organisational capacity

demands (e.g. for monitoring and evaluation) for which they are sometimes less suited. Increasing data collection demands of donors can overburden volunteers or divert them away from their core work, with consequent risks of losing them to the programme.

3. Opportunities and Challenges

Many FBOs have the experience, reach and capacity to engage actively with the particular area of HIV and maternal health.

Evidence gathered for this report provides numerous examples of FBO experience and competency in all of areas listed by Maryse as enablers of community-based initiatives (Maryse, et al., 2012). Attempts to map, and calls for increased mapping of FBO responses are not without tensions. What is often classed as FBOs being poor at documentation may for some be more indicative of a historical lack of trust or alignment with national evaluation and information systems. Tensions also exist around attempts to classify FBOs in typologies dictated by form, function and religiosity (the degree to which an organisation is regarded as religious).

The opportunity and urgency of presenting women's and children's rights as inextricably linked

The review found evidence of failures to include human rights considerations for women in PMTCT and maternal health initiatives). A challenge for all actors including FBOs is to extend the discourse around sexual and reproductive health to address violations of women's human rights such as those described in Section 1 as an opportunity and responsibility compatible with their core values yet needing to be articulated in human rights rather than moralistic terms.

The voices of women, particularly women living with HIV, seemed subdued within the literature surveyed for this research. FBOs are often well placed to ensure women's voices and perspectives are heard, at all levels of decision making, but should also ensure that they inform their own responses and that their own responses are modelling this inclusion.

The strengths and responsibilities of being community based

Among the benefits regularly attributed to FBOs are their reach – often providing the sole or main health and development services in rural or more remote areas-, the fact that they are often community based rather than solely operating from institutions and their longevity within communities. A number of practical implications present:

Prime evidence base. FBOs are in a privileged position to be able to garner information on attitudes, events, concerns and achievements of communities, locally and nationally. Evidence gathered in this report indicates that data collection is often a weak point of locally based FBOs, whether because of lack of skills and experience, or lack of adequate resources. That said, it is important to give detailed consideration to the whole area of data collection, what sort of data should be collected, how and by whom, are key challenges. The dangers of diverting the energies and considerable resources of community initiatives, often reliant on large numbers of volunteers, away from their core work into heavily administrative data collection, should not be under-estimated.

Accountability. This follows as a natural consequence of the last point. Communities are the ultimate arbiters with regard to governments' and agencies' fulfilment of commitments, strategies and programme plans. Community-based monitoring and accountability processes are gaining momentum and have been employed to good effect by various organisations. FBOs are well placed, although not always with the requisite skills, to implement participatory processes and facilitate community engagement with accountability processes.

Follow-up. A barrier to effective HIV and maternal health services identified by respondents can be the loss to follow-up of mothers and their new-born children, beyond the immediate post-partum checks. FBOs are therefore well placed to bridge this gap and to establish and support innovative community based initiatives that provide effective long-term maternal and child health support.

Influence. Religious leaders wield considerable influence both within the communities they serve and also with decision-makers at local and national (and sometimes international) levels. FBOs similarly enjoy considerable influence within communities because of the trust they enjoy and a perceived shared set of values and beliefs. This research affirms that such influence is used to improve knowledge, understanding, attitudes and practices, to denounce stigma and discrimination and to address

injustices. It has also been used on occasions to provide misinformation and to increase the stigma and isolation of people living with or affected by HIV.

Community mobilisation. Faith-based initiatives are effective in eliciting community involvement, whether as volunteers involved in implementing programmes or as lobbying and advocacy groups. In the context of HIV and maternal health, volunteers can make a significant contribution to programme effectiveness through peer support, care, mentoring, livelihoods skills-sharing and much more. They can also be effective in monitoring situations, documenting stories, articulating concerns and making referrals.

The benefits of and need for holistic responses

A holistic response enables FBOs to take a more coordinated and thorough approach, breaking down their own or others' silo mentalities, and addressing the social determinants of health as well as health service needs. A number of faith-based organisations have recorded the effectiveness of their ability to integrate their approaches within the wider health service provision, particularly at local or district level and also at national level. Beyond providing health services, many faith-based organisations address the social determinants of HIV vulnerability and impact as these affect maternal health. This is particularly so for FBOs engaged in various aspects of community health and wider development. FBOs can develop holistic models of response to HIV and maternal health, addressing four domains of health, psycho-social-spiritual support, human rights and economic/livelihoods security. FBOs can give an enhanced understanding to the "value for money" discourse that currently is too often reduced to measuring immediate, tangible productivity against unit of money invested.

The importance of identifying impact

The literature collected and the information from respondents all are rich in examples of FBO activity, yet often lack evidence of effectiveness. Recent tendencies among international agencies and development experts to promote "theory of change" processes may be of particular value to FBOs. Used effectively, theory of change is an on-going and organic process that helps groups to ask "what change can happen/has happened and how do our initiatives affect this?" In the context of HIV and maternal health it may be a valuable process for FBOs that do not already do so, to identify exactly who they are

targeting with their initiatives (and how women feature in this), what change is hoped for and how their particular initiatives contribute to that change.

4. Recommendations

The numerous issues emerging in previous sections give rise to a diverse range of recommendations. These can be summarised under two strands, that affecting programme practice and that affecting the research agenda of those engaging with the area of FBOs, HIV and maternal health.

The following paragraphs outline the main recommendations for each of these strands. Section 4 of this paper sets these out in greater detail, along with supplementary recommendations, and groups them as they apply to FBOs (local or international), researchers, national governments, international agencies and donors.

Programme Practice

In initiatives responding to HIV and maternal health, FBOs, with the support of national governments, international agencies, donors and researchers as relevant, can:

- Develop a fuller and more effective mapping of their involvement in HIV and maternal health ensuring this is Included in government mapping, planning and budgeting.
- Apply mapping and data collection tools that document holistic rather than narrowly medical responses and gather qualitative along with quantitative evidence
- Put the wellbeing of mothers with HIV on a par with that of their babies in PMTCT and similar programmes
- Articulate and address the social, economic, gender, cultural and legislative issues that affect women's ability to access maternal health services
- Audit and challenge stigma or discrimination experienced by women with HIV who access maternal health or sexual and reproductive health services, both within services provided by FBOs and within other locally available services
- Revise their processes to ensure the voices of women living with HIV inform their strategies and practices
- Train Faith Leaders and programme personnel in HIV knowledge and in human rights
- Ensure Faith Leaders name and denounce stigma affecting women with HIV, whether within faith structures or wider health and social services
- Develop initiatives that bridge maternal health support from acute services into community settings
- Develop long-term holistic, community-based initiatives modelled on four domains governing maternal wellbeing as alternatives to medical, top-down, acute intervention strategies
- Identify more effectively specific target groups and how programmes reach/affect these
- Identify the specific changes sought and how each programme contributes to these

Research

Academic and other researchers, working in collaboration with FBOs, governments, international agencies and donors, and with appropriate support and resources, can:

- Identify toolsets and processes to document community-based qualitative experiences and how these also demonstrate impact
- Identify mapping and data collection tools that cover four domains of a holistic response
- Explore and document the synergy between core values of faith and rights-based approaches.
- Identify effective initiatives bridging maternal health support from acute to community setting
- identify processes that combine institutional acute-phase and longer-term community-based services and prove effective alternatives to top-down medical models
- Develop toolsets and processes to document the social assets of FBO initiatives, including their volunteer base, and demonstrate their added impact and value for money
- Identify links between FBOs, social capital and resilience-building capacities of communities
- Identify and promote diverse approaches to scale-up

1. Setting the Scene

Introduction

After establishing the terms related to faith entities that will be used in this report, this section goes on to consider the three pivotal points that together form the framework within which a meaningful response by faith groups to HIV and maternal health must be situated. These are:

a. A recognition of the importance of religion in community structures worldwide and the significant involvement of faith groups in health care as well as social service provision.
b. A resonance between values underpinning faith entities and the rights-based approaches driving HIV and maternal health responses
c. A recognition of the complex medical, social, economic and political issues raised by HIV and maternal health and their relevance to faith groups.

Faith–Inspired Entities: Questions of Definition and Terminology

Faith-inspired institutions and initiatives are diverse in their size, forms, structures, outreach and sense of identity. In its strategic framework for partnership with faith based organisations, UNAIDS describes three main levels (UNAIDS, 2009) in the way faith-inspired institutions operate:

1. Informal social groups or local faith communities; for example: Local women's groups or youth groups.
2. Formal worshipping communities with an organised hierarchy and leadership
3. Independent faith-influenced non-governmental organisations (NGOs); for example: Islamic Relief and Tearfund. These also include faith-linked networks such as the Ecumenical Advocacy Alliance, Caritas Internationalis, World Conference of Religions for Peace, and the International Network of Religious Leaders Living with HIV (INERELA+).

All three are important and all three are usually interlinked in faith-inspired responses to HIV. It is important to consider these three levels as forming an inextricable continuum, rather than as distinct entities, for all that each will have their own distinctive and often complementary characteristics. Faith-inspired NGOs will usually be well placed to articulate a programmatic approach, to represent this within the wider sector nationally and internationally and to secure funding, and technical support and ideological endorsement from that wider sector. Faith-inspired NGOs will almost always work through formal worshipping communities (or their structures) who in turn mobilise, or are mobilised by, informal social groups, to develop together effective, skilled and locally relevant responses. In many instances the initiative will start with informal groups or with a local nucleus of a formal worshipping community and as they take shape the initiatives involve wider sections of all three levels. All three levels are required for effective responses.

> "Faith-inspired NGOs almost always work through formal worshipping communities who in turn mobilise, or are mobilised by, informal social groups, to develop together effective, skilled and locally relevant responses."

Given this interplay it is not always feasible or indeed desirable to neatly identify an initiative as being exclusively that of a local faith community or of a faith-inspired NGO. Rather a more nuanced approach that identifies the collaborative and complementary contribution of each may prove more beneficial. The scope and limitations of the present report do not allow for such nuanced distinctions to be drawn other than by citing examples of programme practice that are attributed to either a local faith community or to a faith-inspired NGO.

The language used to describe faith entities and their initiatives is also fraught with difficulty. A myriad of terms exist, including faith-linked organisations, faith-inspired organisations, faith-based organisations, religious entities, spiritual organisations and more. Even using just one of these terms belies the complexity attached to faith community identities and responses. It is not always useful or possible to describe what a typical faith community response should be. As Rodriguez-Garcia et al state: "The richness of the community response may very well be in its multiple combinations and its variety - its uniqueness in the community's cultural and geographic context." (Rodriguez-Garcia, 2011) However, these authors also note that at the same time, for policy-makers, some systematisation and simplification is necessary in order to suggest broad tendencies, and identify the strengths and potential weaknesses of existing responses. (See Olivier and Wodon, 2012 for a fuller discussion of this topic).

The present report will normally use the terms "faith-based organisations" (FBOs) to refer to an organisation that is inspired or motivated by one or more faiths irrespective of whichever of the three UNAIDS-defined levels is involved.

FBO Involvement in Healthcare and in HIV-Related Initiatives

Faith leaders and FBOs enjoy possibly unrivalled trust and acceptance within many societies. This can often be attributed to their proven track record of commitment to community service and wellbeing, the degree of influence they can have within and on behalf of communities, and their provision of quality social, health, educational and livelihoods support services that together enhance the human flourishing of the communities in which they are present.   Faith groups often have extensive reach and access throughout many countries, through the services and infrastructure they provide.

Estimates of the extent of faith-related involvement in health care vary considerably. The African Religious Health

Assets Programme (ARHAP) research noted the wide variation in reports of this involvement, indicating that in Africa, FBO contributions to healthcare were reported to range from 2% in Mali to around 30% in Uganda and Zambia at country level, with even higher percentages in rural areas and up to 70% in some rural areas of Zambia (Schmid, et al., 2008) (ARHAP, 2006).

> ## "WHO reported that one in every five HIV responses is faith-related."

Research undertaken for the Tony Blair Faith Foundation estimated there were around 100,000 FBOs working on health in Africa (TBFF, 2012). These were most numerous and played a larger part in East and Southern Africa, and were predominantly Christian, although Islam and other faiths were also recorded and, the report acknowledges, are probably undercounted. In a 2007 report on faith based models for improving maternal health, authors Sarla Chand and Jacqui Patterson collated data on the contribution of Christian Health Networks to total health care in a number of African countries, as illustrated in the graph below (Chand, et al., 2007).

> Religion is a key element of community organisation and social structures worldwide. Seventy percent of the world's people identify themselves as members of a faith community. Their faith shapes their perceptions of themselves and of others. It conditions how they respond to their neighbours. It affects how they interact with people living with HIV – the majority of whom are themselves members of a faith community.
>
> (EAA, 2006)

Estimates of the degree of involvement of FBOs with HIV likewise vary. The World Health Organisation (WHO) reported that one in every five HIV responses is faith-related (WHO, 2006). The Vatican reported that Catholic Church organisations provided 25% of HIV care programmes worldwide (Barragán, 2006). A survey of 77 FBOs involved in health care, undertaken by a coalition of international FBOs, showed that 42 came from Africa (10 from West and

Central Africa, 14 from East Africa, 18 from Southern Africa), 17 from Asia, 9 from Europe, 4 from North America and one from South America (Coalition, 2005). The Berkley Centre for Religion, Peace and World Affairs reported that HIV-related faith-based initiatives covered a wide range of services embracing many aspects of care, prevention and advocacy. Around 14% of the total FBO HIV responses were involved in prevention of mother to child transmission of HIV (PMTCT) (Keough, et al., 2007).

The accuracy of some of these estimates has been disputed. Olivier and Wodon detailed weaknesses in oft-cited claims that FBOs provide between 30-70% of health care in Africa (Olivier, et al., 2011). They maintain that often conflicting and disparate indicators are frequently aggregated together. They give four main reasons why some estimates are problematic. Firstly, most estimates are based on data for a few Eastern and Southern African countries where Christian Health Associations or Networks are strong, and then extrapolated to apply to the whole of Africa. Other areas, particularly the Sahel region, where there are lower levels of faith-based health care provision, are under-represented, thus making overall estimates artificially high. Secondly, data sources to back up these estimates are often lacking or poorly documented. Thirdly, there are problems when estimates for particular indicators are used for broader claims (e.g. estimates of hospital beds used as an estimate of all health care provision) and with classifications of some services as faith-inspired or not e.g. health facilities are often co-owned by FBOs and governments. Fourthly, existing estimates are based on fragmentary administrative data and do not take account of stronger systematically gathered data such as nationally representative household survey data.

Even so, it is the case that FBOs are significant actors in health care provision generally and HIV-related services more particularly, in many parts of Africa and in resource-poor countries in other continents. Funding considerations also support this. The Global Fund 2010 report showed that 44 FBOs were principal recipients in the latest round (Round 9 in 2009) in 22 countries as compared with 11 FBOs in 11 countries in 2006. FBOs receive 5% of total funds which, while not changed since 2006, is 5% of a larger pot and with more competition for funds. 77% of active Global Fund Country Coordinating Mechanisms have at least one FBO member (Global Fund, 2010). In 2010, ten of the largest organisations in the Catholic HIV and AIDS Network (CHAN) reported that they had collectively channelled US$241,244,145 to HIV and AIDS activities in low and middle income countries worldwide (CHAN, 2012).

> "More recently, there has been a growing international focus on the responses of faith-based organisations, driven by factors of effectiveness and efficiency."

Importantly recognition of the role of faith-based organisations is increasingly constructive rather than confrontational (Green, 2003; UNFPA, 2004; Tearfund, 2006) . This reflects a willingness of secular organisations, including governments, donors and NGOs, to engage with faith-based organisations despite, or even because of, the potential challenges (Haddad, et al., 2008). It also reflects an increased recognition by faith institutions that they have sometimes been part of the problem (SECAM, 2002; Smith, et al., 2003). Religious leaders have acknowledged that HIV affects them personally.   An example of this is the formation of INERELA+, the International Network of Religious Leaders (both lay and ordained, women and men) Living With or Personally Affected by HIV.

More recently, there has been a growing international focus on the responses of faith-based organisations, driven by factors of effectiveness and efficiency. The failure of existing systems to deal effectively with HIV, coupled with the need to find more capacity within the system, but

Contribution of Christian Health Networks in Selected African Countries
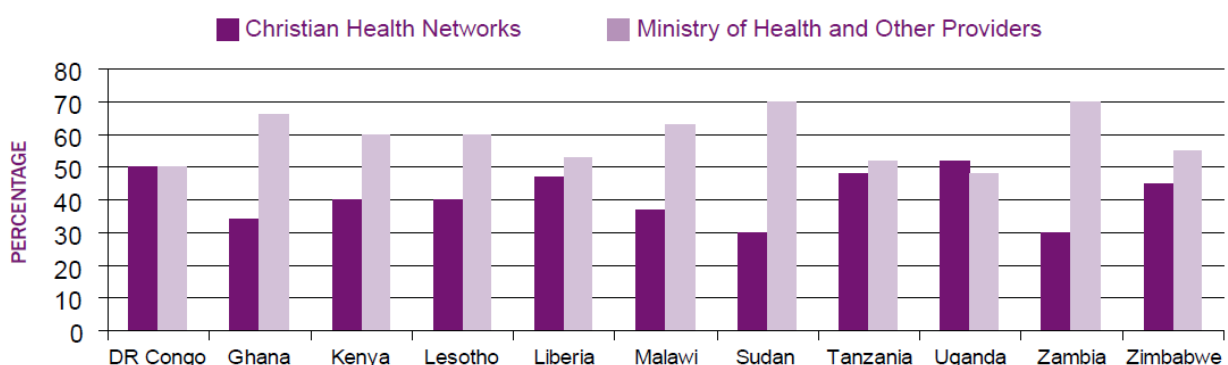
Reproduced from Chand S and Patterson J, Faith-Based Models for Improving Maternal and Newborn Health, USAID, 2007

without costing more, has highlighted the need to look more widely for answers. This is set in the current light of global spending cuts and the 30th anniversary of the discovery of HIV, thus drawing attention to the need for significant progress in prevention, treatment, care and support. In a time of austerity, talk of value-for-money has become an increasingly important part of the dialogue on HIV.

The UNGASS meeting in June 2011 expressed serious concern that the global financial crisis continues to have a negative impact on the HIV response at all levels. At the same time, Heads of State and governments welcomed the leadership and commitment shown by faith-based organisations, naming them as one of the key actors (UNAIDS, 2011). In recent years, many activists and practitioners have worked to create a space for dialogue and understanding to bridge the gap between secular and faith institutions working on parallel trajectories (Marshall, et al., 2007). However, some report that "religionophobia" still exists, in the form of suspicion, doubt and negative perceptions of religions and their involvement in health service provision, (Cochrane, 2008) (Marshall, 2009) and is evident in a number of areas of HIV-related initiatives.

Two reasons emerge to explain a renewed interest in the involvement of FBOs in HIV-related initiatives (Olivier, 2011):

1. A recognition of the importance of religion to individual and community behaviours and decision-making, arguing for strategies that are cognisant of that, coming after the failure of many initiatives found to be culturally inappropriate and a belated realisation of the importance of religion to the lives of most people affected by HIV (Benn, 2002).
2. The possibility of assets held by religious entities being leveraged through partnership in a context of limited resources and economic austerity (Haddad, et al., 2008)

The role of FBOs cannot be considered in isolation from that of the wider community-based engagement with HIV which in its turn must be set within the overall multi-sectoral response. FBOs are not a group set apart, exclusive or excluded, self-contained and remote. FBOs cannot claim privilege because of their identity, nor should this automatically penalise them (Karpf, 2012). Rather they need to be seen and to see themselves as essential contributors to this multi-sectoral response, integrated within the whole. Maryse et al describe the enablers essential for community involvement in maternal health provision, all of which apply to FBOs and in the context of HIV and maternal health (Maryse, et al., 2012):

Policies: comprehensive policy framework and clarity of roles and tasks, continuity, consistency and coordination in policy development and implementation, decentralization in existing community structure;

Multi-stakeholder coordination and involvement: strong community ownership and involvement, government coordination, NGO, bilateral and private sector involvement and alignment and provider consultation;

Training and education: standardisation of curriculum, fit for purpose, pre-service training with in-service support and continuous education;

Recruitment and retention: community involvement in selection, clear criteria for community based provider's profile, incentives and motivation packages, recognition (i.e. awards), career opportunities;

Enabling environment: political commitment, sufficient supplies and adequate working conditions (including workload), teamwork and supervision, quality assurance mechanisms;

Community data collection and analysis to strengthen services

FBOs may claim their spiritual and pastoral reservoirs and their commitment to the long-term wellbeing of individuals and entire communities, as additional enablers.

Resonance Between FBO Values and Rights-Based Responses to HIV

The continuing tragedies of HIV infection, and maternal morbidity and mortality are world-wide phenomena and major social, as well as medical, challenges. Tackling the complex social determinants of health, requires a global response to the injustice and inequity of poverty and marginalisation, of gender-based discrimination and violence, of stigma, prejudice and discrimination, and the many other social factors that make people more vulnerable to life threatening infections including HIV. Human rights are foundational to human health. This is why a rights-based response to such global health challenges is required.

HIV and maternal health raise issues of human rights. Women's rights and

> babies' rights are inextricably linked. Happy, healthy and safe women mean happy, healthy and safe babies.
>
> A member of the International community of Women living with HIV (ICW)

The faith communities can exert powerful leverage to reduce vulnerability to ill-health, since the major world religions express a commitment to respecting the dignity of every person, regardless of age, gender, sexual identity, ethnicity, social position, or political affiliation. Religions also promote a commitment to solidarity with all and most particularly with the poorest, those marginalised or stigmatised, those deprived of voice, liberty or status, and a commitment to seeking justice for all. This is especially the case because religions emphasise the unique value of each human being but also regard persons as inextricably connected to one another in a web of relationships and wider community ties that make each of us responsible for the wellbeing of one another. Faith community responses to HIV and maternal ill-health are broadly community-based-rights-informed responses, motivated by recognition of our common humanity and a strong sense of social responsibility.

Areas of convergence exist, therefore, between the core values informing faith-based and rights-based responses to HIV (Kaybryn, et al., 2011) and there may also be areas for mutual learning. For instance, the community-centred approach of faith groups can act as a corrective to some distorted understandings of human rights that view them in selfishly individualistic or antagonistic terms. At the same time, rights-based interventions – such as those promoting equality – can help combat behaviours and practices that perpetuate social inequalities and harmful practices based, for example, on some interpretations of religion, certain aspects of culture or ritual.

HIV has thrown the spotlight, over the past 30 years, on violations of a wide range of basic human rights. Violations of human rights – especially violence against women and the denial of women's human rights, and discrimination against and exclusion of minority groups (whether on the basis of race, nationality, ethnicity, social status, health status, sexual orientation, disability or other characteristics or disparities) – are known to increase vulnerability to HIV infection and prevent access to care and treatment, and are major drivers of the pandemic.

People continue to face many forms of HIV-related stigma, discrimination and exclusion based on their actual or presumed HIV status, undermining their human dignity and human rights, and the efforts of governments to strengthen health systems and deliver greater access to prevention, care and treatment services for people with HIV. Legislation to criminalise HIV transmission or sexual identity likewise increases people's vulnerability to HIV transmission and its impacts, and their inability to access care and support, and to ensure their economic security and overall wellbeing. It also can lead to physical or sexual violence and even murder as in the case of many individuals who have been targeted because of their HIV status and/or their sexual orientation. Of recent note, David Kato was murdered in Uganda in 2011 because of his activism to defend the human rights of gay, lesbian, bisexual and transgender people (Rice, 2011).

"Areas of convergence exist between the core values informing faith-based and rights-based responses to HIV."

Recognition of the centrality of human rights issues to effective HIV programming has grown slowly yet steadily. The first UN General Assembly Special Session (UNGASS) on HIV, held in June 2001, recognised this and wrought a commitment from member governments to address human rights issues set out in its Declaration of Commitment (UNGASS, 2001). This was endorsed more emphatically in the UNGASS 2006 Declaration, *"As the epidemic has evolved, the lessons learned from it confirm that the protection of human rights in the context of HIV reduces suffering, saves lives, protects the public health and provides for an effective response to HIV...The full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV and AIDS pandemic"* (United Nations, 2006). It was further endorsed in the 2011 Declaration (United Nations, 2011).

One of the priorities of the UNAIDS 2011-2015 Strategy, "Getting to Zero" is Zero Discrimination – through advancing human rights and gender equality for the HIV response (UNAIDS, 2010).

The Zero Discrimination strategy prioritises the following goals[2]:

• Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half
• HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions
• HIV-specific needs of women and girls are addressed by at least half of all national HIV responses

These goals will not find wide acceptance among all faith actors because, especially when it comes to sex work and homosexuality, may be at odds with religious norms. This is an area in need of continual dialog so that policy and program interventions complement rather than conflict with religious approaches.

The 2011 report of the UN Special Rapporteur on the Right to Health highlights the interactions between criminal laws and legal restrictions relating to sexual and reproductive health and the right to health (United Nations, 2011). The report notes the discriminatory nature of many criminal and legal restrictions applied to service provision related to pregnancy, contraception and family planning, and the provision of sexual and reproductive education and information, which violate the right to health through restricting access to quality goods, services and information, and infringe human dignity in respect of decision-making and bodily integrity. "By Choice, Not by Chance" -the 2012 State of World Population report of UNFPA - also focuses on a rights-based approach to sexual and reproductive health (UNFPA, 2012).

Some elements of rights-based approaches to health are controversial. Some considerations of reproductive health rights are highly contentious and a major cause of disagreement and dispute. It would be far too simplistic, however, to characterise such rights-based disagreements as an irreconcilable clash of values between secular and religious world-views. On certain reproductive health issues – such as family planning and child spacing, for instance - the faith communities do not speak with one voice. It is clear that much more work and continuing dialogue need to take place between secular and religious actors on issues such as reproductive health. The fact remains, however, that on most questions connecting HIV and maternal health, faith communities of all persuasions, and

the many and varied secular agencies, share a common purpose in saving lives, promoting health and human flourishing for all.

This very cursory consideration of some of the core values of major faiths and of the human rights issues posed both by HIV and by sexual and reproductive health, suggests there is considerable resonance between values-based and rights-based approaches. Whilst differences remain it signals the potential for collaborative endeavour in place of polarised opposition. A more in-depth analysis of the key principles related to the HIV response, within the theology and ethical teachings of major religions and in the rights-based approach, is required in order to identify the synergies and intersections between these.

The Intersection of Maternal Health and HIV and its Relevance to FBOs

The relationship between HIV and maternal health was brought into more prominent focus with its recognition at the UN General Assembly Special Session on AIDS (UNGASS) 2001 with a call for a 50% reduction in vertical (mother to child or parent to child) transmission by 2010. UNAIDS reported significant progress towards this, with a fall of 43% since 2003, but considerable challenges remain (UNAIDS, 2012). A Lancet publication in 2010 stressed the importance of focusing on HIV as a leading factor in maternal deaths particularly in countries or areas where HIV prevalence is highest (Foreman, et al., 2010). In this context, Millennium Development Goal 5 (to improve maternal health by reducing maternal mortality and achieving universal access to reproductive health services) and Goal 6 (to have halted and begun to reverse the spread of HIV by 2015 and to provide universal access to treatment by 2010) are inextricably linked.

While much effort has been invested and progress is reported in addressing the intersection between these two goals, the focus all too often is excessively narrow and fails to reflect the complexities of maternal health and HIV-related issues for women who are also mothers. Issues tend to be addressed from a predominantly medical model, within a concentrated time frame (usually that of pregnancy, birth and immediately after birth) and without sufficient acknowledgement of the social, cultural, economic, political and legal issues that wield enormous influence. Services are also too often set up in parallel silos,

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[2] It is worth noting that some FBOs remain wary of both the wording and content of some of these goals

as one respondent commented, "the HIV treatment clinic is at one end of the hospital and the sexual health service at the opposite end".[3]

Discourses on maternal health are frequently reduced to maternal mortality, defined by WHO as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes" (Gaul, et al., 2011). WHO defines maternal health in similarly constricted terms: "Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period" (WHO, 2012). Such definitions, while an essential starting point for effective strategies, shape paradigms for the maternal health narrative for organisations at all levels including FBOs that risk excluding efforts to address issues beyond the medical and the immediate.

"PMTCT initiatives often focus narrowly on provision of antiretroviral treatment to protect the unborn and newborn baby."

HIV-related initiatives to address maternal health tend to focus mainly on prevention of vertical or mother to child transmission (PMTCT) and on safer childbirths, often through addressing issues of resources and skills of healthcare staff or traditional birth attendants. PMTCT initiatives often focus narrowly on provision of antiretroviral treatment to protect the unborn and newborn baby, just one of the four pillars defined by the UN as essential with consequent failures to reach the targets agreed locally and nationally (ITPC, 2012). The complementary and essential other three pillars are preventing HIV among women of reproductive age (pillar 1) meeting the unmet family planning needs for women with HIV (pillar 2) and HIV treatment and care for women living with HIV and their families (pillar 4).

At the High Level Meeting on AIDS in 2011 world leaders launched and ratified their commitment to PMTCT through "The Global Plan towards the Elimination of New HIV

Infections among Children by 2015 and Keeping Their Mothers Alive" (UNAIDS, 2011). Its goal is to move towards eliminating new HIV infections among children and keeping their mothers alive. This plan focuses on reaching pregnant women living with HIV and their children — from the time of pregnancy until the mother stops breastfeeding. Prior to pregnancy, and after breastfeeding ends, HIV prevention and treatment needs of mothers and children should be met within the existing continuum of comprehensive programmes to provide HIV prevention, treatment, care and support for all who need it.

Two Global Targets are outlined in the Plan: Global Target 1: Reduce the number of new childhood HIV infections by 90%. Global Target 2: Reduce the number of HIV-related maternal deaths by 50%.

In order to ensure that these Global Targets are met, the Global Plan outlines six key conditions:

- All women, especially pregnant women, have access to quality life-saving HIV prevention and treatment services—for themselves and their children.
- The rights of women living with HIV are respected and women, families and communities are empowered to fully engage in ensuring their own health and, especially, the health of their children.
- Adequate resources—human and financial—are available from both national and international sources in a timely and predictable manner while acknowledging that success is a shared responsibility.
- HIV, maternal health, newborn and child health and family planning programmes work together, deliver quality results and lead to improved health outcomes.
- Communities, in particular women living with HIV, are enabled and empowered to support women and their families to access the HIV prevention, treatment, care and support that they need.
- National and global leaders act in concert to support country-driven efforts and are held accountable for delivering results.

There is much to applaud in the commitment underpinning the Global Plan and it has galvanized high level political and intensified programmatic action around this critical goal over the last year. A number of concerns have been expressed by communities however (Chitembo, et al., 2012). Among these are the absence of any mention of HIV testing being voluntary or of informed consent (the words "voluntary" "confidential" and "informed consent" are not used at any point in the document), the dominance of a definite top-down approach premised on a medical/public health model, and a sensethat the main concern is the elimination of new infections among children..

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[3] Source: interview for this research with a woman living with HIV (name withheld), 2012.

Nevertheless, there has since been progress in including communities such as GNP+ and ICW in inter-agency teams, such as Inter-Agency Task Team on EMTCT, which has helped to ensure the concerns (such as forced sterilization which continues to be a challenge) are recognized and addressed through rights-based approaches. Morever, there are two targets in the Global Plan, one being a maternal health indicator (50% reduction in HIV-related maternal mortality). Arriving at this target, as UN experts on HIV/AIDS note, was a huge gain in PMTCT/EMTCT.

Another global target to reduce new HIV infections in among children by 90%, requires preventing HIV in women, and rights-based prevention of unintended pregnancies, both of which benefit women.

In April 2012 WHO published of its Option B+ currently being piloted in selected countries (WHO, 2012). Option B+ "a new, third option proposes further evolution—not only providing the same triple ARV drugs to all HIV-infected pregnant women beginning in the antenatal clinic setting but also continuing this therapy for all of these women for life. Important advantages of Option B+ include: further simplification of regimen and service delivery and harmonization with ART programmes, protection against mother-to-child transmission in future pregnancies, a continuing prevention benefit against sexual transmission to serodiscordant partners, and avoiding stopping and starting of ARV drugs. While these benefits need to be evaluated in programme settings, and systems and support requirements need careful consideration, this is an appropriate time for countries to start assessing their situation and experience to make optimal programmatic choices."[4] WHO is still assessing this as an option and plans to issue new guidelines for general rollout in 2013. Option B+ proposes to extend the provided triple antiretroviral therapy (ART) to all pregnant women living with HIV, not just during antenatal care (ANC) but for the rest of their lives, regardless of the CD4 count (until now used as a marker to decide when individuals with HIV should commence ART) of the women. This is proposed because of a perceived shortage and expense of CD4 counters, and as a public health measure and a means of protecting the baby, the mother and her sexual partner. This approach has been challenged by some communities on a number of counts, including the low cost of CD4 counters in reality, and the increased risks of resistant strains of HIV, with consequent implications for personal and public health

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[4] http://www.who.int/hiv/pub/mtct/programmatic_update2012/en

(Welbourn, 2012; Chitembo, et al., 2012). A uniform approach also challenges the rights of women to decide when and how they commence long term treatment for themselves (UNAIDSb, 2012). WHO is currently conducting consultations with a range of partners including women living with HIV to address these concerns and to draw up guidelines on ART treatment and Option B+ (Smith, 2012).

The Every Woman, Every Child Initiative launched by UN Secretary General Ban Ki-moon at the UN Millennium Development Goals (MDG) Summit in September 2010, places equal emphasis on the health of women and of their children as essentially interlinked and crucial to ensuring progress in all of the other MDGs. It seeks to mobilise and intensify international and national action by governments, multilaterals, the private sector and civil society to address the major health challenges facing women and children around the world. The effort puts into action the Global Strategy for Women's and Children's Health – a roadmap on how to enhance financing, strengthen policy and improve service on the ground for the most vulnerable women and children (Ki-moon, 2010). This strategy underlines the importance, not only of providing health care to women and children but also, of removing the social, economic and cultural barriers preventing women from accessing these services.

A number of contextual factors are most likely combining at this juncture in the HIV pandemic, to drive what might be termed a "re-medicalisation" of HIV and AIDS, i.e. one where a heavily medical/clinical model shaped by health professionals and policy-makers prevails and which fails to take account of key complex social, cultural and economic considerations. Such contextual factors include what many refer to as "AIDS fatigue" among governments and international agencies, a sense that it is time to move on. Scientific advances together with an escalated effort to provide universal access to care, prevention and treatment in recent years may unwittingly fuel the view that "if we can make science happen, we can end AIDS".

Politically, and at a time of enormous economic constraints and pressures to show results, keeping babies free of HIV becomes not only a hugely laudable aspiration but also a more immediate and tangible outcome that fulfils short-term targets. One-off interventions that produce effective and measureable results, are highly attractive to organisations and service providers (Karpf, 2012). In the context of "AIDS fatigue" however, an important consideration is for new initiatives that produce robust results which are important to rekindle interest and funding in times of financial hardship. These should also serve to strengthen the case for sustained, rather than one-off interventions, and for making the long-term health of

HIV+ mothers co-equal with and essential to that of their babies.

Traditionally maternal and child health service provision in both state run and FBO managed facilities have been overly medicalised and top-down. The HIV epidemic has been characterised by a different way of working, including the involvement of people living with HIV in advocacy, demand creation and service provision. Although overlooked at the outset, the Global Plan has provided a platform in more recent months for inclusion of the voice of women living with HIV. Women living with HIV and civil society representatives are now involved in national responses to varying degrees in all 22 focus countries (Smith, 2012).

Missing too in traditional approaches to maternal and child health and in over-medicalised models of service provision is the recognition of the serious social, political, cultural and economic considerations that prevent women accessing HIV and maternal health services and that therefore must be taken into account in any effective engagement at that intersection point of HIV and maternal health (Chitembo, et al., 2012; GCWA, 2012; UNAIDSb, 2012). More recent efforts have sought to redress this imbalance (Smith, 2012). Issues include:

Stigmatisation and discrimination by communities, families and even health care staff of women living with HIV, prevents them from accessing services. Fear of stigma prevents others from seeking to know their status. Women living with HIV wishing to have children are further stigmatised and judged guilty of spreading the infection. Where legislation has criminalised HIV this becomes an added deterrent and cause of fear (UNAIDSb, 2012). Many women report a fear of discussing the need for PMTCT with their husbands/partners.

Abandonment, abuse, violence. Fear of these, or their actual occurrence, along with blame by partners, other family members and the local community prevent women from accessing HIV and maternal health services.

Lack of male involvement or support for their partner accessing HIV and maternal health services is a strong deterrent.

Poverty and economic dependence on men and/or wider family members prevent many women from accessing services, because of the costs of some treatments, tests or even transportation. This is particularly true for women in rural communities, where economic dependence is usually stronger. Other evidence indicates a significant link between poverty and nutrition, citing lack of nutritional

support for pregnant women and new mothers as a significant barrier to them accessing and benefiting from services (CHAN, 2012; Hardee, et al., 2012). By contrast, it is noteworthy that PMTCT initiatives regularly provide infant formula feed as an alternative to breastfeeding, once again indicating a focus mainly on the baby's health.

Access in rural or remote areas is difficult as too often services are located within urban settings or localised services are inadequately staffed to cope with demands or staff lack the required skills. Again economic dependence is a barrier, often combined with cultural constraints. Also, for various reasons, and particularly in rural settings, anecdotal evidence suggests many women are lost to on-going services or follow-up provision (CHAN, 2012).

Cultural influences can make women's health a low priority or require women to seek their partners' permission to travel, seek medical help or sexual health advice (CHAN, 2012). They may also dictate different behavioural expectations for women and for men and can increase the stigmatisation of women known to have HIV or women, especially young women seeking to access services for issues of sexual and reproductive health. Early marriages and child marriages, dictated as the norm in many cultures, also affect women's vulnerability and inability to access services (Hardee, et al., 2012).

Failure to integrate services. Location of HIV and sexual health services in different places is common and requires extra travel costs, extra time.

Meaningful Participation of women living with HIV is essential, and a central plank of the global plan. Yet, women identified the lack of their meaningful involvement as a barrier to the effective implementation of prevention of vertical transmission programmes. This was noted at all levels, from the development of plans and programmes, to the implementation and monitoring and evaluation. While some women reported having been asked to participate and asked for their recommendations, they noted that there remained a gap in terms of their recommendations being truly listened to and acted upon.

Violence against women *within* **health service provision** Additionally, women with HIV who were pregnant reported being **coerced or even forced into being sterilised** (see "Robbed of Choice" video testimonies from with women living with HIV[5]) (Kasiva, 2012) and being **tested for HIV**

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[5] http://www.youtube.com/watch?v=TObwGI5xFfI

without informed consent or confidentiality (APN+, 2012; Gatsi-Mallet, et al., 2012).

There is clearly a need for effective programming that requires a variety of initiatives reaching beyond the narrowly medical, and beyond acute-care institutional settings to longer term, sustainable community-based engagement. This agenda can and should engage FBOs responding to HIV and maternal health.

Observations and Key considerations

- Faith leaders are well placed to exert considerable influence within local communities and with national and international policy-makers

- FBOs play a significant role in health care provision and HIV-related initiatives, particularly in Southern and East Africa, but also in parts of Asia and much of Latin America, as evidenced by mapping (albeit incomplete and with some data that is contested) and funding evidence

- There is considerable resonance between FBO core values and rights-based programming and this signals the potential for collaborative endeavours rather than polarised opposition

- Maternal health services focus too narrowly on the short term of pregnancy childbirth and immediate post-partum period. Implementation of PMTCT initiatives of national governments or international agencies is concerned primarily with provision of ART and preventing infection of babies

- The wellbeing of mothers and the voice of pregnant women with HIV seem secondary, and the serious social, political, cultural and economic considerations that prevent women accessing HIV and maternal health services get scant acknowledgement

- There is evidence of stigmatisation and violation of human rights of women with HIV attending antenatal clinics or ART services

- There is need for a variety of initiatives reaching beyond the immediate, the narrowly medical, to longer term, sustainable community-based engagement. This indicates an agenda that can and should engage FBOs responding to HIV and maternal health and challenge those FBOs providing services to examine their own models of service delivery.

2. Findings from the Research

Introduction

This section reports on the points emerging from the literature review, request for information and structured interviews (steps 1, 2 and 3 of the research process). Some of the findings illustrate the benefits of FBO involvement in responding to HIV and by implication to HIV and maternal health, and also the factors that can present barriers to such involvement.

The points gathered are also set out as they apply to each of the key questions set down in the terms of reference for this project by Learning Hub members. The information under each question gives an indication of the profile of responses received in the request for information along with illustrative examples of some programme responses. It is important to stipulate that while these examples supply numerous illustrations of the range and diversity of FBO initiatives it is beyond the scope of the present project to assess the quality of the work described or of training materials and similar resources cited. They are illustrative and as such bring a valuable indication in practical terms of the degree of involvement of FBOs in responding to the many challenges posed by HIV. A database has been compiled to give more detailed information for some of the key questions, found in the literature surveyed. (This is available as a separate document annexed to this report).

Benefits and Barriers

Numerous reports coincide in identifying both the many benefits brought by FBOs and points that can prove barriers to their effective engagement with HIV generally (Bandy, et al., 2008; Keough, et al., 2007; Gaul, et al., 2011; CHAN, 2012; Kaybryn, 2010; RaD, 2011; Courtney, 2011; Vitillo, 2007). All of these would apply equally to considering FBO engagement with HIV and maternal health and some are particularly pertinent in this area of work.

Several authors have cautioned against tendencies to list benefits and barriers, for a number of reasons. Such lists are often unreferenced, difficult to track and rarely tied to any apparent systematic evidence base, thus stereotyped representations are given more power (Olivier, et al., 2011). They can be used to defend any position regarding the HIV response of FBOs (Olivier, 2010). Treichler points out that while HIV and AIDS are complex cultural phenomenon that produces diversity and contradiction, dominant meanings also emerge – default meanings that can be expressed with little fear of being challenged (Treichler, 1992). In the literature addressing the religious response to HIV and AIDS, the dominant ideas around the comparative advantage tend to be in direct opposition with equally powerful dominant themes about comparative disadvantage, and researchers and policy-makers are left to negotiate these opposing views (Olivier, et al., 2011).

Mindful of these cautions, it is nonetheless helpful in the context of the present report to note the benefits and barriers that have been identified in a variety of publications. Points listed below are referenced as far as possible and although often cited by a number of authors, references are limited to just one or two for each point cited. Some points are also contributed from the experiential knowledge of the authors or other Learning Hub members.

Benefits Identified Include:

Moral Motivation
- Moral motivation and shared values among faith groups; teachings of faith groups that underpin

engagement in development (social justice, human value and dignity, injunction to loving one's neighbour, etc.) (Courtney, 2011).

- FBOs seek to provide a preferential service to the poorest sectors (Vitillo, 2009; TBFF, 2012).

A Broad Understanding of Care

- Holistic perspective that integrates physical, economic, spiritual and social components of wellbeing and includes family and community and not just the individual. This makes them well-placed to address the complexity of HIV-related challenges (Gaul, et al., 2011; Keough, et al., 2007).
- FBOs provide pastoral and spiritual as well as physical care (CHAN, 2012; Zuurmond, 2008).

Sustainability and Endurance

- FBOs engage in advocacy and in fund-raising at local, national and international levels, depending on particular capacities and opportunities (Keough, et al., 2007; Gaul, et al., 2011).
- FBOs engender a greater sustainability of community responses that precede any formal funding arrangement and will continue on after it has come to an end (Courtney, 2011).

- FBOs are committed to people and places and are usually there for the long term and not the time-frame of a programme or funding strategy (Gaul & Marshall, 2011) including in more remote and rural places with a lack of government capacity to run health facilities (Ward, Kaybryn, & Akinola, 2010).

Cultural Sensitivity, Trust and Influence

- FBOs are culturally aware and relevant. People implementing faith-based initiatives are drawn from the local community and thus have a deeper understanding of and sensitivity to the cultural context.
- Faith-based approaches, informed by local knowledge and faith dimensions often engender a greater sense of trust and acceptance by communities (Courtney, 2011; Vitillo, 2009).
- FBOs can facilitate community mobilisation and buy-in for proposed initiatives (CHAN, 2012). They can also often engage members of their own religious community wary of or alienated by the approach taken by secular organisations (RaD, 2011).
- Religious leaders are numerous, even in remote areas, are well placed to influence people, events and policies both locally and nationally and at family and

community levels. They have the power of the pulpit and as community exemplars. Religious leaders living with or affected by HIV can have a particular role in breaking the silence (CIFA, 2011).

- Religious leaders and communities can be pivotal in tackling stigma and discrimination. They can equally, as is acknowledged below, be sources of increased stigma and discrimination.

Faith Reach & Infrastructure

- The pervasive presence of faith groups at all levels of society which indicates their potential reach and strength. It also means that their HIV-related initiatives can link in with other, social and development issues and initiatives as they usually also have capacity and expertise in other development areas (Kaybryn, 2010; UKCAID, 2012).
- Infrastructure assets (schools, clinics, community centres, hospitals, etc.) facilitate voluntary counselling and testing, diagnosis and treatment of opportunistic infections, antiretroviral therapy, palliative care and PMTCT (Courtney, 2011).
- FBOs often have strong national networks, some of which also connect with international networks and associations (UKCAID, 2012)
- Highly committed networks of staff and volunteers work with a strong senses of altruism. Volunteers strengthen the capacity of FBOs and the altruism of these as of staff increase the ability to reach people in remote areas (Vitillo, 2009; TBFF, 2012).
- Places of worship and community meetings serve as locales to deliver youth-friendly services FBOs are well-placed to gather accurate data over prolonged time periods within a given location, which can provide a strong evidence-base for programming, funding and advocacy agendas.
- There can be a cumulative benefit from FBOs' potential to aggregate evidence across a country and between countries.

Serving Women

- Women – particularly in rural areas – may have their only form of non-kin association through membership in a faith community (Agadjanian, 2005).
- Women's groups – often church-based-make a significant contribution to providing home-based care for people living with HIV (both a benefit and a reminder of the many pitfalls for women of their being the main carers) (UKCAID, 2012).

A common theme is the contribution of social capital, (a term used in this context to refer to the range of often intangible and unquantifiable benefits over and beyond those described in programme plans, that contribute to the overall wellbeing of individuals and communities)- resulting from bodies of faith. There has been a growing recognition that for lasting change, there must be interaction with civil society organisations, including faith groups. A report by ARHAP captures the contributions of social capital from faith groups, stating that increasingly, bodies of faith are being seen as "the most viable institutions for responding to health crises as they have developed experience in addressing the multidimensional impact of epidemics such as HIV, are seen to have access and infrastructure where other organisations do not, command extensive networks of people, and could affect behaviour change more effectively through the authority they hold with their members" (Olivier, 2006 p. p.32)

Finally it is important to note that FBOs have an important transformational and advocacy role within their own faith traditions as they bring the evidence of programme experience to bear on that faith's understanding of its identity and mission, using this experience to influence teachings and theological discourse while being informed in their turn by evolving theological reflection in response to the challenges posed by HIV. This has engendered extensive and enriching theological reflection not often acknowledged but which can exert considerable influence on those holding teaching and governance roles within their faith structures (MMI, 2011).

When FBOs undertake this role they can also bring a more in-depth reflection into the discourses of some secular agencies that perhaps may subscribe too easily to seemingly appropriate but unproven "quick-fix" solutions. They can also serve as an important bridge between secular discourses grounded in sound evidence and some more conservative elements within their own faith communities.

Alongside these benefits a number of factors may become barriers to effective engagement by FBOs. These have been identified both in the literature review and in replies to the request for information circulated for this research. Some of these are internal to FBOs while others come from the external environment:

Internal Barriers:

Lack of Formal Documentation and Processes

- Documentation of the nature, range, scope and impact of faith-based initiatives is often poor or lacking, especially at local community level. Monitoring and evaluation can also be poor. They may also work from a limited or unconvincing evidence base (Keough, et al., 2007).

- FBOs can also lack coordination within their own networks and initiatives (Gaul & Marshall, 2011).
- Local FBOs are sometimes (not always) found to lack skills and professionalism (Gaul & Marshall, 2011).
- FBOs can find it more difficult to access funds from governments or international donors whether because of the capacity of some to pursue applications, their remoteness from decision-making locations or their exclusion from grant-issuing processes (Gaul & Marshall, 2011).

Differences Between 'Faith' and 'Public Health' Worldview
- FBO responses may not always conform to the norms of public health strategies or other national plans (Keough, et al., 2007).
- Prevention messages often focus on sexuality with uneven effectiveness (Keough, et al., 2007).
- Some FBOs can be slow to work collaboratively and may work in silos rather than linking up with other NGOs, community organisations, health providers, governments etc. (Gaul, et al., 2011).
- Suspicion regarding the agenda of secular actors may, in some instances, increase this reluctance to collaborate.
- FBOs can be slow to engage with some key HIV-affected populations especially where linked behaviours or lifestyles are deemed to be at odds with the moral codes or teachings of the faith group (Kaybryn, Informed Decision Making: Partner Perspectives, 2010; RaD, 2011).
- A tendency among some FBOs to use programmes as a means to proselytise (Gaul & Marshall, 2011).

Attitudinal Dimensions
- Judgmental attitudes of some religious leaders and communities can increase stigma and discrimination (Courtney, 2011).
- Some religious attitudes to sexuality and marriage can be underpinned by a rigid judgmentalism, or an endorsement of power and gender inequality in relationships. This can lead to exclusion or alienation of a large proportion of those most vulnerable to HIV and many needing to access sexual and reproductive health services. It can also reinforce practices that increase women's vulnerability to domestic and sexual violence, and their inability to access appropriate health and legal support (Gaul, et al., 2011).
- Teachings and beliefs of some religious traditions (both actual and perceived or misrepresented) on sexuality and on gender may serve as further barriers (Keough, et al., 2007; Kaybryn, 2010; Kaybryn, et al., 2011; Koltai, 2012).
- Harmful gender norms and practices within FBOs alienate and reinforce cultural isolation of women and

prohibit their ability or willingness to access services (Gaul, et al., 2011).
- Religions can impose conflicting and competing demands on programme personnel (Gaul, et al., 2011; Kaybryn, 2010).
- Religious leadership that is primarily hierarchical and male can prove to be a barrier (Gaul, et al., 2011).
- Senior post-holders in FBOs may often be recruited from within their own faith traditions and because of their perceived allegiance or trustworthiness rather than their expertise in the key requirements of the post (RaD, 2011).
- FBOs can be guilty of interfaith competition, suspicion and misconceptions (Courtney, 2011).
- The recent growth of "healing" ministries can undermine the impact of care, treatment and prevention (Courtney, 2011).

External Barriers:

Recognition
- The work of FBOs is often little known, in part at least because of its localised (and therefore decentralised) nature and the wide variety of areas of engagement (Keough, et al., 2007).
- There can be little knowledge of how FBOs interface with public or other NGO programmes and a possible lack of alignment of the services of each (Keough, et al., 2007; Ward, et al., 2010).
- There is often poor literacy among donors regarding FBOs and among FBOs regarding donors (Gaul, et al., 2011).

Perceptions of Poor Efficacy
- Heightened emphasis on the need to prove value for money means that the less tangible assets, characteristic of FBO activities, are less attractive as they are harder to measure (Courtney, 2011).
- Potentially different targets between secular agencies focused on results within a fixed time frame and FBOs concerned with individual and community wellbeing in the long term (Courtney, 2011).

Misunderstandings
- Lack of understanding of what constitutes the faith sector or of how this functions (Courtney, 2011).
- Preconceptions, prejudices and stereotyping of FBOs and a belief that they are all one homogeneous entity without recognising the diversity of approaches, attitudes and expression of values that exist, even within a single faith tradition in a given context (Courtney, 2011).

- Ignorance or unfounded pre-conceptions among governments, other NGOs and donors of the potential contribution of FBOs, can result in their exclusion from strategy development and implementation (Courtney, 2011).

Barriers to Collaboration
- Development agencies' desire to maintain the boundaries of Church-State relations (Courtney, 2011).
- Dominant paradigms and discourses from secular agencies often fail to account for a significant part of the faith community that do not fit into their scheme or frameworks (Courtney, 2011).

Reduction of funding by multi-lateral and bi-lateral donors (EAA, 2010). Complex, time-consuming and heavily bureaucratic funding application processes and reporting requirements are serious deterrents to FBO engagement whether because of lack of capacity of already overstretched programme personnel, or lack of relevant skills or familiarity with the processes and funders, or the constraints of their often remote locations far from regional or national capitals where funding decision-makers are situated

Observations and Key Considerations

- The numerous benefits and barriers of FBO s need to be acknowledged while cautioning against the risks of reinforcing stereotypes or polarisation

- The social capital of FBOs is a strong feature of the benefits. The advocacy role of FBOs sits alongside that of service provision

- FBOs have a transformational role within their own faiths, both through theological discourse and internal advocacy and accountability processes

- Respondents to requests for information noted mostly external barriers such as lack of funding, with a smaller number acknowledging some of the internal barriers

- One interviewee thought that despite the significant investment in HIV and maternal health, the contribution of FBOs was not unique compared to secular responses

Range of Services

Do FBOs and local faith communities contribute to improved integration of services – and if so, how across the spectrum of health promotion, prevention, treatment, care and support, etc?

Reports suggest that a comprehensive worldwide mapping of FBO HIV responses has not been undertaken and that there is little reliable national data (Keough, et al., 2007). Nonetheless, numerous publications indicated that HIV-related faith-based initiatives generally span a wide range of responses. Initiatives are both institutionally based (usually health care facilities) and located in the community, with the latter being the strongest focus of most FBOs. They sit alongside other services provided by FBOs and for the most part are integrated into the wider range of services and activities held by these and in many cases into those provided by government ministries.

The Berkley survey of 77 FBOs (Keough, et al., 2007) showed that initiatives covered a wide range and in the following pattern:

- Advocacy, prevention, and education (38%);
- Home-based care programs (23%);
- Care and support of orphans and vulnerable children and support for people living with AIDS (20%);
- Prevention of mother to child transmission or voluntary counselling and testing programs (14%).
- Training of religious leaders and/or congregations (7%)

From the documents collected for the present project, 17 were selected for a more detailed study of the FBO responses mapped by their research (details in separate annex). Although in no way a rigorous systematic mapping exercise, the data offer some interesting insights. Roughly 115 projects were named between all the publications, of which 74 were from Christian faith context, 19 Muslim, 12 multi-faith, 6 Buddhist and 2 Hindu. Geographically, 24 reports were of projects in Africa, 61 in Asia and Middle East, 5 in the Pacific region, 12 in Central and South America and 6 were global. While the majority were community based, a larger than expected number (roughly 40%) were partly or completely institutional in nature, mainly hospital or health clinic services.

We would stress that this is by no means a scientifically controlled survey, rather a very rough reckoning of information, which is skewed by the publications selected and various other factors. Nonetheless a few inferences can be drawn, for example the higher number of projects

cited from Asia may reflect a recent increase in documentation of initiatives in this geographical area (recent documentation was deliberately sought) than in Africa, where the HIV epidemiology and experiential knowledge suggest a vastly larger number of HIV-related FBO responses exist. The limited information from Central and South America is more likely a reflection of the fact that the literature survey was limited to English language publications. These publications suggest a significant proportion of HIV initiatives of FBOs are institutionally based

> The paths that have led faith institutions towards their present engagement on HIV/AIDS are varied, and this explains in part the fissures and differing approaches towards HIV/AIDS among faith communities. Faith-inspired institutions with long experience in health care have been drawn into work on HIV/AIDS initially through their medical missions. Other faith communities have come more indirectly to work with HIV/AIDS, such as through work with children or with women affected by violence.
>
> (Keough, et al., 2007)

The reach, scale and range of projects are also striking. The Imam Training Academy of the Islamic Foundation of Bangladesh has a Training curriculum for Imams that includes reproductive health, gender empowerment and HIV-related topics. 40,000 imams have been trained to deliver HIV prevention messages (Berkley, 2010). HIV education is part of the Islamic studies department which provides higher educational/academic qualifications to

Imams and Muftis at Jamia Milia Islamia University New Delhi (Herwadkar, 2012)

The Catholic Diocese of Ndola (Zambia) health care programme operates in 5 towns, 32 shanty compounds, covering a population of more than 400,000; involves 11 different agencies in providing home care to people with chronic illness, including HIV; engages 750 community volunteers; provided home-based care to 9,000 people during 2005; supported 15,000 orphans;- responded to the needs of an estimated 77% of chronically ill people in the surrounding area (Vitillo, 2009). In 2008, a mapping exercise to evaluate the extent of HIV work among Catholic religious orders received 446 responses indicating circa 4 million recipients of education/information provision; 348,169 recipients of care and support services and 90,154 recipients of ART services in the year prior to the survey (USG & IUSG, 2008).

The DREAM project (Drug Resource Enhancement Against AIDS and Malnutrition), operating across Mozambique, is fully integrated into the National Health System. It has proven an effective means of ensuring access to voluntary counselling and HIV testing, prevention services, ART and extensive maternal health support alongside PMTCT services. Key components of this programme are optimal use of personnel, intensive training, scaling-back investment in institutional development, and investing instead in a stronger field presence, and intensive use of technology and innovative methods in the fields of communication, information and diagnostics (Marazzi, et al., 2005).

The Asia Muslim AIDS Network reported that their members were involved in behaviour change communication, knowledge, attitudes and practices surveys, capacity building of religious leaders, provision of care and support and production of publications (Sabur, et al., 2005). A 2004 report maps the Muslim response in Bangladesh, Thailand and South Africa and adds issues of gender and human rights, plus involvement of religious leaders and development of teachings of Islam, to this list (Lim, et al., 2004) while a more in-depth report by Positive Muslims in collaboration with UNAIDS, details responses across North, West Africa, south Asia and the Middle East additionally names issues of drug dependency (Esack, 2007).

Asia Interfaith Network on HIV and AIDS (AINA) resulted from work of faith leaders and FBOs initiated by Christian Conference of Asia. AINA represents faith communities across Asia Pacific. One of its areas of work is raising awareness among faith communities of the issues faced by women and children   AINA has also initiated national

networks on HIV, e.g. in Thailand, Cambodia, South Korea and other countries. Some countries initiated their own movements e.g. India Interfaith Coalition on HIV and AIDS (IICA) which subsequently linked to AINA. AINA works closely with INERELA+ Asia Pacific and UNAIDS at the Asia/Pacific level (Herwadkar, 2012).

Art of living (AOL) in India, with the support of INERELA+ Asia Pacific, India Interfaith Coalition on HIV and AIDS (IICA), and Asian Interfaith Network on HIV and AIDS (AINA), is promoting a national interfaith response and global Hindu response to HIV .The largest interfaith meeting on HIV and AIDS was organised by AOL with INERELA+ Asia Pacific, AINA and UN organisations which garnered the largest personal commitment of faith leaders to respond to HIV epidemic (Herwadkar, 2012).

"Churches, Channels of Hope" programme equips faith leaders with the knowledge and attitudes to support HIV related processes and run workshops in their local communities.

The Christian AIDS Bureau for Southern Africa (CABSA), in Southern Africa, specialises in training facilitators in the "Churches, Channels of Hope" programme which equips faith leaders with the knowledge and attitudes to support HIV related processes and run workshops in their local communities (Rooyen, 2012). Channels of Hope has been adapted for Orthodox, Catholic and Muslim contexts, with the latter through a partnership between World Vision and Islamic Relief (Fitzgibbon, et al., 2012). It is a methodology adopted by World Vision which has used it extensively in its work. World Vision operates in over 100 countries, and in almost all of them it works on health issues. HIV work has been refocused to 20 priority countries. World Vision describes two distinct approaches to HIV and to mother and child health. (Greyling, et al., 2012)

Caritas Internationalis has been offering training consistent with Catholic teaching, since 1989, and has developed several published editions of a pastoral training manual. The manual covers topics such as transmission, prevention, factual knowledge on HIV and AIDS, social impact, emotional impact, response of the Church, and what activities parishes and ministries can carry out in response to the pandemic. It integrates factual, scientifically-based information and guidelines provided by such organisations

as UNAIDS and World Health Organisation with Catholic Church doctrine and pastoral reflection. The resource is available in English, French, Spanish and Portuguese. Adapted versions are available in Ukrainian, Russian, Burmese, and Vietnamese. The resource is designed for training of clergy, religious Sisters, Priests and Brothers, and lay leaders engaged in HIV and AIDS response of the Catholic Church (Caritas Internationalis, 2007).

IMA World Health has produced Safe Motherhood sermon guides for Muslim and Christian leaders to educate congregations about maternal and child health, which have been used in many countries of Africa (Berkley 2011).

The PACT project (Promoting Access to Care and Treatment) of Catholic Bishops' Conference of India (CBCI) has, as part of the National AIDS Control Programme, set up "*Community Care Centres (CCCs) for People Living with HIV and AIDS (PLHA) in the States of West Bengal, Gujarat, Orissa, Bihar, Chhattisgarh, Assam and Jharkhand since June 2007. To date, a total of 49 CCCs have been successfully functioning, and have enrolled more than 53,100 PLHA for care and support services. Moreover, 93 people living with HIV are working as project staff whose presence is not only inspirational for their peers but also brings in much more sensitivity and ownership into the project team. This can be considered as a concrete expression and example of the CBCI policy on HIV & AIDS – 'Commitment to Compassion and Care'*" (CBCI, 2012).

The Rwanda Interfaith Network against HIV & AIDS partners with UNICEF to implement a project focussed on training faith based change agents (20 in six districts) in behaviour change communication on maternal health and Child survival and development, and dissemination of materials on essential household practices. The network also partnered with UNFPA, USAID and the Ministry of Health to produce a sermon guide based on the Christian and Muslim holy texts and linking faith messages to promoting maternal and infant health (Niragire, 2012).

Pastoral Activities and Services for People with AIDS Dar-Es-Salaam Archdiocese (PASADA) is an example of a faith-based service provider in Tanzania. It provides - Voluntary counselling and testing for HIV, PMTCT, treatment for TB/HIV, Paediatric care, support to orphans and vulnerable children, home-based and palliative care, early diagnosis of cancer and community education (Chiziza, 2012).

Concern Worldwide works with national providers in Africa to strengthen health systems to deliver high quality HIV and AIDS related services: VCT, PMTCT, ART, STI diagnosis and treatment, opportunistic infection treatment, PEP, and in health and child survival programs for safer delivery, supporting health workers and birth assistants, child spacing, and anti-malaria and under-nutrition interventions (Gahan, 2012).

Samaritan's Purse works with organisations in Africa, Southeast Asia and Central America to provide antenatal care: promotion of 4 or more ANC visits; maternal tetanus toxoid vaccination: promotion of 2 or more tetanus toxoid vaccinations before birth of youngest child; Skilled Birth Attendant: births attended by skilled personnel; postnatal visit to check on newborn within the first 2 days after birth; insecticide treated nets use: pregnant mothers sleeping under a long lasting insecticide treated nets to prevent malaria; midwifery training; promotion of iron/folate supplement tablets during pregnancy; promotion of iodized salt during pregnancy; recognizing danger signs in pregnancy; PMTCT; and VCT (Bauler, 2012).

Working with faith leaders one-by-one

Islamic Local Development Organisation (ILDO) in Battambang province, Cambodia, works with Buddhist and Muslim religious leaders and communities in its immediate surrounding locale to raise awareness in relation to sexual and reproductive health and birth spacing. ILDO's greatest advocate for birth spacing is a local Imam who was previously its most vocal detractor because he opposed contraception use due to religious beliefs in relation to the sanctity of life. Although he was initially resistant to birth spacing messages, the Imam turned to ILDO for advice after his wife miscarried. After discussing the process of conception with ILDO staff, the Imam concluded condom use could not harm a fertilised egg and was therefore not against his beliefs and values. The Imam and ILDO continue to work together to raise awareness in relation to sexual and reproductive health and promote birth spacing among communities.

(Kaybryn, et al., 2011)

The "Called to Care" initiative coordinated by the AIDS office of the Southern Africa Catholic Bishops' Conference (SACBC) supported a wide range of initiatives' including 40 home-based care programmes, extensive community-based prevention education, access to treatment for adults and children and PMTCT initiatives, livelihoods and nutritional support, capacity building of over 140 community-based organisations, care material, spiritual and psychosocial support for children affected by HIV, theological reflection, and advocacy work in liaison with SACBC's Justice and Peace Department and its Parliamentary Liaison Officer, and as part of national activist campaigns. The programme had enabled the establishment of at least one HIV-related initiative in each of the 40 dioceses of Southern Africa. Many of the initiatives were carried out in partnership with government services, particularly health care services, and were complementary to those services. The SACBC AIDS Office is represented on the World Conference on Religion and Peace, and such national networks as the National Religious Association for Social Development, and its coordinator has represented faith communities on the South Africa national AIDS Council (Vitillo, 2006).

World Vision implements three interlinked HIV prevention and care programming models which work with both communities and religious leaders. The organization relies on a set of core standardized input and output indicators to monitor implementation through the Core HIV and AIDS Response Monitoring System (CHARMS). The overall aim of the programme is the well-being of children, and in that way all community-based organisations and structures within a community are involved in the programme. It is a model for working on prevention, care, advocacy and capacity building activities. There are 14 area development programmes in Chad, with over 400,000 beneficiaries.

Observations and Key Considerations

- Published mapping of FBO responses is incomplete, yet shows significant engagement. A strikingly stronger response is recorded for Asia than Africa, reflecting differing capacities or traditions regarding publishing work

- Most initiatives are community-based, though a stronger than expected proportion are also involved in institutional formal services, mostly health care

- Responses are widely diverse, spanning prevention, home-based care, advocacy, treatment, care for children, PMTCT, training of faith leaders and congregations

- The scale of initiatives ranges from multi-country (e.g. international networks of religious congregations surveyed reaching circa 40 million with education) to localised one-to-on (e.g. ILDO in Cambodia)

- Of materials cited, only four are published while 13 are grey material i.e. reports sent by respondents or self-published on their websites. With one exception, all descriptions of training resources came in grey material

Integration of Services

Do FBOs and LFCs contribute to improved integration of Services across Reproductive Health, HIV, Mother and Child Health, and Prevention of Mother to Child Transmission of HIV?

In the context of this review, integration refers to the synergy, coordination and complementarity of services provided both within individual health facilities and between them. While FBOs have long engaged in providing maternal and newborn health care in Africa, there is little recognition or mapping of this. Widmer et al undertook a systematic review of literature in 2011, using MEDLINE and EMBASE to search for articles published between 1989-2009 (Widner, et al., 2012). The review found that the services offered by FBOs tend to be similar to those offered by governments, the quality of services may be better, satisfaction was higher and in some instances are considered to be the best available in their region. The report is limited to institutionally-based services but notes that relatively little is known about the role of FBOs in home deliveries, which is where most births still occur.

> "While FBOs have long engaged in providing maternal and newborn health care in Africa, there is little recognition or mapping of this."

As noted earlier, providing reproductive health, HIV, mother and child health, and PMTCT services are inextricably linked. A number of information sources reviewed for this project cite PMTCT initiatives and/or training of traditional birth attendants (TBAs) as indicative of their involvement in HIV and maternal health (Melillo, 2012). With regard to PMTCT it is not always evident in reports as to how or whether these benefit maternal health more broadly, as reports often focus on the immediate benefits of reducing the number of children born with HIV. Thus the concerns set out in Section 1 should be borne in mind and could provide a valuable lens through which to gather more detailed information about FBO PMTCT programmes.

Training of TBAs forms a significant part of community-based programmes for many FBOs. Maryse et al report that international attention had shifted away from *traditional*

birth attendants to *skilled* birth attendants by 1997, though some countries continue to invest in the former (Maryse, et al., 2012). A Cochrane review in 2008 concluded that "after more than three decades of experience the evidence to support traditional birth attendants, training has been limited and conflicting" (Cochrane, 2008). The review found particularly that there was no conclusive evidence showing an improvement in maternal health. However, traditional birth attendants can still fulfil an important role in supporting women and referring them during pregnancy and childbirth (Sibley, et al., 2007) and integration of TBAs into formal health systems can lead to an increased use of those facilities and skilled delivery (Byrne, et al., 2011). In light of this, FBOs can play an important role in ensuring the integration of TBAs into formal health care and referral systems.

The following paragraphs offer examples of FBO engagement with and integration of sexual and reproductive health and maternal health services and HIV, some very localised and small scale and some extended to national or multi-country level.

The Latin America Council of Churches is a network of over 200 FBOs in the Latin American Region (including Anglicans, Methodists, Baptists, Episcopal Churches, Pentecostals, Morava Churches, Presbyterians, and others) across 20 countries. Its members at national and community level provide information related to HIV prevention; care to people living with HIV and AIDS; and many of its members at country level support pregnant women with information, medical care and family planning services (Tamez, 2012).

Buhimba Child Care Initiative (BCCI) in Uganda links people living with HIV to midwives who provide education and information about family planning and maternal health (Turyatunga, 2012).

A Catholic church-run health facility in Papua New Guinea provides comprehensive VCT services including permanent drop-in VCT at clinics; weekly antenatal screening for HIV and STIs; monthly mobile health patrols which provide VCT to rural/hard to reach mountainous villages; home care kits for people living with HIV located away from town; PMTCT, family planning services (although discrete) at permanent clinics. It is the largest non-government ART provider in the province (Shih, 2012).

Muslim Aid created the Women's Resource Centre (Nepal), and along with a local partner, the Young Muslim Women's League, focused on economic opportunity, education, and maternal health and nutrition caused by conflict. The Imam Training Academy of the Islamic Foundation of Bangladesh training curriculum of Imams includes reproductive health, gender empowerment and HIV-related topics. Approximately 40,000 imams have been trained to deliver HIV prevention messages. The Christian Commission for Development in Bangladesh has trained 30,000 practising traditional birth attendants through an 11 day basic training course (Berkley, 2010).

The Catholic Bishops' Conference of India supports 13 PMTCT centres - most supported by the Catholic Medical Mission Board (CMMB) - in Andhra Pradesh, Tamil Nadu & Karnataka. Between September 2005 and August 2006, 4590 pregnant women were counselled and tested in a pilot PMTCT project supported by CMMB and the Abbott Foundation and implemented by the CBCI Health Commission in seven rural hospitals in Karnataka and Andhra Pradesh. A total of 438 (9.5%) of the expectant mothers were found to be HIV positive and received Cotrimoxazole and Nevirapine prophylaxis. No cases of mother-to-child transmission were reported (Vitillo, 2006).

World Relief's Care Group Model uses a cascade approach to train volunteers who deliver community health, and runs maternal and child health programmes in nine countries (Keough, et al., 2007). Collaborating with the Indian Ministry of Health and other NGOs, from 2003-07, World Vision developed an effective method of delivering health messages to pregnant women in Uttar Pradesh, India which has since been replicated across the region and supported the training of traditional birth attendants in Ethiopia. The number of births attended by TBAs increased from 0.3% to 30% in just 2 years. IMA World Health produced Safe Motherhood sermon guides for Muslim and Christian leaders across Africa to educate congregations about maternal and child health (Gaul, et al., 2011).

> "In Zimbabwe, World Vision works directly with faith leaders to build their capacity to provide information on HIV and maternal health to congregations."

Christian Aid, through its network of partner organisations in Malawi, Burundi, Kenya, Nigeria, and Ethiopia, implements family planning interventions and training of midwives/traditional birth attendants, engages faith leaders to promote messaging to encourage women to access maternal health and HIV services, and broadcasts radio programmes on family planning and HIV. Christian Aid's strategy to increase access to PMTCT for women in Malawi and Burundi includes engaging men to participate. Mobile health outreach clinics in Kenya reach women in areas not currently covered by the Ministry of Health (Sinclair, 2012). Some examples of results from Christian Aid's work in the last 12 months are:

- In sexual health and HIV prevention, results have been seen across Malawi, Nigeria and Kenya. In Malawi, 17 health facilities have reported 4,800 incidences of STIs between May 2011 and February 2012, down from 7,200 incidences in the same period in the previous year. This is attributed to increased access to condoms and an increase in knowledge of HIV prevention.
- In Nigeria, reports from partners indicate an increase in the number of women who now use one form of modern family planning method or another, as advised by healthcare practitioners. This contrasts with the baseline situation of women who either had no knowledge of any family planning method or who were not convinced of the need to employ one.
- In Malawi, staff from the district hospital conducted quarterly routine visits to support groups in collaboration with Christian Aid partners. This more coordinated approach has doubled access to treatment, care and support for PLHIV with 18 people per month referred on average from around eight people per month prior to the project.
- In Kenya a mechanism for measuring positive prevention has been developed with experience from the Filling the Gaps project, where support group meetings hold discussions on prevention issues. As a result, PLHIV have put in place measures to avoid infection or re-infection (Sinclair, 2012).

IMA World Health responds to HIV and maternal health in DR Congo, South Sudan and Tanzania and provides voluntary counselling and testing, prevention of mother to child transmission, antenatal care, emergency obstetric care, community based training and awareness, community mobilization for prevention of HIV, training of Religious Leaders to promote mother and child health behaviour change through Sermon Guides, and Safe Motherhood Kits. At a more national policy level IMA collaborates closely with the Ministries of Health and AIDS commissions in the country it works in, to promote healthy living and prevention of diseases (Chand, 2012).

In Zimbabwe, World Vision works directly with faith leaders to build their capacity to provide information on HIV and maternal health to congregations, provide counselling to couples on mother and child health, c-PMTCT (community PMTCT), breastfeeding, complementary feeding, safe deliveries at health facility, family planning, food supplements for pregnant women (Sibanda, 2012). To improve mother and child health responses, World Vision ensures the local health system actors are actively involved in the workshops for faith leaders and their spouses, which strengthens the system and build confidence, trust, collaboration and support (Greyling, et al., 2012).

The Extending Service Delivery Project produced a 5-day training curriculum designed to equip male and female Muslim Religious Leaders with the necessary information and skills to better understand, accept, and support the provision of maternal and child health, reproductive health and family planning (MCH/RH/FP) information and services at the community. The manual presents concepts of MCH/RH/FP from a perspective that is consistent with and supported by the teachings of Islam (Mason, et al., 2008).

'Pastoral da Criança in Brazil is an example of a successful partnership between the Catholic Church and UNICEF. Pastoral's mission statement emphasises the right of every child to live a rich, healthy life. It thus works through a vast network of volunteers to help children survive by providing expectant mothers and families with education about how to care for their young children. A secondary programmatic focus is education aimed at prevention of domestic violence… Since 1983, Pastoral has grown into one of the world's largest NGOs. It utilises the energy of more than 150,000 unpaid volunteers who reach 1.6 million children under 6 years of age, and 77,000 pregnant women in about 3,000 municipalities across Brazil. Pastoral provides basic health and nutritional information and promotes awareness of good practices in nutritional supervision, oral rehydration, vaccination, and infant development.

The organisation reaches the community in a number of ways. The primary method is through volunteers who carry out monthly home visits to families participating in the programme. Municipalities also sponsor a monthly Weighing Day at which time families bring their children for health check-ups and also benefit from workshops that emphasize different aspects of physical, psychological and spiritual wellbeing of the children. In addition, Pastoral has utilised television and radio to reach an even broader audience with information on family planning and related issues. The total cost of Pastoral is approximately $0.50 USD per child/month, including administrative, production and distribution of educational materials, training and accompanying activities. Since 1995, Pastoral has received

nearly a quarter of its funds through an annual television campaign.' (Berkley, 2009).

From our experiential knowledge we are aware that a similar model, Pastoral da AIDS, has been initiated more recently and has at least one HIV-related initiative in each of the 215 dioceses spanning the entire country. It would be valuable to identify the degree of actual or potential collaboration and coordination between these two initiatives on issues of HIV and maternal health.

The DREAM programme of the Community of Sant' Egidio offers community-led HAART and nutrition therapy with a focus on PMTCT. A survey of Catholic Religious Institutes by the Union of Superiors General, in 2005, found that 104 of the 446 respondents provided PMTCT services, 75% of these were in Africa, 12.5% in Asia and Middle East, and 1.9% in South America (the remainder being in Europe, North America and Oceania). An Ecumenical Advocacy Alliance (EAA) survey in 2010 showed 11 of the 19 FBOs interviewed indicated PMTCT is a substantial focus of their HIV-related services (EAA, 2010).

World Vision has developed an integrated approach to community-based prevention of mother to child transmission of HIV c-PMTCT. Key activities fall into four areas; primary prevention of HIV, prevention of unplanned pregnancies, prevention of HIV transmission from a mother to her infant and providing appropriate treatment care and support for women living with HIV and their children. Their maternal and child health strategy is built on evidence-based and cost effective measures and is termed the 7-11 strategy as it sets out 7 interventions targeted at pregnant women and 11 at children up to the age of two (Greyling, et al., 2012).

Research conducted by CHAN in 2012 on the contribution of Catholic FBOs to the Global Plan in the 22 priority countries of the Plan found that 67.5% reported previous awareness of the Global Plan but only 17.5% had been previously involved in its development or implementation. However, 92.5% of respondents said they would like to be involved in the future. Only one reported being consulted in the development of their country's Global Plan.

Samaritan's Purse use research through a methodology called "Barrier Analysis" which analyses the determinants that enable or impede people to do or avoid certain behaviours. For example, the organisation has used this approach to determine barriers to exclusive breastfeeding practices and good infant and young feeding practices, and

plan to use this methodology in all its health and wider programming (Bauler, 2012). This approach is similarly used by World Vision, albeit with differing terminology. Through the Channels of Hope training, in which religious leaders and health workers participate, exercises identify the social, religious, political and economic environment which makes children/men/women vulnerable to HIV transmission (issues of gender, poverty, traditional norms and practices, spiritual and psychological wellbeing surface) and lead participants towards planning for care and advocacy. In Channels of Hope for mother and child health, World Vision uses a problem/solution tree to determine what the issues are that impact on mother and child health. A separate session focuses on "Why people do, and why they do not" – leading towards embracing of specific healthy behaviours. Issues of culture, social and gender norms surface and inform the future planning of participants (Greyling, et al., 2012).

Catholic Relief Services (CRS) in Kenya received funding from the United States Agency for International Development (USAID)/Centers for Disease Control (CDC) to implement a "men as partners" programme at the community level. The programme supported by CRS and the Ministry of Health, is based on a community-based, primary health care strategy. Implementation of the programme includes mobilisation of community volunteers, who educate the communities on the roles of men in PMTCT and other health issues. The programme also includes support groups for men, couples living with HIV, and discordant couples. Such programmes enlist men to serve as mentors; they encourage other men to join the support groups and thus function as "role models." Education is done in barazas, where men give testimonies.

Encouragement of male involvement in HIV-related services is a key component of CRS' approach worldwide. CRS international headquarters in the United States has issued two publications that expound on this work (CRS, 2009; CRS & AIDS Relief, 2012).

As a pilot project operating in three provinces within Kenya — Rift Valley (Narok District), Nairobi (Ngata and Karen Districts) and Central (Kirinyaga District), the programme creates male-friendly spaces in antenatal clinics and health centres in order to increase the accompaniment of women by males to health facilities. Most health centres currently focus on serving women and children. If husbands accompany their wives to the clinics, there is an added incentive that such women are seen first by the health care workers (CHAN, 2012).

Observations and Key Considerations

- There is scant mapping published of the engagement of FBOs in maternal health
- Respondents most often cited PMTCT as their programme response to maternal health and HIV. There is little indication of how this specifically addresses the needs of mothers, as the emphasis is more often on unborn or new born babies
- A number of respondents train traditional birth attendants. Publications show these are an important first contact and point of referral for mothers, and that they are only effective if integrated into formal health systems, signalling an important role for FBOs
- Other initiatives listed included VCT, antenatal screening, mobile patrols to reach rural areas, family planning, ART provision, condom provision, prevention, community PMTCT and positive prevention, and training of faith leaders, volunteers, midwives and traditional birth attendants Initiatives to provide economic opportunity for women, or address intimate partner violence, or give nutritional support to new mothers or pregnant women, were mentioned just once.
- One programme stressed the importance of involving men
- FBOs reported high awareness of the UNAIDS Global Plan but low involvement or consultation
- Roughly 75% of programme information was reported through grey material
- A variety of training resources were reported, again in grey material received

Holistic Approaches to Health

Do FBOs and LFCs employ a more holistic approach to health by, for instance, addressing social determinants of health and not just service delivery (in possible contrast to the health sector) – and if so, how? e.g., by addressing traditional norms and practices, gender norms, basic economic needs, food and malnutrition, spiritual and psychological well- being, social protection, etc. rather than the more fragmented approach of the health sector.

Numerous reports indicate that FBO involvement in healthcare generally and in HIV-related initiatives more specifically are holistic (e.g. (ARHAP, 2006; TBFF, 2012; Keough, et al., 2007; Global Health Council, 2005; Lim, et al., 2004) with initiatives addressing livelihoods, nutrition, stigma, gender equity, psychosocial and spiritual support, and advocacy concerns all featuring. The diversity of workshops at the EAA Faith and AIDS Conference, Washington 2012 likewise denotes the holistic approach to HIV taken by FBOs (EAA, 2012).

Samaritan's Purse use research through a methodology called "Barrier Analysis" which analyses the determinants that enable or impede people to do or avoid certain behaviours. For example, the organisation has used this approach to determine barriers to exclusive breastfeeding practices and good infant and young children feeding practices, and plan to use this methodology in all its health and wider programming (Bauler, 2012). This approach is similarly used by World Vision, albeit with differing terminology. Through the Channels of Hope training, in which religious leaders and health workers participate, exercises identify the social, religious, political and economic environment which makes children/men/women vulnerable to HIV transmission (issues of gender, poverty, traditional norms and practices, spiritual and psychological wellbeing surface) and lead participants towards planning for care and advocacy. In Channels of Hope for mother and child health, World Vision uses a problem/solution tree to determine what the issues are that impact on mother and child health. A separate session focus on "Why people do, and why they do not" – leading towards embracing of specific healthy behaviours. Issues of culture, social and gender norms surface and inform the future planning of participants (Greyling, et al., 2012).

BCCI initiated a women's association group to address household needs, through training them to be entrepreneurs and mitigate financial crises. The group was encouraged to carry out credit and saving schemes. BCCI also mobilizes women to overcome traditional gender

expectations and train them in rights awareness particularly for girl children (Turyatunga, 2012).

Resources for Supporting and Mapping Holistic Responses

Resources for programme practitioners or for faith leaders and communities likewise take a more holistic approach. The Strategies for Hope toolkit, "Called to Care" is a set of practical, action-oriented workbooks that seek to empower church leaders, their congregations and their communities with the knowledge, attitudes, skills and strategies they need to plan and implement effective responses to the challenges of the HIV epidemic, especially in sub-Saharan Africa. Called to Care addresses social, spiritual and ethical issues along with stigma and practical aspects of care and prevention (Strategies for Hope, 2012).

Tools developed by CAFOD (Catholic Agency for Overseas Development, London) for mapping and monitoring quality of life of people living with or affected by HIV identify four domains affecting quality of life: health, psycho-social/spiritual, economic/livelihoods security and legal/human rights. The organisation asks programme partners to map their own initiatives and those of other service providers against key statements for these domains. Service users self-assess their quality of life using a simple "batteries" tool modelled on these domains A review found these to be effective and applicable in many and diverse cultures and contexts (Drew, 2011). A similar mapping tool for monitoring engagement in combination or comprehensive HIV prevention has also been developed (CAFOD, 2011). The organisation has, for many years, promoted a comprehensive approach to HIV prevention as being compatible with its identity as a faith-based development agency (Smith, et al., 2004).

IMA World Health addresses the social determinants of HIV through providing services linked to its HIV and maternal health work such as nutrition initiatives; literacy training at antenatal care clinics; physical, psycho-social, legal, and economic responses to sexual and gender based violence; and water and sanitation (Chand, 2012).

Recent trends and strategies of international agencies and governments seem to run counter to a holistic model, or at most make reference to this after extended narrative on access to treatment, health care for HIV and associated infections such as TB and malaria, and HIV prevention services. For example, the UK's position paper on HIV in the developing world (DFID, 2011) describes its commitments for the next 20 years largely in terms of preventing new infections, providing cheaper ART and improved and scaled-up access to this and to wider health care, with only passing reference to social and economic considerations. The latter include commitment to reducing gender-based violence and harmful gender norms, improving access to education especially for girls, using cash transfers for the economic empowerment of women, and initiatives to reduce stigma, though there is little explanatory narrative attached to any of these.

A consequence of such trends is that funding for wider holistic responses, most of which will be community based, is increasingly hard to secure. One interviewee, with links to networks of women living with HIV in Uganda, spoke enthusiastically of a community-based project of support to HIV positive mothers by positive mothers that has potential for replication in a number of countries of East Africa and then described the heart-wrenching and failed efforts of its founders to get funding. A further consequence of such trends is that NGOs and FBOs adjust their focus and priorities in order to pursue funding in an ever more competitive environment. In the UK, some FBOs have dropped HIV as an organisational priority, while others have swept it under the health umbrella and now address HIV, TB and Malaria as a unit.

Observations and Key Considerations

- Publications indicate that FBO responses to HIV are holistic, addressing livelihoods, nutrition, stigma, gender equity, psychosocial and spiritual support, and advocacy concerns alongside health needs
- Few of the respondents gave examples of holistic responses.
- Just two resources were named, one as a training resource and another as mapping tools for and client monitoring of holistic responses in care and prevention
- Trends in strategies of international funders and agencies are focusing more on the medical aspects of health, provided in the main from institutional settings, making it more difficult for community-based and more holistically focused initiatives to secure funding.

Reducing HIV-Related Stigma

Do Local Faith Communities demonstrate the capacity to reduce HIV-related stigma, silence, denial and discrimination?

As the section on benefits and barriers suggests, faith leaders and communities can be instrumental both in denouncing and increasing stigma. Descriptions of the scene at the funeral of Ugandan activist David Kato illustrate this graphically. Kato was among the 100 people whose names and photographs were published in October 2010 by the Ugandan tabloid newspaper Rolling Stone in an article which called for their execution as homosexuals. He was murdered in January 2011. Present at the funeral were family, friends and co-activists, many of whom wore t-shirts bearing his photo in front, and having rainbow flag colours inscribed onto the sleeves.http://en.wikipedia.org/wiki/David_Kato - cite_note-17 However, the Christian pastor preached against the gays and lesbians present, making comparisons to Sodom and Gomorrah, before the activists ran to the pulpit and grabbed the microphone from him, forcing him to retreat from the pulpit to Kato's father's house.

> *"Stigma polarises communities (faith and non-faith alike) and causes enormous physical, emotional and economic stress for those stigmatised."*

An unidentified female activist angrily exclaimed "Who are you to judge others?" and villagers sided with the preacher as scuffles broke out during the proceedings. Villagers refused to bury Kato at his burial place; the task was then undertaken by his friends and co-workers, most of whom were gay.http://en.wikipedia.org/wiki/David_Kato - cite_note-18 In place of the preacher who left the scene after the fighting, Anglican Church of Uganda bishop Christopher Senyonjo officiated Kato's burial in the presence of friends and cameras. Rowan Williams, the Anglican Archbishop of Canterbury, spoke on behalf of the Anglican Communion, "Such violence [as the death of David Kato] has been consistently condemned by the Anglican Communion worldwide. This is a moment to take very serious stock and to address those attitudes of mind which endanger the lives of men and women belonging to sexual minorities." (Multiple Sources, 2012)

While extreme, this is just one example of how stigma polarises communities (faith and non-faith alike) and causes enormous physical, emotional and economic stress for those stigmatised, whether because of their HIV status (known or suspected) or their sexual identity or related matters. A number of faith-based initiatives have been established to address issues of stigma.

Legislative moves to criminalise homosexuality, or HIV transmission, have been mooted in several countries, more particularly in a number of African countries. Criminalisation of HIV transmission has included, in a number of African countries, women with HIV who transmit the virus to their babies. In Sierra Leone, women with HIV were at risk of being jailed for up to seven years for transmitting HIV during childbirth until a proposed law was rescinded under international pressure (Weait, 2011). In Guinea, Guinea-Bissau, Mali and Niger, a mother can be criminally charged for not taking steps for PMTCT (CHALN, 2007).

The 2009 Anti-Homosexuality Bill[7], a piece of legislation put before the Ugandan Parliament by David Bahati MP in October 2009, enhances existing legislation that criminalises same-sex relations in Uganda to include a new offense of 'aggravated homosexuality'. Current Ugandan legislation, based on British colonial law, makes homosexual practice punishable with up to 14 years imprisonment. The new Bill proposes to extend this punishment to life imprisonment in some instances, and (at least initially) proposed the death penalty for 'aggravated homosexuality'. Anyone found guilty of aggravated homosexuality will be forced to undergo a status. It also allows for the extradition of Ugandan citizens who have been charged with committing homosexual acts or aggravated homosexuality abroad. At the time of writing, this Bill has not yet been promulgated into law. However, the majority of members of the Ugandan Parliament and most governmental officials have publicly supported this legislation. Religion plays an undeniable role in this topic, with some religious leaders openly encouraging the legislation while others are totally opposed.

The Faith Working Group of the UK Consortium on AIDS and International Development (Consortium members include, Tearfund, CAFOD, World Vision, Christian Aid among other FBOs) prepared a background paper for the Consortium's 2012 AGM, the theme of which was criminalisation of homosexuality and its links with faith (Matarazzo, 2012). In a survey of members, 50% of

respondents identified themselves as faith-based. Both faith-based and secular members saw criminalisation as a serious issue. Current activities of respondents on criminalisation are mainly advocacy and awareness-raising focused - within UK Parliament, the faith community and international development sector. In addition, a small number of frontline health programmes are reaching out to, and supporting, Lesbian Gay Bisexual Transgender (LGBT) communities but these are currently limited in scope and geographical focus.

With regards to a policy position on criminalisation, all respondents backed equal human rights/non-discrimination on the grounds of sexuality and opposed any form of criminalisation of homosexuality. Respondents saw the impact of criminalisation on HIV as denying a group which is at higher risk from contracting HIV from accessing services – denying them their human rights. Criminalisation would also enhance stigma around HIV and LGBT communities - "doubly stigmatised" - and potentially push individuals further underground – making them even harder to reach for health and wellbeing services. Criminalisation was seen as a disincentive for LGBT communities to go for HIV testing or treatment. Respondents from FBOs expressed opposition to the Ugandan Bill from human rights and theological positions, as well as from practical concerns about health and community impact. The Consortium is continuing to focus on the issue of criminalisation and to identify further opportunities for action.

INERELA+ is the International Network of Religious Leaders – lay and ordained, women and men – Living with, or Personally Affected, by HIV. It is recognized that religious leaders have a unique authority that plays a central role in providing moral and ethical guidance within their communities; indeed their public opinions can influence entire nations. INERELA+ looks to empower its members to use their positions of respect within their faith communities in a way that breaks silence, challenges stigma and provides delivery of evidenced-based prevention, care and treatment services. Members, in partnership with others, overcome self- and societal stigma, engage in stimulating faith responses and influence policies and service provision. INERELA+ has national organisations in many countries of Africa, Latin America and Asia Pacific (INERELA+, 2012).

INERELA+ originally developed the SAVE approach[6] – which Christian Aid supports – as a way of working more effectively to prevent HIV infection (Christian Aid, 2012). SAVE provides a holistic way of preventing HIV. It incorporates the principles of the ABC approach (Abstinence, Be faithful and Condom use) while also providing comprehensive information about other, non-sexual routes of HIV transmission and prevention, promoting support and care of those already infected and actively challenging HIV-related stigma and discrimination, (Sinclair, 2012; Koltai, 2012).

In Burundi, Christian Aid supported the establishment of BUNERELA+, the Burundi Network of Religious Leaders who are Living with HIV or Personally Affected by HIV. Strategies including mutual learning, support and capacity building supported this expansion, with BUNERELA+ members now reaching large numbers of people through disclosure training sessions, AIDS prayer days and sermons within Sunday church and Friday Muslim services. In Kenya, religious leaders trained on the SAVE approach have supported messaging at community level through formation of regional and local networks and anti-stigma rallies. Religious leaders across denominations have publicly apologised for having stigmatised people living with HIV (Sinclair, 2012).

> **Churches challenge gender norms and taboos**
>
> "I use the Genesis mandate to show that both male and female are equal in the eyes of God, despite them having different bodies."
>
> Fountain of Life Church, Zambia (Kamangala, 2012)
>
> "We break down traditional taboos and speak out about sexual issues in

[6] SAVE is an abbreviation of Safer practices, Access to treatment, Voluntary counselling and testing, Empowerment.

churches."

Mission 21 (Chung, 2012)

The Framework for Dialogue is a proposed methodology for country-level use to support initiation and/or strengthening of dialogue between PLHIV networks and religious leaders, faith based organisations and faith communities. Steered by four international partners - EAA, GNP+, INERELA+ and UNAIDS, the Framework for Dialogue has emerged as an outcome of the Summit of High-Level Religious Leaders held in Den Dolder, The Netherlands, in March 2010. Each of the four international partners are members of the Strengthening Religious Leadership in the Response to HIV (SRL) working group, convened by the EAA to oversee the follow-up to the 2010 Summit. This wider group, which includes religious leaders from a range of faith traditions, has provided guidance to the four international steering partners overseeing the development of the Framework where appropriate. The 'methodology' articulated in the Framework follows a simple timeline of: 1) familiarization of evidentce by PLHIV on experienced and perceived stigma; including the review of data from the national stigma index survey 2) understanding perceptions and experiences of faith based responses to HIV; 3) engaging in dialogue to determine what are areas of collaboration, areas where further dialogue is needed, and developing a joint action plan; and ultimately 4) maintaining dialogue in a systematic and long-term approach. The framework is currently being piloted in a number of countries, with publication and launch planned for early 2013. (Burford, 2012).

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World Vision has helped to develop Channels of Hope, with CABSA as mentioned above, an interactive mobilisation and transformational process that engages community and faith leaders on HIV. Channels of Hope combines thorough appreciative inquiry with topical education for attitude and behaviour change, aiming at widespread stigma reduction, transformation of harmful values, and enhanced prevention and community care for people affected by HIV and AIDS. Findings from a randomized community trial study indicated that implementation of Channels of Hope methodology led to significant reduction in HIV-related stigma, and significant increase in HIV testing among faith leaders and community members (Chege & Murry 2007); local faith communities implementing HIV prevention and care interventions and knowledge of HIV prevention and transmission methods (Chege, et. al, 2010).

An experience of addressing stigma from Pastor Alexandre at a Baptist Church in DRCongo illustrates the complexity and in-depth engagement that some faith leaders face. A young woman was rejected by her parents when she tested positive for HIV who firmly believed that God had punished their daughter for her immorality. They decided she equally deserved to be banned from their home for her disgrace and dishonour. It was the parents who felt stigmatised by their daughter's status and in turn stigmatised her. Pastor Alexandre was determined to reconcile the family which took two years to significantly reduce their stigma and accept their daughter again (Mukinda, 2012).

The Circle of Hope, implemented by Evangelical Association of Malawi (EAM), a Tearfund partner, is a multi-stakeholder project which focuses on "fighting HIV/AIDS stigma through gender and rights based approaches" (EAM, 2009). One of the objectives of the programme is to work with religious and traditional leaders to influence them regarding "risky religious and cultural attitudes, beliefs, values and practices that promote stigma and discrimination" (EAM, 2009).

The Buddhist Leadership Initiative was launched in Cambodia since 2000 by the Ministry of Cult and Religion, with UNICEF support. It mobilises Buddhist monks to reach

out to people living with HIV in 239 communes in 10 provinces reaching approximately 2,300 adults living with HIV and 1,500 vulnerable children. A significant component of the initiative is cash transfers but the impact of the acceptance shown by monks towards the most vulnerable people living with HIV appears to have been profound, according to a recent assessment (Kaybryn, 2012). Monks are highly respected among community members, and people living with HIV who were ostracised had their lives transformed when a monk visited them in their home. This public statement of acceptance of the person living with HIV caused neighbours and community members to rethink their previously discriminatory attitudes and behaviours.

Stigma experienced by faith community members in Ethiopia, Kenya and Zambia:

Pilot project

CAFOD is currently piloting a three-year project (2011/2014) in Ethiopia, Zambia and Kenya, which explores the stigma experienced in faith communities, in order to develop evidence-based stigma reduction initiatives to be implemented by faith leaders in partnership with people living with HIV (Ademe Asres, et al., 2012; Dodo, et al., 2012; Jones, et al., 2012) .

The project has been developed in partnership with international (GNP+) and national networks of people living with HIV [NZP+ (Zambia) NEPHAK (Kenya) and NEP+ (Ethiopia)] and with CAFOD faith-based partner organisations. Using a questionnaire modelled on the "People Living with HIV Stigma Index" and national Stigma Index data as baseline, and a longer term programmatic process, 123 people living with or affected by HIV were trained as interviewers and 2,863 respondents also living with or affected by HIV were interviewed. In some instances faith leaders were among the interviewers and the interviewees. 150 faith leaders were recruited and trained to participate. The results were used by participating Christian and Muslim faith leaders and local networks to plan programme responses. Repeat surveys will be carried out at middle and end-points of the pilot and the process evaluated for impact and scale-up potential.

The findings from the initial surveys included:

- In Ethiopia >14% of people living with HIV and 4% of people affected by HIV were excluded from religious activities in the previous 12 months because of HIV-related stigma

- In Zambia 8% of people living with HIV and 12% of those affected experienced discrimination from someone in their community in the previous 12 months

- Some faith leaders actively and constructively support people living with and affected by HIV

- Some faith leaders continue to promote language and ideas that encourage stigmatisation

- Some act in a directly discriminatory way towards people living with and affected by HIV

- Many have only a basic understanding of HIV that lacks depth and nuance

- Some faith leaders lack the skills and knowledge to address their own vulnerability and treatment needs

- Some faith leaders are simply misinformed while some intentionally promote actions contrary to public health messages, such as healing with prayer in place of treatment adherence

- Many faith leaders are willing to take up these challenges

Observations and Key Considerations

- Experiences abound both of faith-based groups driving stigma and discrimination and of faith-based initiatives to denounce and remove stigma

- The role of faith leaders in addressing stigma is critical, and within these, that of faith leaders living with or affected by HIV who openly identify as such

- International FBOs have an important role in raising their voices to condemn stigma and in supporting initiatives to tackle stigmatising attitudes and actions

- Local and international FBOs need to address stigma, both within the local communities where they work and within the health, educational, livelihoods and worshipping services provided by faith entities

- A number of transformational (experiential), community-rooted initiatives undertaken by FBOs were reported, most of these documented in grey literature received

Reaching the Most Vulnerable

Do Local Faith Communities demonstrate the capacity to reach the most vulnerable, e.g. to meet needs of young women and adolescents?

When identifying who the most vulnerable are, women and adolescents feature prominently in the responses of the many FBOs, as do the very poorest members of communities (Turyatunga, 2012; Sinclair, 2012; Chand, 2012; Gahan, 2012), although data and evidence on outreach to youth and adolescents was not identified strongly in the literature reviewed for this research. The teachings of major faiths all urge members to attend preferentially to the poorest and most vulnerable, without discrimination or judgment, and this applies to HIV-related initiatives. This aspect becomes more challenging with a more nuanced consideration of who are the most vulnerable, particularly in relation to key HIV affected population. In many places they include men who have sex with men (MSM), people who inject drugs, female and male sex workers, as well as women more broadly affected by cultural and legislative conditions preventing gender equity. FBOs' involvement with these more challenging areas include some who have effective outreach, support, prevention and advocacy, others who define their programmes as general community-based (without specific targets) and others again whose agenda in engaging with some most at risk populations is one of proselytising.

Ojus Medical Institute in Mumbai, India defines as most vulnerable, and works with, people living with HIV faith leaders living with HIV, children living and affected by HIV, women living and affected by HIV, men who have sex with men, injecting drug users and transgender people. It provides special support as part of its HIV response to the children of sex workers, men who have sex with men, and other key affected populations in partnership with INERELA+ Asia Pacific. It also hosts the secretariat of INERELA+ Asia Pacific and coordinates interfaith responses on HIV in India (Herwadkar, 2012).

For some faith-based organisations responding to key HIV-affected populations is an area of work that has received support at leadership levels: "We have recently received a strong steer from some of our Trustees supporting a proposed CAFOD programme working with key populations [in this instance advocacy against violence to MSM]. They affirmed that Catholic Social Teaching as well as CAFOD values encourage us to reach out, to key/most at risk populations given their particular stigmatisation and exclusion." (CAFOD, 2011)

Over a century of experience

A minority of faith-based organisations have a longstanding history of working with key affected populations. The Oblate Sisters of the Most Holy Redeemer may occupy a unique place in the story of faith and HIV responses in that it was established in 1864 specifically to promote the health, well-being and safety of sex workers.

The Antonio Center in the Philippines was established in 2000 and is managed by the Oblate Sisters. The nuns running the Antonio Center adopt a practical approach to supporting women: engaging with sex workers in entertainment venues, supporting them to stay safe and healthy. There is also a rehabilitation centre targeting sex workers who have experienced violence at the hands of their clients. Life skills and re-training opportunities are provided at the centre.

The sex workers reportedly appreciate the non-judgmental approach adopted by the nuns, who do not aim to persuade them to leave the sex industry, but rather aim to protect them during their time as sex workers, and to support them to find alternative livelihoods if and when they choose to leave sex work.

(Kaybryn, et al., 2012)

Buddhism and Society Development Association (BSDA), in Kampong Cham Province, is one of eight faith-based organisations working with drug users in Cambodia (Kaybryn, et al., 2011). BSDA provides people with drug addictions with educational and spiritual guidance and helps them design treatment plans to overcome their

addiction. The organisation also educates local communities about the prevention of and stigmas associated with HIV and AIDS, and carries out livelihood training. *"Few faith-actors currently engage [intravenous drug users] directly. An exception is BSDA's programme, run through partner pagodas, which encourages harm reduction by providing counselling and treatment to [people who use drugs]. Through peer facilitators, BSDA brings addicts to the pagoda where trained, ordained volunteers provide counselling, education, and meditation classes to help them overcome their addiction"* (WFDD, 2010 p. 111). BSDA also

Numbers of faith-based initiatives working with key affected populations (by gender) from a survey of 51 organisations in Cambodia

Key affected populations	Female	Male
Drug users/injecting drug users	8	8
Sex/entertainment workers	6	2
Prisoners	5	5
Sex trafficked victims/survivors	4	2
Indigenous peoples	3	3
Clients of sex/entertainment workers	2	4
Migrants and mobile workers	2	2
Men who have sex with men	0	3
Transgender persons	0	0

Reproduced from Kaybryn J and Moriarty K,
National Review of Faith-Based Responses to HIV in Cambodia, UNICEF, 2011

provided clean syringes to injecting drug users as part of its harm reduction programme but had to drop this initiative because the government revoked their licence at a time when it required such harm reduction responses to supply a list of participant names and BSDA chose not to comply (Kaybryn, 2011). This condition of syringe exchange programmes has since ended.

In a national review of faith-based responses to HIV in Cambodia conducted by the National AIDS Authority, Ministry of Cult and Religion and UNICEF in 2011, a survey of 51 organisations found that 44% responded to at least one category of key HIV affected population (Kaybryn, et al., 2011).

Gender equality is an important focus for NCA Vietnam which works towards equal health/HIV rights and opportunities for male and female rights holders. Its work extends to identified areas of specific gender gaps, such as addressing female inmates living with HIV in closed settings (including prisons) (Koltai, 2012). NCA Vietnam also works with people who inject drugs, and people who are mobile including migrating workers.

Asian Interfaith Network on HIV and AIDS (AINA) along with INERELA+ Asia Pacific and with support from UNAIDS, is currently organising the first regional dialogue of faith leaders with key affected population and roll out of SAVE toolkit developed by INERELA+ (Herwadkar, 2012).

Faith influencing government to protect key affected populations

The Pink Triangle (PT) Foundation, a multi-faith volunteer community-based organisation in Malaysia, works with five vulnerable sectors: drug users, sex workers, transgender, men who have sex with men, and people living with HIV and AIDS. Its services include education, prevention, care and support and sexuality awareness. PT created a space for young marginalized groups, especially men, to discuss their sexuality in a non-judgmental setting. Working in collaboration with the Government and other Islamic groups, the Foundation has been running outreach services, a drop-in centre and providing referrals that have started to make an impact in reducing the risk of HIV transmission.

Since 1997, PT has worked to sensitise JAWI (the Religious (Islamic) State Department). At the request of the transsexual community, JAWI offers religious classes twice weekly. Transsexuals have been taught how to conduct religious rites for burials. Raids on sex workers and transsexuals have ceased in Kuala Lumpur, and PT's outreach programme is no longer interrupted. Some joint programmes are now being undertaken with JAWI.

(UNICEF, 2008)

People living with HIV are vulnerable groups for numerous reasons in many countries. Their inclusion in all stages of planning and implementing programmes is essential and recognised as good practice across the sector. In 1994, the

GIPA (Greater Involvement of People Living with HIV and AIDS) principle was formulated at the Paris AIDS Summit, when 42 countries agreed to "support a greater involvement of people living with HIV at all…levels…and to…stimulate the creation of supportive political, legal and social environments" (UNAIDS, 1999). Trócaire and CAFOD programme partner The Brothers of Good Works in Addis Ababa provide community-based care and prevention services in some of the poorest areas of the city and include sex workers and other more vulnerable groups in

their outreach work. In order to ensure the involvement of people with HIV in the planning and implementation of their work they teamed up with Mekdim, the Addis branch of the national network of people living with HIV. This was recognised as an effective means of involving people living with HIV in recent evaluations of the programme (Drew, 2011; Watson, et al., 2012).

Observations and Key Considerations

- Women and the poorest feature prominently in FBO responses

- The literature reviews gives little evidence of outreach to youth and adolescents

- The teachings of all major faiths urge preferential attention to the poorest and the most vulnerable, without discrimination or judgment

- The teachings or their interpretation can challenge the role of FBOs in working with some key populations e.g. sex workers, MSM and with regard to gender equality

- A few programme examples (all grey material or from interviewees) were given of programme responses to key populations, including sex workers and people who use drugs. Some described outreach, support, prevention and advocacy, others reach out to proselytise

- Many FBOs define their programmes as broader community-based and not targeted at any specific vulnerable group, unless these fall within the broad base

- People living with or affected by HIV were identified as more vulnerable and examples of their involvement in programme planning cited (GIPA)

- Respondents indicated the importance of having the support of programme decision-makers e.g. trustees, faith leaders etc.

- FBOS have a local and national advocacy role for and with more vulnerable groups

Complementarity with Wider Health Services

Do Local Faith Communities demonstrate that they can complement the health sector/public services e.g. supporting retention of health workers, reinforcing health messages/campaigns, mobilizing communities around service demand, uptake and retention?

Existing national HIV and maternal health guidelines and protocols were cited by a number of organisations responding to this question as a method of ensuring complementarity with wider health services. Samaritan's Purse follows IMCI or C/HH IMNCI (Community and Household Integrated Management of Childhood and Newborn Illnesses) guidelines and protocols and also ICCM (Integrated Community Case Management) protocols for sick children. The organisation seeks to support and strengthen existing MOH health guidelines and protocols through capacity building and integration. For example, to avoid duplicity of health services, Samaritan's Purse uses the MOH's appointed health workers and volunteers to promote health messages, train MOH nurses and doctors, and provide health services within the MOH health facilities (Bauler, 2012).

Some organisations integrate their approaches to promote broad health outcomes. Christian Aid integrates prevention of infections (e.g. HIV, malaria and other) communicable diseases, community-based care, treatment and support for women, children and people living with HIV; enabling poor women and men to participate in improving their own health outcomes by providing them with the required knowledge and skills, influencing and holding decision-makers to account, challenging stigma and discrimination linked to HIV, and strengthening community and health systems (Sinclair, 2012).

Health system strengthening is an approach that many organisations have embraced. The Global Fund for AIDS, TB and Malaria describes health systems strengthening within the context of the Global Fund's mandate as 'activities and initiatives that improve the underlying health systems of countries in any of the six areas of the WHO building blocks for a health system (WHO, 2007) and/or manage interactions between them in ways that achieve more equitable and sustainable health services and health outcomes related to [HIV, malaria and tuberculosis]" (GFTAM, 2008).

Tearfund conducted research in 2010 to identify how local faith based partners contribute to health systems strengthening and how they can contribute further (Ward,

et al., 2010). Six local partner organisations in Malawi and four in Chad took part in the research along with key government health and donor stakeholders. The research identified a number of challenges in assessing whether a faith-based HIV programme contributes to or detracts from the health system as a whole (Ward, et al., 2010). Where organisations provide an integrated range of HIV and broader health services they can more clearly be seen as strengthening the national health system. Where hospitals and clinics exist in place of government-initiated infrastructure, as in the case of Christian Health Association of Malawi (CHAM) in Malawi, their HIV services are not parallel duplicative services that divert funding away from the health system, and can be seen as a partly diagonal approach (as opposed to vertical or horizontal) because it specifically addresses capacity issues through training nurses.

The Tearfund research noted, however, that vertical programmes need not automatically undermine the broader health system. The services that community organisations, including local faith communities, provide may focus on linking people with existing medical health services, providing peer support to people living with and affected by HIV, and doing outreach that is often outside the capacity of formal health facilities, such as home-based care and awareness raising. From these perspectives, faith-based HIV responses reduce the overall demand on health systems and therefore their work can be seen as factors that do not contribute to the weakening of health systems.

> "In some cases, both horizontal and vertical HIV responses by faith-based organisations may have only a weak positive impact."

In some cases, both horizontal and vertical HIV responses by faith-based organisations may have only a weak positive impact, for example, providing a limited amount of referrals with no formalised relationship between the faith-based organisation and the health clinic. In other cases, the faith-based programmes themselves may be of low quality because of weak infrastructure, lack of monitoring and evaluation processes, low awareness of HIV and AIDS issues and limited programme activities by religious leaders

and staff. These may result in a restricted range of services being provided, discrimination against people of other denominations, and increased stigmatisation of people living with HIV.

In these contexts, individual faith-based organisations whether implementing horizontal or vertical programmes, may unwittingly increase the burden on health systems and therefore contribute to weakening them. Overall it is difficult to quantify whether faith-based organisations are contributing to strengthening health systems for many reasons. One of the reasons is that strengthening health systems may be an unintended outcome of their work, and it is often explicit neither in their objectives nor their monitoring and evaluation (Ward, et al., 2010).

Faith and secular coordination at local level

Caritas is one of three organisations operating in Sot Nikom district, in Siem Reap province, Cambodia and has developed strong linkages with local partners (Kaybryn, et al., 2011). In consultation with the district health authority, the three organisations avoid duplication and maximise coverage by sharing responsibility for the district's 23 health centres and nearby villages. Caritas Cambodia is responsible for 14 villages and 16 health centres. The close relationship between Caritas Cambodia and these health centres results in practical cooperation which saves lives.

One community member shared her story: When she was pregnant, Ream accessed HIV testing but did not return for her result. Health centre staff realised she had tested positive for HIV, knew she was pregnant, knew what village she lived in, and were aware that Caritas Cambodia worked in that village. Without breaching Ream's privacy and her right to confidentiality, a midwife from the health centre accompanied Caritas Cambodia staff the next time they visited her village. When the midwife found Ream, she passed on the message that her test results were ready for her to collect. Ream returned

to the health centre, collected her test results and ultimately accessed PMTCT services. As a result, her twins were born HIV-negative.

Despite the challenges, the research identified positive impacts on health systems among a number of Tearfund partners in Chad and Malawi which are highlighted here (Ward, et al., 2010).

- CHAM manages 171 health facilities in mainly remote rural areas across the country (CHAM, 2008), account for 37–40 per cent of all health facilities in the country. As of December 2008, CHAM provided HIV voluntary counselling and testing in 134 facilities, antiretroviral therapy in 66 health facilities and prevention of mother-to-child transmission services in 127 facilities, and nine health facilities offered paediatric antiretroviral therapy (CHAM, 2008). CHAM runs training centres which train the majority of nurses in Malawi. Funding was provided by the government in the past, and more recently by the Global Fund. This training contributes importantly to health system strengthening because it directly increases the number of qualified health workers in Malawi.
- Malawi Interfaith AIDS Association (MIAA) is recognised by the Malawi National AIDS Commission as representing the faith community HIV response in Malawi (Ward, et al., 2010). MIAA has contributed at a national level to the HIV strategy, the national AIDS plan and the HIV law, and on an annual basis is asked to input into the National AIDS Commission implementation plan. MIAA is also part of the Malawi Equity Health Network, an advocacy organisation monitoring drug procurement and health service provision in Malawi. The MIAA network has also been used by the Ministry of Health to promote other health issues, such as the cholera campaign, and both organisations are in the process of working with WHO to consider how to collaborate on TB issues.
- Programme Chrétien d'Animation Rurale[7] (PCAR) in Chad implements agriculture, income-generation activities and HIV and AIDS activities (ACT, 2009). It carries out information, education and communications activities in the community and gives people a health card if they are interested in taking a HIV test. The hospital recognises these cards, and when they are presented staff know that the person

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[7] Christian Programme for Rural Development

has already received a certain amount of counselling before coming for a test and that the person will also be supported by the faith-based organisation on their return. The health personnel commented that the

the management of health facilities, if the largest hospital in a district is faith-based then it will assume the management role of the health facilities in that district. They also supply anti-retroviral therapy,

work of PCAR through the information, education and communication programme and the introduction of the health cards have assisted the hospital in encouraging more people to come for HIV tests.

- Bureau d'Appui Conseil[8] (a ministry within Entente des Eglises et Missions Evangéliques au Tchad[9]) manages four hospitals and 101 health centres in Chad. These health facilities work within the policies of the Ministry of Health. Some of the nurses and doctors in the health facilities are paid by the government and the health centres receive subsidised drugs. In relation to

voluntary counselling and testing and prevention of mother-to-child transmission services. Bureau d'Appui Conseil contributes to strengthen health systems by providing health services in remote rural areas where there are no state health facilities. This strengthens health systems and HIV and AIDS programmes if they are also following national health and HIV and AIDS guidelines.

World Health's approach to health system strengthening focuses on the delivery of primary health care. All of its health services are integrated along a continuum of care, even when funding sources are varied and for vertical programmes, IMA integrates them for a given geographic coverage (Chand, 2012). Concern Worldwide works with national providers in strengthening health systems to

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[8] Support Council Office
[9] Covenant of Evangelical Churches and Missions in Chad

deliver high quality HIV and AIDS related services including health and child survival programmes for safer delivery, supporting health workers and birth assistants, child spacing, and anti-malaria and under-nutrition interventions (Gahan, 2012). Ojus Medical Institute avoids duplication of government services and makes referrals to existing facilities rather than implementing parallel services. It promotes institutional delivery, sponsors training of midwives and trains rural traditional midwives in safe delivery (Herwadkar, 2012).

The CHAN research found that 95% of responding organisations in the 22 countries surveyed are involved with their National AIDS Programmes, and follow national guidelines for HIV and AIDS, PMTCT and maternal-child health (MCH). Their level of involvement ranged from receiving funding from Government or National AIDS Programme (22.5%); receiving anti-retroviral drugs (ARVs), lab equipment and/or other supplies (57.5%); representation of the respective organisation on the National AIDS Programme advisory committee (22.5%); and participation in workshops, trainings and seminars provided by the National AIDS Programme (77.5%). Most of these organisations are also members of Christian Health Associations and of various interfaith networks.

Observations and Key Considerations

- FBOs reported their adherence to national guidelines, particularly those of National AIDS Programme, PMTCT and child health guidelines, thus ensuring their integration
- A number of respondents gave examples of work to strengthen health systems and Ministry of Health guidelines, and numerous examples of integrating HIV into broader health services existing locally
- Vertical programmes need not undermine the broader health system when they make effective referrals, provide peer support and outreach services not otherwise supplied
- Vertical and horizontal FBO programmes making few referrals, having limited capacity and low quality, or are discriminatory are of limited effectiveness

Accountability of Health Services

Can FBOs and Local Faith Communities demonstrate that they can hold their health services (and where possible, similar government services) accountable e.g. do they demonstrate conformity to minimum standards of public health, quality of service delivery, reporting mechanisms, and other accountability measures?

The majority of Christian FBOs in Africa are members of their national Christian Health Associations which, in addition to providing coordinated approaches to health care are also a strong channel for holding their governments to account (Olivier, et al., 2011; Chand, 2012). The Christian AIDS Network Alliance (CANA) is similarly influential, with a membership of over 350 organisations (Keough, et al., 2007). CABSA guides and supports Christian communities towards HIV competence, through advocacy information services, mobilising, training and networking.

A number of FBOs are active signatories to international initiatives e.g. World Vision International is among the organisations listed as committed to Every Women Every Child through its HIV programmes. This provides a means of holding to account both national governments and international agencies who are signatories to such commitments. Many FBOs and their national or international networks are also actively involved in activist movements monitoring the progress of government commitments. For example members of the Ecumenical Advocacy Alliance, of CHAN and of the worldwide federation of Caritas agencies were all actively involved in events around each of the UNGASS launch and review meetings held New York in 2001, 2006 and 2012.

Many international FBOs are members of their in-country HIV-focused NGO networks, such as the UK Consortium for AIDS and International Development, Dóchas in Ireland, Osservatorio AIDS in Italy and Action Against AIDS in Germany, and exert significant influence and monitoring capabilities with their own governments and with international agencies and donors.

Samaritan's Purse follows national guidelines and protocols for service quality, as well as developing proprietary project management guidelines with a number of maternal health and HIV related indicators. The organisation also follows donor minimum standards, such as USAID's Rapid CATCH[10] (Bauler, 2012). IMA also follows the protocols and guidelines of the Ministry of Health of the country it works in as well as internationally recognized standards in HIV and maternal health service delivery (Chand, 2012). Concern Worldwide supports the 'Three Ones' and national health and HIV strategies in-country and advocacy initiatives in-country and internationally (Gahan, 2012).

Christian Aid promotes external accountability by mobilizing communities around service demand and supporting them to understand their rights to health and advocate for better quality service provision from government. In terms of its own accountability, Christian Aid is one of 13 agencies that is HAP certified – independently assessed as meeting the Humanitarian Accountability Partnership (HAP) Standard in Humanitarian Accountability and Quality Management, which includes incorporating beneficiary feedback into programmes (HAP, 2007). To become certified Christian Aid was audited centrally and in India and Burkina Faso. Beyond this, Christian Aid encourages communities to feedback (positive and negative) to partners who will log feedback themselves (to avoid Christian Aid being seen as 'policing' the partner). Some Christian Aid offices are developing complaints policies that extend to the community level, but encourage communities to feedback to partners first (Sinclair, 2012).

> **"The role of external donors includes holding faith-based organisations to financial transparency and accountability standards."**

Concern is a signatory to the Code of Good Practice for NGOs responding to HIV and AIDS since 2004. Concern and CAFOD are HAP certified, and staff follow the IASC Guidelines for responding to HIV in emergencies. Both organisations also endorse the Sphere standards (Gahan, 2012; Burford, 2012). NCA Vietnam is also HAP certified and

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[10] Core Assessment Tool on Child Health (CATCH)

rolling HAP training out to its partner organisations (Koltai, 2012).

The role of external donors includes holding faith-based organisations to financial transparency and accountability standards (Herwadkar, 2012). DFID has a Programme and Partnership Arrangement (PPA) with number of NGOs, through which it provides substantial funding over a multi-year time frame. Organisations are required to submit detailed annual reports on progress against agreed outcomes and DFID also commissions mid-term independent reviews, which identify progress and indicate areas where organisations may need to give further attention. The following is a sample of comments from the recent review for CAFOD (including its HIV programme), which overall was affirming, and ratified achievements while also identifying challenges.

Advantages of holistic and faith responses

"The IPR team have found that the holistic approach is appropriate for the communities that CAFOD works with, and is reflected in the projects visited in the field which although may be labelled (for example) "livelihoods" could be working on HIV, Water and Sanitation, health and education. CAFOD's faith identity has the potential to, and does add value to CAFOD's work. It can be used as an entry point to communities and decision makers. The non NGO status of the church also enables CAFOD to work in areas and on subjects that other NGOs may not be able to work"...

"M&E processes are leading to changes... For example the HIV monitoring tools have been useful for allowing staff and partners to identify gaps at the local/country level. In Kenya we saw examples of partners, having identified through the Care Mapping Tool areas in which they are weak, linking with other partners with more technical expertise, or developing funding proposals to support those areas of work where they are weaker."

(Watson, et al., 2012)

Cordaid has introduced Results Based Financing to its work with partner organisations in DR Congo, Burundi, Central African Republic, Zimbabwe, Cameroon and Congo-Brazzaville. According to Cordaid, healthcare providers are only paid when they can demonstrate that their medical services have been improved and they have effectively treated more patients with the allocated funds (Cordaid, 2012). Simultaneously, Cordaid also approaches HIV and sexual health responses through the lens of facilitating

informed decision making among the clients of services (Kaybryn, 2010) with its partner organisations in DRCongo, Burundi, Central African Republic, South Sudan, Ethiopia, Cameroon, Malawi, Uganda, Sierra Leone, Afghanistan, Bangladesh, and Ghana. Through this lens, Cordaid aims to address barriers to community members accessing services including the availability of services at faith-based clinics and the knowledge, attitudes and confidence of health staff.

With both approaches, Cordaid reported that thus far, those partner organisations that previously felt constrained by religious messages that conflicted (or were perceived to conflict) with public health messages have been able to use the frameworks of results based financing and/or informed decision making to introduce changes to their services to increase their comprehensiveness. However, those that do not want to increase their range of services or continue to feel uncertain about the implications of doing so, seem able to maintain the status quo. In the case of results-based financing, local faith-based service providers can simply choose to opt out of delivering specific components (such as family planning services) and receiving funding for those that they omit.

In the case of promoting informed decision making, Cordaid partners are required to introduce an organisational policy. Ultimately it will take time for training and sensitisation among staff members to fully understand and implement the policy. Changes are slow to occur, with some staff indicating that they now feel more confident to refer a married woman to a service that they do not provide such as to access family planning options, but remain hesitant and in some case reticent to refer an unmarried younger woman (Mensvoort, 2012). Cordaid is commissioning research into the impacts of the informed decision making policy on its partner organisations and community members who access their services which is due to take place in 2013.

Gaps between secular and faith-based responses can sometimes be caused by a mutual suspicion, which can be a result of a lack of mutual accountability (Karpf, 2012). Although faith-based organisations may adhere to national policies and guidelines, as well as having accountability to their external donors, there can be a reticence to comply with the specific government regulations that would ensure that they are formally ensconced in the national response. In some cases faith-based organisations prefer to maintain a level of control over their operations and exhibit territorialism, in others the government is perceived as interfering, and in others still the peripheral position of a faith-based organisation to the national or secular response may simply be caused by the historical organic evolution of

the faith-based response over many years. It is important to note that the recognition of faith-based responses to HIV and maternal health by government and secular quarters may require some movement towards them by faith-based organisations, particularly in terms of compliance and regulation conditions that other secular health responses are required to meet (Karpf, 2012).

Observations and Key Considerations

- FBOs' ability to hold national governments and international agencies to account is strengthened through membership of national FBO networks, relevant NGO networks and activist groups and as signatories of international agreements

- FBOs accountability regarding their programme standards and practices is monitored through (usually voluntary) subscription to internationally agreed codes of practice and programme standards and through obligatory monitoring and evaluation requirements of donors

- Results-based financing can strengthen some FBOs wishing to provide more comprehensive services. Others will choose to maintain the status quo

- Respondents made little reference to community-based monitoring of FBO programmes or of governments or secular NGO initiatives

- Gaps between secular and faith-based responses can sometimes be caused by a mutual suspicion, which is a result of a lack of mutual accountability

- FBOs need to show the same degree of compliance and regulation conditions as other secular health responses are required to meet

Sustainability and Ability to Scale Up

Do FBOs and LFCs demonstrate the ability to operate sustainably and the ability to go to scale in these areas? – And if so, how?

Sustainability can be interpreted in a number of different ways and applied to impact, organisational capacity and funding, to name a few. FBOs acknowledge that a response's ability to be scaled up can be difficult to measure.

Organisations, such as NCA Vietnam, have concentrated its sustainability objectives into the capacity of partner organisations, and supported them to access funds from other donor sources (Koltai, 2012).

Funding was cited as a barrier to scaling up responses by a number of the organisations that shared their views for this research. However, at community level, there are factors which have helped some organisations scale up their response, albeit in a relatively small way compared to a national programme. For example, BCCI has access to natural resources in its locale so has been harnessing this by making bricks to generate funds to increase its activities (Turyatunga, 2012). But for such smaller organisations as BCCI the impediments to scale up, or to even continue their work, are numerous. Financial constraints limit coverage of responses because of lack of human resources and transport to reach people.

Certain understanding and models of scale-up promoted by some international agencies and donors, which equate scale with the size of individual initiatives, may not always be appropriate for faith-based and other community-based endeavours. The Called to Care Initiative of SACBC expanded its initiatives over time; building on the lessons learnt from pilot projects or documented successes in one location to develop a broader, concerted, locally relevant while well-coordinated programme linked to the regional network. The programme's experience showed that scale-up does not have to be necessarily through the expansion of a single central service. Through the Choose to Care initiative the Church scaled up service provision by the replication of smaller scale programmes rooted in and responsive to their immediate communities' needs.

The review of this programme shows that such an approach is effective when undertaken within common guidelines and coordination, and given central support (Vitillo, 2006). For FBOs (and others) working within coordinated networks, scaling-up may legitimately be achieved through "scale out" i.e. replication of proven effective initiatives into a series of locations, rather than increase in size of a single operation.

Observations and Key Considerations

- Respondents provided little information on questions of sustainability, possibly because sustainability is interpreted in a number of ways, and applied to impact, organisational capacity, funding, and more

- Lack of funding was the obstacle to scale up most often cited

- The understanding of scale-up needs to be expanded take account of the diversity of situations and opportunities of faith based and other community based initiatives

- Scale-up may not always be about getting bigger but about effective replication i.e. scaling out

Volunteerism, Mobilising Communities and Resources

How relevant are issues of volunteerism, the ability to mobilise communities and resources, and factors such as in-country vs. external donor funding?

Characteristic of almost all FBOs is both their capacity to mobilise a strong contingent of volunteers from within their congregations and wider communities, and their reliance on a large volunteer base for the implementation of their work. In a presentation at a 2007 conference Dr. Geoff Foster estimated a value of US $5 billion for the contribution of faith-based volunteers responding to the needs of people living with or affected by HIV in the so-called "AIDS belt" in sub-Saharan Africa. Using what he labelled as "matchbox calculations", he arrived at this estimate by hypothesising that each of the 1 million congregations in this region has at least five volunteers working on HIV-related activities, that each volunteer donates at least two hours per week (or 1/20 of fulltime work) to such service provision, and that a value of US $20,000 per annum could be attached to such service, if it were done on a full-time basis (Foster, 2007).

A survey of 51 faith-based organisations in Cambodia that respond to HIV and AIDS found they engaged a total of 4,769 volunteers, with medium sized organisations (of 20-29 paid staff) having an average ratio of staff to volunteers of 1:26 (Kaybryn, et al., 2011).

Volunteerism affords significant advantages such as ability to identify, reach and provide a contextually -sensitive response to a broader beneficiary base, a channelling of local knowledge, the empathy of peer involvement and

much more. Effective use of volunteers requires considerable investment by FBOs of staff time and resources to recruit, train, supervise and provide on-going support as well as to core expenses incurred by volunteers. Sustainability is always a concern as volunteer turnover can be high as individuals leave to take up paid work (often more skilled because of their volunteering) and their expertise and client relations are lost to the faith-based initiative. Nonetheless FBO experience confirms that, with well-planned programmes for training and deploying volunteers the challenges of sustainability can be overcome and volunteerism can be a strong and effective arm in all of their initiatives to address HIV (CAFOD, 2006).

Requirements on FBOs to be more rigorous in their monitoring, along with tendencies of recent years to press programmes to "do more with less" or "show value for money" are causing considerable concern among FBOs because of the effect this is having on the volunteerism so essential to the success of their work. An anecdotal account is illustrative. The director of an FBO in Southern Africa, that has a national HIV care, prevention and livelihoods programme of proven effectiveness, confronted donors at a satellite session of the 2012 International AIDS Conference, in despair at the amount of data collection required by them. He had diverted many of his large contingent of volunteers into gathering this data and reported that many of them had left the programme as a result, complaining that they had joined in order to provide home based care or peer support to people affected by HIV and not to spend their time doing administrative work collecting data (Burford, 2012).

Ratio of paid staff to volunteers from a survey of 51 faith-based organisations in Cambodia

Organisation size	Total number of volunteers	Average number of volunteers per organisation	Average ratio of staff to volunteers
Less than 10 paid staff	296	19	1:4
10-19 paid staff	304	14	1:2
20-29 paid staff	3347	669	1:26
30+ paid staff	107	36	1:1
Number of paid staff unknown	717	143	N/A
	4769 (Total)	119 (Average)	

Reproduced from Kaybryn J and Moriarty K, National Review of Faith-Based Responses to HIV in Cambodia, UNICEF, 2011

Observations and Key Considerations

- Significant numbers of volunteers are mobilised by faith-based organisations, although estimations of numbers are often difficult to ascertain

- Organisations can rely heavily on volunteers which reduces operational costs

- Quantifying the contributions of volunteers in monetary terms can be difficult, and FBOs do not seem to routinely calculate or include the contribution of volunteers in the costs of programmes submitted to donors or their efforts to show impact or value for money

- However, a lack of professional and paid staff can mean that FBOs increasingly rely on the volunteers to meet organisational capacity demands (e.g. for monitoring and evaluation) for which they are less suited

- Increasing data collection demands of donors can overburden volunteers or divert them away from their core work, with consequent risks of losing them to the programme

3. Opportunities and Challenges

The information presented in sections 1 and 2 identifies a wide variety of diverse, interesting and demanding opportunities and challenges. In Section 3 we consider those that strike us as key to the particular task delineated in the Terms of Reference for this project. The recommendations in Section 4 are ordered under the same headings as those below denoting the opportunities and challenges emerging.

A. Many FBOs have the experience, reach and capacity to engage actively with the particular area of HIV and maternal health.

Evidence gathered for this report provides numerous examples of FBO experience and competency in all of areas listed by Maryse as enablers of community-based initiatives (Maryse, et al., 2012). It also indicates weaknesses among many (but by no means all) FBOs particularly regarding data collection and analysis and demonstration of effectiveness. Although many valuable mapping resources were gathered for this research a comprehensive mapping worldwide of FBOs' engagement with HIV is lacking.

A mapping or similar systematic data collection that ensures that evidence-based faith-based initiatives are included among records of national and regional responses to HIV, which national plans and budgets reflect and support this and that policies and strategies of governments, donors and international agencies, would be enormously valuable. It would also serve as a means of fostering integration between faith-based initiatives and other actors and of avoiding duplication of initiatives or mutual isolation in silos. In some cases, the methodology of data collected at national level by governments does not capture whether a clinic or response is faith-based (Karpf, 2012).

Such mapping would need to provide more particular details as to the specific area of engagement with HIV and who the intended targets or beneficiaries. This degree of precision was lacking in the responses received for this research area and in much of the literature reviewed, even when there is a breakdown of responses into particular areas. For example, citing involvement in PMTCT programmes does not of itself indicate how this benefits maternal health, nor should it be automatically assumed that it does. This point is taken up again under heading e of this section.

Strikingly, the [English language] literature reviewed offers little evidence of HIV-related faith based responses in Central or South America. Most surveys cite numerous examples of initiatives in East and Southern Africa, fewer but still significant references to work in South and South-East Asia, yet there is a dearth of information for Latin America. This is despite the fact that HIV epidemiology shows significant prevalence rates for many countries of Central America, and for Brazil, and also documents social, economic and gender-related issues for all countries of that continent that increase people's vulnerability to the virus. It is also despite the fact that faith groups (mainly Christian) are key actors in providing health and other basic services for the most disadvantaged sectors of society and are often strong catalysts of community-based advocacy.

The present report cites a few examples encountered in the literature reviewed, and more are documented in a separate annex. A similar point applies to evidence from countries of Asia, the Middle East, Francophone Africa and other areas where the scope of the present project restricts access only to information published in English.

Attempts to map, and calls for increased mapping of FBO responses are not without tensions. What is often categorised as FBOs being poor at documentation may for some be more indicative of a historical lack of trust or alignment with national evaluation and information systems (Haddad, et al., 2008). It should not be assumed that all FBOs would automatically see the benefits of being included on national or international policy maps (Olivier,

2010). Representation can also be a critical issue with current systems often being over-representative of certain formal and denominational groups and under-representative of other religious groups (Haddad, et al., 2008). Increasingly, statements by international agencies and funders recognising the important role of FBOs and their under-utilisation, when set in the context of shrinking resources, can leave faith leaders feeling "used" by the instrumental way in which they are drawn into government programmes (Haddad, et al., 2008; Olivier, 2010). Tensions also exist around attempts to classify FBOs in typologies dictated by form, function and religiosity (the degree to which an organisation is regarded as religious). Olivier presents a fuller analysis of these tensions together with a proposed process for moving towards more operational typologies (Olivier, et al., 2011).

B. The opportunity and urgency of presenting women's and children's rights as inextricably linked

The review found evidence of failures to include human rights considerations for women in PMTCT and maternal health initiatives. Teachings of all faiths uphold the equal dignity of all, the right of all to life, health and wellbeing, and a commitment to protecting all and particularly those marginalised or discriminated against. FBOs often shy away from discourses on sexual and reproductive health or may be excluded by the wider sector because of anticipated (often unfounded) judgmentalism. A challenge for all actors, including FBOs, is to extend the discourse around sexual and reproductive health to address violations of women's human rights such as those described in Section 1 as an opportunity and responsibility compatible with their core values yet needing to be articulated in human rights rather than moralistic terms.

Also much documentation around maternal health and HIV focuses mostly on prevention of infection of babies born to mothers with HIV and the longer term (and sometimes short term) health needs of mothers seem secondary. This presents limitations of many PMTCT programmes especially when predicated on a wholly medical and top-down model. It also risks setting the needs and rights of women and their babies in opposition to each other, at a time of limited resources and political pressures to show immediate effectiveness. Such top-down models may well be replicated across the health sector and prevail also within some services provided by FBOs as in those supported by government or other providers. However, because of their characteristic community involvement, and their wider health and development work as well as a commitment to advocacy, FBOs are well placed to expand HIV and maternal health initiatives to balance the long-term health needs of mothers with preventive measures of PMTCT, and also to address the important social, economic, nutritional, cultural issues that act as barriers to effective maternal health initiatives.

Modelling HIV and maternal health on the four quality-of-life domains described in CAFOD's Care Mapping and Batteries Tools (Drew, 2011) could be valuable. These would be 1) health, including sexual and reproductive health, 2) psychosocial and spiritual support 3) initiatives to address legislative discrimination, abuses of women's and their children's human rights and work to counter stigma and 4) initiatives to strengthen economic and livelihoods security – including nutritional security.

"Nothing for us without us." The voices of women, particularly women living with HIV, seemed somewhat subdued within the literature surveyed for this research. FBOs are often well placed to ensure women's voices and perspectives are heard, at all levels of decision making, but should also ensure that they inform their own responses and that their own responses are modelling this inclusion.

The social contexts of countries can hinder the implementation of responses and some approaches can come into conflict with expected societal norms. One organisation attempted to provide training in midwifery in Afghanistan by approaching women, which caused serious offense to their husbands. They had to request permission from the men in the community to allow women to participate in the training (Bauler, 2012). Another organisation noted that further work is needed to engage men, some of whom hold negative cultural beliefs and attitudes which act as a barrier to themselves and to women in accessing health services, including HIV prevention services.

C. The Strengths and Responsibilities of being Community Based

Among the benefits regularly attributed to FBOs are their reach – often providing the sole or main health and development services in rural or more remote areas-, the fact that they are often community based rather than solely operating from institutions and their longevity within communities. A number of practical implications present:

Prime evidence base. FBOs are in a privileged position to be able to garner information on attitudes, events, concerns and achievements of communities, while also having extensive access to formal services (health, education, government and international agencies etc.) locally and nationally. They enjoy the trust and support of the communities where they work, which often gives them unrivalled access to information, stories and life

experiences. In the context of HIV and maternal health they are well positioned to document in a systematic fashion the opportunities, challenges and achievements with regard to HIV and maternal health and to influence the development of future strategies in this regard. Within this broader role, they can document the medical, social, cultural and economic considerations and concerns for women as well as their children. They can have a pivotal role in building up a dossier of practices around sexual and reproductive health and reproductive rights[11] – human rights – of women affected by HIV and presenting this as evidence calling for immediate action.

Evidence gathered in this report indicates that data collection is often a weak point of locally based FBOs, whether because of lack of skills and experience, or lack of adequate resources. Various avenues can be pursued to address this, whether through national networks of faith organisations or of NGOs more generally, peer learning between FBOs, access to government training or that provided in many countries by international agencies.

That said, it is important to give detailed consideration to the whole area of data collection. Who should collect such information, how and why? While there seems to be more consensus on the value of both qualitative, context-rich information and systematic quantitative data tensions remain in getting the balance right and in having tools capable of integrating and interpreting multiple dimensions (Olivier, et al., 2011). The dangers of diverting the energies and considerable resources of community initiatives, often reliant on large numbers of volunteers, away from their core work into heavily administrative data collection, should not be under-estimated. Furthermore, essential to all data collection requirements is a discernment of who it benefits, and how.

Accountability: This follows as a natural consequence of the last point. Communities are the ultimate arbiters with regard to governments' and agencies' fulfilment of commitments, strategies and programme plans. Community-based monitoring and accountability processes are gaining momentum and have been employed to good effect by various FBOs. World Vision is developing comprehensive community level assessment tools on the

status of health (related to mother and child health and HIV) in communities and has done extensive work in recent years on community-based accountability more generally. Other participatory methods enabling community-led monitoring and accountability exist, and FBOs are well placed, although not always with the requisite skills, to implement such processes and facilitate community engagement with accountability processes.

> ## Joined up approaches
>
> **Bridges of Hope** starts with building trust between the staff and the client, and then supports the client to rebuild relationships with their family. The client's future sustainability is developed through various support services and ultimately through a business plan based on their individual skills and aspirations. They are supported emotionally and financially to provide their own economic needs and garner the support of their extended family to increase the potential of long term success for both themselves and their family. The key elements are:
>
> **Building an individual bridge for each client**: intensive focus on clients continues during first three months of the client's new venture into employment or small business. Cash transfers continue to be provided for food and housing support, if required during this period.
>
> **Holistic focus on the family**: Staff work hard to reunite clients with their families, even in cases of extreme family dysfunction.
>
> **Case management system**: Each counsellor/social worker takes responsibility for his or her own clients and also consults with colleagues at team meetings.
>
> **Home visits**: These are a critical element in building trust, so that clients can express both their hopes and fears.
>
> **Group counselling**: These sessions allow clients to share their feelings and experiences to break through isolation caused by HIV, and see that others have similar experiences.
>
> **Planning for the future:** Clients attend workshops on making a plan for the future. The workshops provide structure and advice to help them decide on the best course of action.
>
> (Maher, 2008)

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[11] This is the terminology of the ICPD Programme of Action: Noting, which is noted herein for ease of reference, while bearing in mind concerns maintained by important religious voices, and related on-going – and unresolved – debates within international, intergovernmental and civil society fora.

Follow-up A barrier to effective HIV and maternal health services identified by respondents can be the loss to follow-up of mothers and their new-born children, beyond the immediate post-partum checks. FBOs are therefore well placed to bridge this gap and to establish and support

innovative community based initiatives that provide effective long-term maternal and child health support. Bridges of Hope, developed as part of the Maryknoll AIDS Programme in Cambodia, to support people on ART, may provide pointers to a bridging model applicable to HIV and maternal health contexts.

Collaboration with existing initiatives such as the Mama's club in Uganda, a community-based organisation led by women living with HIV focused on addressing the impact of HIV, reducing the associated stigma, and providing support to and empowering HIV-positive mothers. Mama's Club provides psychosocial peer-to-peer support and provides training in HIV prevention and income-generating skills. Members travel to nearby local communities to mentor other mothers (Mungherera, 2012). Stepping Stones Plus uses the participatory community based processes developed in the original Stepping Stones training to engage women and men of all ages within a community on a prolonged process of learning and action. Stepping Stones Plus includes a section on HIV and motherhood and on sexual and reproductive health and reproductive rights of people living with HIV (Welbourn, 2012).

Influence: Religious leaders wield considerable influence both within the communities they serve and also with decision-makers at local and national (and sometimes international) levels. FBOs similarly enjoy considerable influence within communities because of the trust they enjoy and a perceived shared set of values and beliefs. This research affirms that such influence is used to improve knowledge, understanding, attitudes and practices, to denounce stigma and discrimination and to address injustices.

It has also been used on occasions to provide misinformation and to increase the stigma and isolation of people living with or affected by HIV. A challenge for FBOs is to ensure initiatives are grounded in sound evidence of effectiveness while underpinned by key values of their faith that enhance the dignity, respect, acceptance and equality of all, and by a process of self-assessment to eliminate attitudes and practices that are stigmatising and judgemental. This is particularly challenging in the context of HIV and maternal health, where the approaches of many faiths to questions of gender and of sexuality and reproductive health are ambiguous. It is noteworthy that, while a number of publications reviewed in this research identified religious beliefs or attitudes as a potential barrier for effective engagement of FBOs, few of those who completed the request for information questions did so. Rather these responses focused mostly on factors external to their faith context, such as economic, social, geographic or cultural constraints.

Community Mobilisation. Faith-based initiatives are effective in eliciting community involvement, whether as volunteers involved in implementing programmes or as lobbying and advocacy groups. In the context of HIV and maternal health, volunteers can make a significant contribution to programme effectiveness through peer support, care, mentoring, livelihoods skills-sharing and much more. They can also be effective in monitoring situations, documenting stories, articulating concerns and making referrals.

Despite the reported move towards skilled birth attendants, TBAs are still a reality in most communities and several respondents in this study listed training of TBAs among their activities. FBOs can ensure that TBAs are sufficiently skilled, that they are able to make referrals appropriately and that their services are recognised and integrated within the formal healthcare system (Melillo, 2012).

The power of community-led advocacy is extensive and again FBOs have a pivotal role in enabling community advocacy informed by documented experience-based evidence.

D.   The benefits of and need for holistic responses

A holistic response enables FBOs to take a more coordinated and thorough approach, breaking down their own or others' silo mentalities, and addressing the social determinants of health as well as health service needs. The four domains proposed in B above would work well within this holistic approach and might offer a framework for defining what we understand to be a holistic response. This approach also enables a seamless joining of health issues with wider development, justice and advocacy concerns and responses. A number of faith-based organisations have recorded the effectiveness of their ability to integrate their approaches within the wider health service provision, particularly at local or district level (e.g. Caritas Cambodia), and also at national level (e.g. CHAM). Beyond providing health services, many faith-based organisations address the social determinants of HIV transmission and maternal health, particularly those FBOs that are not medical institutions. What is important is that organisations, whether they provide responses which reduce vulnerabilities or whether they provide health services, should link closely with health and other service providers and with the wider development agenda to ensure that community members access the full range of services available to them.

FBOs can give an enhanced understanding to the "value for money" discourse that currently is too often reduced to

measuring immediate, tangible productivity against unit of money invested. Articulating the more intangible social assets connected to the work of FBOs, in large part resulting from their long-term commitments to the wellbeing of individuals and communities, their involvement in a range of health and development initiatives that enable their more holistic responses and their ability to mobilise a strong and committed volunteer base in many instances, is challenging. To some extent this becomes an issue of having the toolset to document qualitative evidence mentioned already in this section. It also requires FBOs to be more adept at articulating their conceptual frameworks in terms that include e.g. the roles and contributions in kind of volunteers, the effects on quality of life and on human flourishing for entire families and communities, of initiatives targeted at individual members. Such articulation could valuably inform funding applications, programme reviews, national surveys and reports against objectives, etc.

E.   The importance of identifying impact

The literature collected and the information from respondents all are rich in examples of FBO activity, yet often lack evidence of effectiveness. This may reflect, in part, the differing focus of FBOs and of secular agencies already noted. Where secular agencies are primarily concerned with demonstrating results within a fixed time-frame (though these are not always synonymous with "impact") FBOs are often more concerned with the wellbeing of individuals and communities in the long term. It may also be partly attributable to the lack of data collection as a standard practice among some FBOs or a lack of clarity as to who the target groups are for specific initiatives, precisely what change is hoped for from the effects of that initiative and what evidence exists to show the change is happening.

Recent tendencies among international agencies and development experts to promote "theory of change" processes may be of particular value to FBOs, while acknowledging the danger that these become just the latest "fad" or funding requirement. Used effectively, theory of change is an on-going and organic process that helps groups to ask "what change can happen/has happened and how do our initiatives affect this?" rather than the more typical approach fostered by logical frameworks and similar of asking "what are our

achievements?" (O'Flynn, 2010; O'Flynn, 2012; Vogel, 2012). In the context of HIV and maternal health it may be a valuable process for FBOs that do not already do so, to identify exactly who they are targeting with their initiatives, what change is hoped for and how their particular initiatives contribute to that change.

Lack of clarity as to who is being, or should be targeted, can be a challenge also for secular agencies interacting with FBOs. The Malawi Religion Project (MRP) is a large-scale cross sectional, mixed methods data collection project which studied the AIDS-related activities of religious congregations in three districts of rural Malawi in 2005. A telling finding of early analyses of these data indicated *"wide gaps between national denominational authorities – to whom external intervention efforts are targeted – and the local congregation leaders who are often supposed to implement them... At each level of leadership, Muslim leaders are more isolated than their Christian counterparts with respect to the flow of AIDS-related information, raising important questions about the position of Muslims in diffusion processes that demographers have identified as crucial for conveying information about prevention and treatment"* (Adams, et al., 2009).

Samaritan's Purse, in addition to using the Barriers Analysis, also uses other tested methodologies in it work. Changes related to HIV stigma are measured through KPC (Knowledge, Practice and Coverage) surveys using LQAS (Lot Quality Assurance Sampling) survey methodology. A baseline is conducted at the start of the programme to determine baseline coverage indicators related to HIV

practices and attitudes. In its four-year MET programme

(Mobilizing, Equipping and Training Youth for HIV

Prevention) "mini-KPCs" were conducted yearly with a final

baseline survey to measure changes, including changes related to HIV stigmatization and discrimination. For example, one example of an indicator used was "percentage of respondents who would purchase goods or food from a shopkeeper living with HIV or AIDS" (Bauler, 2012).

4. Recommendations

The numerous issues emerging in previous sections give rise to a diverse range of recommendations. These can be summarised under two strands, one affecting programme practice and one affecting the research agenda of those engaging with the area of FBOs, HIV and maternal health. The following paragraphs outline the main recommendations for each of these strands. The remainder of this section then sets these out in greater detail, along with supplementary recommendations, and presents them as they apply to FBOs (local or international), researchers, national governments, international agencies and donors.

Strand 1. Programme Practice

In initiatives responding to HIV and maternal health, FBOs, with the support of national governments, international agencies, donors and researchers as relevant, can:

- Develop a fuller and more effective mapping of their involvement in HIV and maternal health ensuring this is Included in government mapping, planning and budgeting.
- Apply mapping and data collection tools that document holistic rather than narrowly medical responses and gather qualitative along with quantitative evidence
- Put the wellbeing of mothers with HIV on a par with that of their babies in PMTCT and similar programmes
- Articulate and address the social, economic, gender, cultural and legislative issues that affect women's ability to access maternal health services
- Audit and challenge stigma or discrimination experienced by women with HIV who access maternal health or sexual and reproductive health services, both within services provided by FBOs and within other locally available services
- Revise their processes to ensure the voices of women living with HIV inform their strategies and practices
- Train Faith Leaders and programme personnel in HIV knowledge and in human rights

- Ensure Faith Leaders name and denounce stigma affecting women with HIV, whether within faith structures or wider health and social services
- Develop initiatives that bridge maternal health support from acute services into community settings
- Develop long-term holistic, community-based initiatives modelled on four domains governing maternal wellbeing as alternatives to medical, top-down, acute intervention strategies
- Identify more effectively specific target groups and how programmes reach/affect these
- Identify the specific changes sought and how each programme contributes to these

Strand 2. Research

Academic and other researchers, working in collaboration with FBOs, governments, international agencies and donors, and with appropriate support and resources can:

- Identify toolsets and processes to document community-based qualitative experiences and how these also demonstrate impact
- Identify mapping and data collection tools that cover four domains of a holistic response
- Explore and document the synergy between core values of faith and rights-based approaches.
- Identify effective initiatives bridging maternal health support from acute to community setting
- identify processes that combine institutional acute-phase and longer-term community-based services and prove effective alternatives to top-down medical models
- Develop toolsets and processes to document the social assets of FBO initiatives, including their volunteer base, and demonstrate their added impact and value for money
- Identify links between FBOs, social capital and resilience-building capacities of communities
- Identify and promote diverse approaches to scale-up

The following fuller recommendations include and expand those listed above and are grouped to mirror the key opportunities and challenges identified in Section 3.

A. Many FBOs have the experience, reach and capacity to engage actively with the particular, and integrated, areas of HIV and maternal health

Researchers

1. can work to develop toolsets that enable effective documentation of qualitative experience-rich evidence that can be incorporated alongside quantitative evidence for more complete mapping of FBO reach and capacity. Expansion of the model proposed by Olivier et al 2012 for mapping operational typologies, might be one option to pursue.

International FBOs

2. could be commissioned to carry out a desk-based mapping, informed by their existing records. For example, 10 such organisations might focus on a specified number of countries in different regions of Africa, Asia, Central and South America, and simply document their initiatives by operational type.

Local FBOs

3. can strengthen their coordination, mutual learning and information sharing through being part of national networks of faith-based organisations and contributing, through them, to national mapping and data collection initiatives.
4. Can ensure their data is disaggregated for age and gender in order to focus attention on specific issue for women of different age groups with regards to HIV and maternal health.

International agencies and donors Governments

5. can promote inclusion of qualitative evidence of FBO engagement on a par with quantitative analyses and can assign funding to this.
6. can ensure that FBOs are included more effectively in mapping exercises, consultations with local communities, and in the strategies resulting from these.

B. The opportunity and urgency of presenting women's and children's rights as inextricably linked

Researchers

7. can foster work by theologians and proponents of rights-based approaches to identify areas of synergy and non-synergy between core values of major religions and key principles of rights-based approaches that apply to the work of HIV and maternal health. Such research could also describe the complexity within the multiple frameworks of major religions and further probe assumptions related to rights-based approaches that might merit more critical analysis.
8. can gauge the degree to which FBOs are aware of the human rights concerns raised regarding the treatment of women with HIV in some ante-natal and ART access services.

FBOs

9. can ensure that PMTCT and similar initiatives place the wellbeing of mothers with HIV on a par with that of their babies.
10. can name and address the social, economic, gender, cultural and legislative aspects that affect women's ability to access maternal health services.
11. can advocate for integration of values of justice and equity within faith-based initiatives and within broader government-based health care service provision.
12. can revise their processes to ensure the voices of women living with HIV inform their strategies and practices.
13. can audit and challenge experiences of stigma or discrimination experienced by women with HIV who access maternal health or sexual and reproductive health services, both within services provided by FBOs and within other locally available services.
14. can advocate for (and provide) human rights education to be standard in initial and on-

going training of health care personnel, (particularly in FBO health care institutions).

15. supported by government policies and the strategies of international agencies and funders, can promote both locally and at international levels, training of faith leaders in HIV-related knowledge, human rights, gender equity and also in a deeper and more accurate understanding of the tenets of their faith.

| Governments and donors | 16. | can review strategies to ensure the implementation of rights-based approaches for women as well as for children in initiatives addressing HIV and maternal health, and that these take into consideration faith-based perspectives. |

16. can review strategies to ensure the implementation of rights-based approaches for women as well as for children in initiatives addressing HIV and maternal health, and that these take into consideration faith-based perspectives.

17. can earmark resources to support faith-based initiatives and best practices which simultaneously target women and children's needs while engaging men.

18. can earmark resources to support FBOs to work with other civil society organisations, in challenging harmful cultural norms at the individual as well as family and society levels.

19. can revise their processes to ensure the voices of women living with HIV inform their strategies and practices.

C. The strengths and responsibilities of being community based

Researchers

20. can identify and develop processes that gather stories and first-hand evidence from communities, of their experiences related to HIV and maternal health. These will need to be participatory, easy to embed within community life and structures, attuned to community timeframes and diverse in methodology to accommodate cultural norms, literacy levels, local languages and more.

21. can identify models of good practice among FBOs and other community based initiatives, in bridging the support to mothers (including mothers with HIV) and children within the community setting and after the immediate post-partum services have ceased.

FBOs and researchers

22. can identify, and FBOs can replicate, effective community-based systems of providing effective long-term home- or community-based follow-up for mothers, including mothers with HIV, and their children, beyond the immediate pre and post- partum periods.

23. Can identify and replicate the use of community-based accountability monitoring processes.

FBOs, governments, international agencies and donors

24. can promote the roles of faith leaders in strengthening community understanding and tackling stigma and discrimination, including within the structures of worshipping communities and faith organisations. They can further identify and publicise proven processes and methodologies, particularly those which reach the most marginalised and vulnerable and which involve several stakeholders in a collaborative manner.

Governments, international agencies and donors

25. can strengthen their understanding of FBOs. This includes appreciating the nuances of the language of faith leadership, while also realising the diverse positions and modalities of FBO engagement. It requires governments and international agencies to recognise that faith leaders are, first and foremost, moral and spiritual guides for their communities, concerned with the holistic welfare of their congregations, including their physical, emotional, and spiritual health. It also requires them to understand the diversity that exists between and within different faith responses, and a capacity to discern which FBOs are best suited to which type of initiative, whether because of skills, capacity or organisational mindsets.

FBOs

26. can strengthen their understanding of the diversity of secular agencies, national and international strategies on HIV and maternal health, and the functioning and language of international agencies and donors.

27. can improve their systems for recruiting and retaining volunteers, and for documenting their contributions to the success of programme outcomes. They can strengthen their articulation of their programmatic conceptual frameworks in terms of the role and value of volunteers to their success, and include this in funding applications.

Donors

28. can simplify their funding application systems and reporting requirements to better balance the specific administrative demands on FBOs and the ongoing need for evidence of

effectiveness. They can also ensure notice of funding opportunities is circulated to networks and information sources accessed by FBOs such as national faith networks, local networks of community-based organisations, and the like.

29. can support training initiatives for volunteers as well as operational costs that cover out of pocket expenses and incentives deemed appropriate contextually and measures to strengthen the sustainability of programmes reliant on a heavy volunteer base.

D. The benefits of and need for holistic responses

FBOs

30. can model tools for data collection and impact assessment of HIV and maternal health initiatives on the four quality of life domains described (Drew 2011). These would be 1) health, including sexual and reproductive health, 2) psychosocial and spiritual support 3) initiatives to address legislative discrimination, abuses of women's and their children's human rights and work to counter stigma 4) initiatives to strengthen economic and livelihoods security – including nutritional security.

31. can design and implement holistic programmes that are cognisant of and adhering to national guidelines thus ensuring they gain recognition within national strategies and are supported technically and financially by governments and donors.

32. can use programmatic and impact evidence to advocate for policy makers to recognise the strengths of FBOs within a more holistic approach and to ensure their contributions are included as part of an integrated system.

Researchers

33. can identify processes that prove effective alternatives to top-down medical models for implementing vertical transmission prevention and maternal health initiatives and explore FBO experiences that might contribute to such processes.

34. can ensure that mapping and data collection tools enable identification of initiatives that comprise a holistic response, defining the domains that are essential to such a response.

Governments and Donors

35. can walk the talk: since one size does not fit all, they can fund components of holistic approaches essential for effective responses to HIV and maternal health, e.g. transport costs, nutrition, cash transfers for livelihoods, longer-term community-based follow-up initiatives which integrate psychosocial support including spiritual dimensions.

36. can review their strategic plans and funding criteria to ensure these recognise and support community-based holistic responses in tandem with exclusive medical or only selectively broad responses (i.e. broad but not holistic as noted earlier).

E. The importance of identifying impact

Researchers

37. can develop methods for valuing the social assets that are important features of FBOs and faith-based initiatives, including the intangibles. For example, they could undertake further and perhaps more academically rigorous work along the lines of that reported for Dr Foster in Section 2 question 8, of calculating the monetary equivalent of volunteer contributions. They can also explore how to adapt accepted economic analysis methodologies to quantify impacts, outcomes and responses that conventionally do not have a monetary value assigned to them.

38. Identify and assess the links between faith-based development interventions, social capital and resilience-building capacities within communities, especially in conflict-affected and fragile state contexts.

39. Provide case studies which build on the above, and document how the impact of government-sponsored health service strengthening initiatives can be enhanced (or not), with the inclusion of FBO-specific contributions.

Researchers and FBOs

40. can work together to identify and promote diverse approaches to scaling-up, based on documented evidence of what is effective for FBOs. Ideas such as "scale out", coordinated replication between HIV competent communities and more could be developed further. An exploration of the work of the AIDS Competence Constellation (The Constellation, 2012) could be valuable in this respect.

FBOs

41. can identify the social assets they would attribute to their work, with evidence to this effect, adopt processes that assess their influence on short term outcomes and longer term impact and incorporate this work into their strategies and programme narratives.

42. can strengthen their skills to identify the change sought by particular interventions and their roles in achieving that change, diverting their focus away from documenting organisational outputs and achievements. To this end, methodologies contained within theory of change processes should be explored and developed , effective tools replicated and the learning documented and promulgated.

43. can strengthen their skills in identifying the targets for particular initiatives. In the context of HIV and maternal health they would need to identify, for example, how PMTCT, or home-based care, or community education, or livelihoods programmes are specifically intended to benefit mothers (along with their children) and within these, mothers living with HIV.

44. can strengthen their involvement in national networks of FBOs and in local and national networks of community and other non-governmental organisations, in order to ensure a coordinated approach, complementarity and not duplication, a concerted effort to provide effective programming and a strengthened representation with national and international decision-makers.

Donors, governments and international agencies

45. can target their interventions with both faith leaders and FBOs at the levels which are identified (through more efficient mapping models) as being most effective, and not just engage with the most visible, or articulate or the same established set of faith representatives.

Donors and international agencies

46. can provide funding and technical support to FBOs to strengthen their capacity to identify and document impact, in terms of change realised.

47. can strengthen the capacity of national faith-based network such as Christian Health Associations and Muslim Networks as important means of strengthening the institutional capacities of their members.

The following is a listing of the bibliography (published or "grey material") referred to in the text of this report. It represents only a small proportion of the total documents assembled during this research. Some additional materials are available at www.jliflc.comm.

Major Bibliography Sources

CHART: Collaborative for HIV and AIDS, Religion and Theology

CHART is a collaborative for research, reflection and engagement within the School of Religion, Philosophy and Classics (SRPC) at the University of Kwazulu-Natal, South Africa. CHART has compiled an extensive bibliography of documents which can be searched online through its website http://chart.ukzn.ac.za

UNFPA Database of Faith-Based Social Service Providers

UNFPA has developed a global database of faith-based social service providers, searchable by country, region and/or thematic area of social service. The database is accessible via the UNFPA Extranet.

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Appendix 1: Joint Learning Initiative Faith & Local Communities Steering Group

Chris Bain and James Marchant	**CAFOD**
Rachel Carnegie and Helen Stawski	**Archbishop of Canterbury's International Development Office**
Jean Duff	**Full Circle Partners**
John Drew	**McKinsey**
Atallah Fitzgibbon	**Islamic Relief Worldwide**
Matthew Frost (Co-Chair) and Laura Taylor	**Tearfund**
Christo Greyling	**World Vision**
Azza Karam	**UNFPA**
Rob Kilpatrick (Co-Chair)	**Traidmission**
Jill Olivier	**IRHAP/University of Cape Town**
Sally Smith	**UNAIDS**
Paul Valentin and Sarah Ewans	**Christian Aid**
Chris Blackham	**Samaritan's Purse**

Appendix 2: Questions circulated in Step 2 – Request for Information

JOINT LEARNING INITIATIVE
ON
FAITH AND LOCAL COMMUNITIES

Request for information

Faith groups' activities, contributions and impact on
HIV _and_ Maternal Health responses

ABOUT YOUR ORGANISATION

What is the name of your organisation?	
Is your organisation a service provider, network, academic institution, or a local faith community? (If other, please specify)	
Do you work at local (e.g. community, district or province), national or international levels?	
Which faith(s) inspire your organisation or response?	
Does your organisation/program respond to HIV and maternal health?	YES NO
If NO, what are the reasons for this (for example they may be because of funding or skills limitations, or planning focus in other priorities, or social, political or ideological pressures internally or externally, or other reasons). Please be as specific as you can. If you have answered NO, this section is your sole contribution to this survey and your contribution will provide important insights.	
If YES, Which country(ies) do you respond to HIV and maternal health in?	
Your name and email (Please provide us with contact details if you would like to receive a copy of the report of this research. We will not share your details with anyone without your permission.)	

RESEARCH QUESTIONS ABOUT FAITH ACTIVITIES, CONTRIBUTIONS AND IMPACTS IN RELATION TO HIV AND MATERNAL HEALTH

The following questions ask about your organisation's activities, contributions and impacts. If you belong to a network or are connected to local faith communities, please tell us about the activities, contributions and impacts of other organisations that you know of. If their activities are well documented please point us in the direction of the organisation and their

resources/publications. If they are undocumented (for example, you may work with local faith communities who do not produce publications) please give as much information as possible.

RESEARCH QUESTIONS	Enter text or reference documents in this column
1. Providing HIV and maternal health services Please list activities, contributions or impacts in HIV **and** maternal health in relation to your organisation or other faith groups (e.g. PMTCT, supporting birth attendants, midwifery, family planning services or information, food supplements for pregnant women etc.)	
2. Addressing the social determinants of health Does your organisation (or other faith groups that you know of) have activities, contributions or impacts which address the social determinants of health?	YES NO
If yes, please tell us which issues you address and how. Examples of social determinants of health include social stigma, poor health literacy, punitive legal environment, traditional norms and practices, gender norms, basic economic needs, food and malnutrition, spiritual and psychological well-being, social protection etc.	
3. Addressing HIV related stigma and discrimination What activities, contributions or impact does your organisation (or other faith groups) make in reducing HIV-related stigma, silence, denial and discrimination?	
4. Reaching the "most vulnerable" Does your organisation (or other faith groups) have a specific aim to reach people who are "most vulnerable"?	YES NO
If yes, who/what groups are defined in your response as "most vulnerable" and what activities, contributions or impact can you share about how you reach them?	
5. Relating to other health services How does your organisation or service ensure integration or complementarity with other available service provision? For example, across the spectrum of health promotion, prevention, treatment, care and support, etc… and across different types of services such as reproductive health, HIV, mother and child health, and PMTCT etc.	
6. Relating to the wider health sector What activities, contributions or impact can you share about how your organisation (or other faith groups) ensure integration or complementarity with the health sector/public services more widely? For example, supporting retention of health workers, reinforcing health messages/campaigns, mobilizing communities around service demand, uptake and retention, participating in local/national consortia/networks or policy development groups such as National AIDS committees etc.	

7.	<u>Ensuring accountability</u> Which guidelines or minimum standards of service quality, reporting and accountability does your organisation (or other faith groups) adhere to or maintain? For example, national polices and legislation, organisational policies, international minimum standards or conventions?	
8.	<u>Achieving sustainability and scaling up</u> What factors help you increase the sustainability of your organisation (or other faith groups)? Have you been able to scale up your response? If yes, what factors contribute to the ability to scale up the response? If no, please indicate the factors that prevented scale-up. For example, how relevant are issues of volunteerism, the ability to mobilize communities and resources, and factors such as in-country vs. external donor funding?	
9.	<u>Challenges and barriers to effectiveness</u> What factors hinder your response to HIV and maternal health? Such factors might be <u>social or societal</u> (e.g. gender norms and gender inequality, taboos around discussing sex, disapproval of access to SRH services for young and/or unmarried people, lack of women's decision making power/expectations in health matters, lack of access for women to education or vocational training, cultural practices, HIV and other stigma, conflict, war and political instability etc.). They might be <u>legal or political</u> (e.g. illegality of sexual behaviours, illegality of specific service provision or provision to specific groups e.g. young people, lack of legal status or equity for women, criminalization of aspects of HIV infection etc). They might be <u>religious or faith-based</u> (e.g. tension between the language of rights and values, opposition between public health messages and religious beliefs or teachings, threats to religious freedom, prejudice between faith and secular actors). They might be <u>economic</u> (e.g. the household income levels of clients, educational, earning and savings opportunities for women, competition for human, financial and/or in-kind resources etc.)	
10.	<u>Overcoming challenges and barriers</u> What steps or strategies have you taken or would like to take to overcome any of the challenges and barriers that you've described above?	
11.	<u>Existing evidence including external evaluations</u> Please supply links to case studies, external evaluations, literature reviews, other reports and documents related this topic of faith-based activities, contributions and impacts in relation to HIV and maternal health.	
12.	<u>HIV and maternal health: other issues</u>	

	Are there any other issues related to faith-based HIV and maternal health activities, contributions and impacts that you would like to tell us about?	
13.	Follow up telephone/Skype conversation If you would like to discuss any of the above or related issues, please provide your contact details.	

Appendix 3: List of contributors to Request for Information and to Structured Interviews

Documents and written responses received from

CABSA	Lyn van Rooyen
CAFOD	Georgia Burford
CAFOD	Harriet Jones
Caritas Internationalis	Monsignor Robert Vitillo
Christian Aid	Rebecca Sinclair
CMMB	Sara Melillo
Concern Worldwide	Breda Gahan
Fountain of Life Church	Martin Kamangala (Bishop)
Institute for Global Health	Andrew Tomkins
JLI FLC HIV and Maternal Health Learning Hub	Patti Shih
Joint Learning Initiative on Faith and Local Communities	Jean Duff
Latin America Council of Churches	Carlos Tamez (Rev)
Mission 21	Prof. Meehyun Chung
Nordic Assistance to Vietnam (NAV/NCA Vietnam)	Margareta Koltai
Ojus Medical Institute	Asavari Herwadkar
PASADA	Nelson Chiziza
Rwanda Interfaith Network against HIV & AIDS (RCLS)	Bertrand Thierry NIRAGIRE
Salamander Trust	Alice Welbourn
Samaritan's Purse	Sarah Bauler
SCRIPTURE UNION OF RWANDA	Ezéchias NTIRENGANYA
Strategies for Hope Trust	Glen Williams
Tearfund	Veena O'Sullivan
Trócaire	Noreen McGrath Gumbo
UNAIDS	Sally Smith

UNFPA	Azza Karam
UNFPA	Dawn Minott
University of Cape Town/CHART	Jill Olivier
University of Glasgow	Julie Clague
WFDD	Claudia Zambra
WFDD	Jennifer Cimaglia
WFDD	Katherine Marshall
World Vision	Elie Mukinda
World Vision	Eniko Chenge
World Vision	Jane Chege
World Vision	Logy Murray
World Vision	Christo Greyling
World Vision International	Albert Pancic
World Vision International	Robyn Cawker
World Vision International	Sikotshi Sibanda
World Vision International	Stuart Kean

Interviews conducted with

Boston University	Ted Karpf
Cordaid	Geertje van Mensvoort
Islamic Relief	Atallah Fitzgibbon & Mamoun Abuarqub
Ojus Medical Institute and Asia Interfaith Network on AIDS	Dr Asavari Herwadkar
Salamander Trust	Alice Welbourn
University of Cape Town	Jill Olivier
University of Glasgow	Julie Clague
WFDD	Katherine Marshall,
WFDD	Claudia Zambra
WFDD	Jennifer Cimaglia