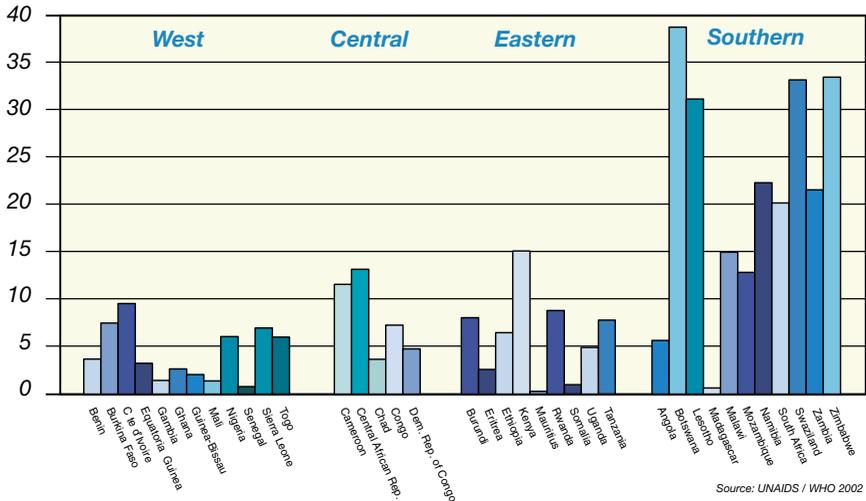


# Responses of the Faith-Based Organisations to **HIV/AIDS** in Sub Saharan Africa

By  
Dr Sue Parry  
Southern Africa Regional Co-ordinator:  
World Council of Churches  
Ecumenical HIV/AIDS Initiative in Africa (EHAIA)

In 2002 UNAIDS reported that the scale of the AIDS crisis now outstrips even the worst-case scenarios of a decade ago. HIV/AIDS marks a severe development crisis in Sub Saharan Africa where 70% of the world's 42 million infected people live: Seven countries in Southern Africa have adult infection levels exceeding 20%, and in four countries, Botswana, Zimbabwe, Swaziland and Lesotho, one in every 3 adults is infected.

*% Adult seroprevalence* HIV prevalence rate in adults 15-49 (%) in 37 countries of sub-Saharan Africa in 2001



The estimated number of orphans in the region already exceeds 34 million, of whom more than 11 million have lost one or both parents to AIDS. By 2010 this number is expected to exceed 25 million (Children on the Brink 2002; USAID, UNICEF and UNAIDS). Despite encouraging changes in the trend in a few countries such as Uganda, Senegal, Zambia, and in antenatal cases in South Africa, Africa remains the epicentre where 70% of all new infections are found.

Although anti-retrovirals (ARVs) have made considerable impact in many countries, specifically developed countries, they remain still a distant illusion for too many countries, particularly in Africa where fewer than 30 000 people were benefiting from ARV by 2002.

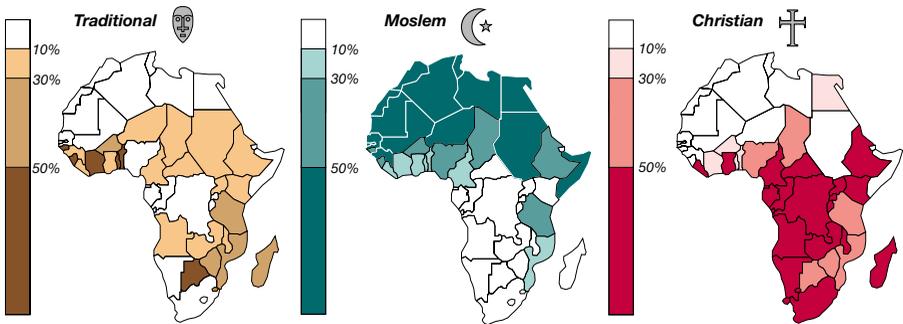
The situation in Africa is compounded by so many factors. HIV/AIDS is an epidemic within epidemics, managed with varying degrees of commitment by different countries depending on other priorities and political appointments.

What is encouraging is that there seems to be an intensifying sense of common purpose, in the global struggle against AIDS. There is a growing realisation of the need for greater networking and collaboration in order to be more effective. Few countries can boast of any great success but there are flickering candle- lights of hope which need to be coalesced and strengthened.

Following the commitment by all the nations of the world at the UN General Assembly Special Session on HIV/AIDS in 2001, including the intention to ensure 3 million HIV positive people in Africa benefit from anti retroviral therapy (ARV) by 2005, it was said that 'we need to mobilize an army in order to achieve these goals.'

We have an army already.

**It is the faith-based organisations (FBO).**



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## Faith-Based Organisations

### **Accusations**

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

While we do not deny that, in too many instances, these accusations have tragically and regrettably been justified, it has not been always and everywhere. Whilst the moral debate – particularly around the condom issue – has raged in many circles, stalemating action and in many eyes discrediting the Churches' commitment to tackling AIDS and saving lives, congregations and parishes have themselves been in the forefront of care and support right across Africa. A great number of these initiatives did not wait for funding in order to begin, they just responded. Their courage and determination in the face of so many obstacles is a humbling challenge and is a reflection of deep compassion in a real world of suffering.

### **Report**

This report is based on a review of the contributions of FBOs to the continuum of care of HIV/AIDS infected and affected people in 53 countries in Africa.

### **Methodology**

The information came principally from reviewing the mapping studies conducted by the WCC over the last 3 years, and assessments of the contributors, as well as from other reports, web-sites, e-mails, discussions and personal visits that were possible within the time constraint. Information was not always easily accessible as FBOs are busy 'doing' but are notoriously bad about, or are not trained for, monitoring, evaluating and documenting their efforts.

This report does not consist of a statistical summary of FBO programmes, as the information was not collected from a research data-base but from narrative reports of varying depths and quality. ***The importance of the programmes lies not in their numerical strength but in their impact, acceptance and coverage.*** This is far more difficult to assess.

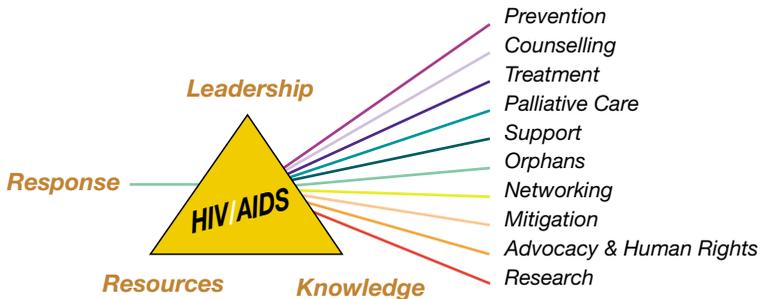
Whilst in some communities the responses have been muted and activities are limited to simple prevention messages on World AIDS Day, in other communities FBOs are providing holistic comprehensive care across a continuum and are major contributors to the national response. This involves providing support for people living with HIV/AIDS (PLWHA) and their families through a network of resources and services. A continuum includes care between hospital and home over the course of the illness. The care incorporates clinical management and care, education, prevention, counselling, palliative care and social support.

Our review indicates that three key elements are necessary for a balanced response:

- Good leadership which creates commitment
- Technical know-how and accurate up-to-date information
- Resources: both financial and human

The continuum of care can be diagrammatically represented as a prism. (Diagram of prism). A prism is a solid triangular piece of glass. Light passing through this is refracted into a spectrum of colours. I would like to equate the prism to HIV/AIDS. The incoming light represents the response. The emerging rays of light represent the different components of a 'continuum of care'. These are:

- |                   |                             |
|-------------------|-----------------------------|
| • Prevention      | • Orphan programming        |
| • Counselling     | • Networking                |
| • Care            | • Mitigation                |
| • Treatment       | • Advocacy and Human Rights |
| • Palliative Care | • Research                  |
| • Support         | • Monitoring and evaluation |



Each of these components can be further 'prismed' into a spectrum of responses.

**Observations**

As I went through documentation of literally hundreds of initiatives from all over Africa, I first tried to establish what criteria are needed for an effective and sustainable response that would make it replicable or have the elements necessary to scale up. The by- words from UNAIDS at the moment are 'Think Big, Act Big.' Could this be possible with the faith-based initiatives? I decided to look at the responses, not as isolated programmes on different issues but contextually within the countries served.

**Stark realities** emerged that have major impacts on programming in Africa:

## **Conflict zones**

Africa is beset with conflicts and wars. Country after country has a recent past or current involvement in some form of conflict or repression. Few countries have been spared. The consequences have been devastating, causing profound individual and collective trauma which has been compounded by poverty, and they leave behind huge numbers of orphans.

## **Consequences of Conflict**

- / *Violence: - physical & sexual*
- / *Refugees & internal displacement*
- / *Poverty: - sudden destitution & capital flight*
- / *Collapse of social & physical infrastructures*
- / *Famine & import dependence*
- / *Disease spread & death*
- / *High HIV in military personnel*
- / *Lack of development & destruction*
- / *Migration & brain drain*
- / *Insecurity & loss of hope*

Conflicts generate and entrench many of the conditions and human rights abuses in which the HIV/AIDS epidemic flourishes. Conflicts are closely associated with physical and sexual violence, forced displacements and separation on family members, sudden destitution, collapse of social structures and increased poverty and powerlessness.

For example studies in Sudan showed that one in four single mothers was selling sex in order to survive. In Sierra Leone, during the height of the war, HIV infection rates amongst female sex workers soared from 26.7% in 1995 to 70.6% in 1997.

Rwanda had a war resulting in the genocide of more than 800 000 people and 2 million fled as refugees into the Democratic Republic of the Congo (DRC) and Burundi. The genocide left a generation of war orphans. The country is now grappling with HIV/AIDS and the thousands of orphans. Government and FBOs have recently taken up the legislative challenge of the rampant sexual abuse of these vulnerable children.

HIV infection rates among armed forces personnel are on average higher than among their civilian counterparts. In Uganda the incidence is three times higher. In Kenya, the Defense Force estimates that 6 –10 soldiers die each week from AIDS related illnesses.

Central Africa is a vast area that has been fraught with conflict, military coups and devastating wars. No less than eight foreign armies have been involved in the war in the DRC leaving over 3 million dead, a massive refugee crisis, a situation where violence has become 'normalised' and the population severely traumatised. All the foreign armies were from countries of high seroprevalence and this will undoubtedly have impacted on the seroprevalence in DRC. Whilst international concern has been raised about what has been looted out of the DRC, I feel an even greater concern should be raised by what has been introduced into the DRC. It is my belief that what has happened within the DRC is an equivalent of an HIV/AIDS 'nuclear explosion' where the 'fall-out' of HIV will be forever.

Cessation of fighting does not necessarily remove the heightened risk of HIV/AIDS spread. Demobilized armies typically are not HIV tested, or counselled, even though returning HIV positive soldiers can place their partners at serious risk of infection.

Ethiopia, a country with a population of 64 million, the third highest infected population in the world with 3.5 million people, is right on the border with Eritrea, a country with a small population of 3.8 million and a seroprevalence half that of Ethiopia. The forth-coming demobilization of 200 000 troops and the recent reopening of their common borders following the war has made Eritrea vulnerable to the high seroprevalence of its neighbour.

On the other side of Ethiopia lies Somalia, a war ravaged country left without effective administration or health services since the collapse of the central government in 1991. Very little information about HIV/AIDS is available in Somalia and ignorance and denial is rampant. The very first public campaign on HIV/AIDS (AIDSOM) took place this year (2003).

Health systems are often severely damaged during armed conflict, and sometimes deliberately targeted, thus affecting delivery of basic treatment and care, antenatal clinics and also sentinel surveillance. HIV/AIDS control efforts are not always integrated into humanitarian, relief and peacekeeping efforts.

*Faith-based organisations have generally remained with the people through these conflicts and, at times, have been specifically targeted when considered to be in opposition to the repressive agent(s).*

Numerous conflict zones have resulted in a massive movement of refugees, and freedom fighters, either from or into neighbouring countries with high HIV seroprevalence.

West Africa is an area that has been fraught with a variety of conflicts, wars, ethnic clashes, religious clashes, coups and military rulings in all but two countries. Vast numbers of refugees have moved between the countries thus adding to ethnic tensions and economic pressure on the receiving countries, as well as spreading HIV/AIDS.

### **Poverty**

Deteriorating economic situations in many countries results in economic migrants – for example in Mali, where one quarter of the total population have migrated to neighbouring (highly infected) countries in search of employment. Urban drift for economic and other reasons coupled with chronic shortages of urban housing, and high levels of unemployment, results in overcrowding and thus increased risk.

Isolation from traditional culture and social networks frequently results in risky behaviour. One of the many occupations that migrants move to is mining. Lesotho's biggest export is labour for the mining sector in South Africa, where 20% of miners are estimated to be HIV positive.

There is also the serious skills drain when the economic and political system drives people to greener pastures, such as Zimbabwe which has lost some 70 000 nurses, and even greater numbers of teachers, social workers, doctors, technical people to countries all over the world. These economic migrants are frequently isolated and there is great need for FBOs to collaborate creatively with civil society in identifying these people for social and psychological support and inclusion in HIV/AIDS activities.

Substantial numbers of the populations live below the poverty line despite extensive efforts at development in many countries. Poverty influences choices people make including behaviour that increases risk of HIV infection such as alcohol abuse, multiple sex partners and sex for money. Poverty is also coupled with poor underlying nutrition and unsanitary conditions and basic education and health services become unaffordable.

HIV is more easily transmitted in these settings. The impact of HIV/AIDS will be most felt at the household level and probably most noted in the area of food security as most of the countries rely on subsistence agriculture. In Burkina Faso, AIDS has reduced food productivity by 25-50% without the impact of other natural disasters.

The humanitarian crisis gripping Southern Africa where millions have required food aid has been compounded by the AIDS epidemic. Food security is a major issue and the onset of the rainy season will not herald the end of the drought crisis. For example:

Lesotho, a small mountainous country in Southern Africa, is predominantly a country of subsistence farmers and migrant miners. It too was hit by the latest drought. Food and Agriculture Organisation and UNICEF personnel recently toured the country and noted that between one quarter and one third of plots of ground, that normally would have been tilled by now in preparation for the next harvest, were lying fallow. Follow-up revealed that virtually all of the abandoned lands belonged to ailing persons, lying sick with HIV and the families unable to either spare the time for agricultural work or the resources left to invest in the crop of the future.

This is likely to be an increasing regional scenario.

FBOs, throughout the region, have responded by expanding their focus from their original long- term goal of HIV/AIDS programmes into short-term responses meeting the immediate crisis of food security. More than at any other time has the multidimensional sectoral impact of HIV/AIDS been exposed and challenged response at all levels. Thus the infrastructure and the established grass root networks of the Churches have made them valuable resource people and conduits for this support – both in identification of need and in transparency of distribution.

### ***Health Services: overburdened***

Health services are often concentrated in urban areas while rural areas, where most of the population lives, are underserved. Mission hospitals and health care centres are frequently the only such services to be in these areas.

Health services are generally over-stretched with for example only one doctor for 29000 in Burkina Faso and Ghana. In Liberia, there are only 40 doctors for the entire country and the majority of the population lack safe water and sanitation. Senegal has well established health service priorities whilst Niger has no rural hospitals.

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

All these services, already inadequate before the onset of HIV, are overburdened with the increased patient load and opportunistic infections especially TB, and the staff are over-worked. With few increases in resources, these same health facilities are having to expand their services to encompass home based care, counselling, testing, prevention of mother-to-child transmission and all the additional documentation that accompanies these activities. Morale is low and there is high mortality within this sector as well.

Voluntary Counselling and Testing (VCT) is an essential service for both prevention and treatment and is the entry point for better care, prevention of mother to child transmission (PMTCT) and behaviour reassessment and change. It should be universally available but coverage in Africa is under 10%. Though it can be expensive to implement, requiring trained counsellors and appropriate facilities, several Mission hospitals are already providing this service. FBO, that offer training in counselling such as in Botswana and Namibia, have been opening their facilities to VCT using trained volunteers, including pastors, to accompany the clients on their serostatus journey. This is a good example of maximizing resources and increasing coverage of service.

With regard to Prevention of Mother-to-Child transmission, many faith-based organisations' health services have implemented this program even before governments have moved beyond pilot projects. They have shown that it works even in the poorest of settings with illiterate people, such as at St. Theresa's in Chirumanzi, Zimbabwe, where over 70% of all antenatal mothers request testing and appropriate follow-up, as do many of the husbands and youth – even without the incentive of ARV therapy. Again, same over- burdened staff and little extra core funding.

Inequality in health care not only implies lack of access to anti retrovirals but also, in so many countries, lack of access to basic medication to treat and alleviate opportunistic infections and to provide quality palliative care. Less than 100 PLWHA in Congo Brazzaville are able to access proper care.

### ***Diseases***

The presence of other illnesses worsens the impact of HIV/AIDS. Both malaria and tuberculosis (TB) are renewed epidemics and, in both Central and West Africa, are still considered a bigger threat than HIV. In countries like Zambia, Malawi and Zimbabwe, governments are not able to ensure that PLWA receive even the most

basic drugs and the control of TB is woefully inadequate. FBOs are increasingly being asked to back up and support previously functioning health care systems.

Condoms are not routinely available or widely accepted. There is strong resistance to the promotion of condom use by many religious leaders.

### ***Gender and Cultural Issues***

Discrimination, inequalities, lower educational status, economic dependence on men and the formidably defended cultural and social norms make it difficult for disempowered women to refuse sex or negotiate for safer sex. Marital rape and domestic violence in these situations is high.

A culture of silence hides the numerous episodes of sexual abuse and violence against women. This lack of response extends from community level through to law enforcement agents and the courts. The unwillingness of community leaders, which includes the church whose hierarchy are mostly men, to speak out against these injustices enables the perpetuation of the situation and the 'protection' of those responsible.

Society implicitly (and sometimes explicitly) condones the subordination of women, thus limiting their options to desperation measures such as prostitution and begging as economic survival strategies, particularly for single women with children to feed.

In many African countries there is belief that sex with a virgin (girl child) will cleanse an infected man of HIV/AIDS. This may have led to a great increase in the incidence of rape amongst young children.

Many African Independent Churches, Syncretic and traditional religions, which command large adherence, do not have a clear stand on cultural practices, still widely practiced, that expose people to infection such as widow inheritance, sexual cleansing, female genital mutilation and polygamy. Many of these groups lack formal structures and thus are difficult to involve in sharing of HIV/AIDS information.

Within churches themselves, there are glaring examples of gender discrimination where women are frequently excluded from decision-making.

### ***Youth***

Approximately 40% of the population across Africa is under the age of 15 years. It is also the age most vulnerable to new infections. In South Africa, for example, at the current infection rate it is estimated that approximately one half of all 15 year olds will die from AIDS. In Namibia, over half of all young women have had their first child by the age of 19 years. Youth are engaging in high risk sexual behaviour because of many factors, including peer pressure, cultural/social norms, poverty and lack of choices, lack of assertiveness and negotiating skills as well as a high prevalence of fatalistic attitudes: "how can we escape?" With this attitude comes a failure to take any risk avoidance measures. Unprotected sex in a promiscuous environment will undoubtedly encourage the spread of HIV.

## **Sex Education**

Culturally the traditional source of sex education has been the paternal aunt/uncle. It was taboo for a parent to discuss sex with his/her child. This cultural tradition has rapidly become eroded and lost some credibility in the process of urbanization and social change. Negative attitudes, towards sex education provided by schools and other such institutions, have been legion, and sadly promoted by many Church leaders. The perception is that it violates religious teaching, is insensitive to cultural traditions, is a parent's domain, will encourage early sex and that abstinence should be the rule of the day. At the same time, young people are exposed to double standards and receive mixed messages from media, advertising, culture and religion. In the name of morality, culture or religion, young people are also often denied their right to education on reproductive health and risk behaviours without important tools and services for protection. There is lack of access to youth-friendly health services and negative attitudes from health workers are what often deter youth and others from soliciting services from clinics. Youth are also vulnerable to abuse and exploitation and the age of sexual debut, especially for girls, is very young.

Peer education programmes were pioneered by FBO in Africa, specifically Uganda and of note is Sr. Dr. Miriam Duggan's 'Youth Alive' programme on 'Education for Life.' This programme has been adopted by other countries and formed the bases for other similar programmes. With the facilitation of the Mormons, over 100 000 Zimbabwean school children have completed this course, and formed on-going clubs, and over 12 000 facilitators have been trained in the last 7 months alone.

The focus is to give youth the information to empower themselves with value systems, respect and responsibility, teach them negotiating skills and to withstand negative social and peer pressure.

The YMCA, operating in 6 countries in West Africa, is seeking to address reproductive health issues in youth.

Despite these, and similar noble initiatives, youth remain one of the most neglected sectors of society when it comes to tackling AIDS. They are an untapped resource and are seldom involved in the development of programmes for them.

## **Orphans**

FBO again have taken the lead in many countries with the provision of care for orphans and vulnerable children (OVC). This care has taken the form of institutional care, community based, fostering and adoption, day care centres, street children programmes and hospices for abandoned and HIV positive children. Moreover, the provision of psychosocial support, the training in parenting skills for child headed households, skills training and life skills provision has provided models for other agencies to emulate.

*However, the magnitude of the orphan crisis is yet to be felt right across Africa. Though there are currently millions of such children, there are millions more to come given the high seroprevalence in Africa.*

*The serious urgency to respond far more proactively is not being adequately addressed either by Governments, NGOs or FBOs. We delay at our peril.*

Orphans are an extremely vulnerable sector of the population. Not only are they subjected to all forms of abuse and exploitation, their situation often limits their choices. There is little motivation to consider the risks of HIV when day-to-day survival is all they can cope with. This is the major area for 'Think big, Act big.'

### ***Rampant denial and stigma***

Denial is rampant from the political level right down to community level, particularly amongst the youth. 'If a person looks healthy, he/she can't possibly be infected.'

Few people actually know their HIV status and the motivation to find out is constrained both by the lack of subsequent availability of treatment and denial.

South Africa is a country of vastly superior resources and yet it lost valuable time whilst its President vacillated over the issue as to whether or not HIV actually did cause AIDS, and while he refuted the efficacy of Nevirapine to protect unborn babies.

West Africa has a lower prevalence rate than in the other regions. It represents infection from both HIV-1 and HIV-2 virus. HIV-2 is a slow progressor, thus an infected person may live with HIV for 20 years or more before succumbing to AIDS. The concurrent presence of HIV-2 limits the spread of HIV-1. The longevity conceals the seriousness of the infection rate in the country and thus the sense of urgency in dealing with it and proactively planning for the consequences.

Many Francophone countries still view HIV/AIDS as a medical condition and the response is still widely limited to one of awareness raising and preventative measures. Catholics are to the fore of all the other religious communities in their response and have a well structured prevention policy. In Senegal they have established a "Health Promotion Centre," the first of its kind in the sub-region, for psychosocial, medical and spiritual care, free VCT and follow up at all levels. Foreign Missions and ecumenical associations are the most engaged in care.

Overall, in both West Africa and Central Africa, it is considered that, in general, churches are ill equipped to confront the epidemic. Problems faced by the clergy concerning HIV/AIDS have included a lack of knowledge on preventative measures, counselling, advocacy, community mobilization and networking, coupled with a deep cultural taboo about open discussions on sexual issues. Thus a culture of silence, denial, stigma and discrimination has largely been the response.

There is a lack of Advocacy and Activism from those that can make a difference, with notable exceptions, the voice of the religious has been muted.

### ***Literacy levels / Education / Information***

Literacy Levels across Africa are relatively low, particularly in West Africa, ranging from 14% in Niger to 65% in Ghana. In Liberia, schools are barely functioning.

Secondary school enrolment is particularly low, less than 8% in Mali and Niger. Given the low literacy rates, the high incidence of HIV in teachers will negatively impact on already depleted educational services.

Educational disparities exist between religious leaders and many of the technical agencies. The lack of education does not reflect on their levels of commitment or their influence of people but it can negatively reflect in strategic thinking and planning and, in some cases, the inability to move beyond the condom debate.

**Collaborative responses** between denominations and ecumenical bodies are represented in different forms throughout the region. For example:

Mozambique is a country which suffered 16 years of civil war, cyclic floods and a severe drought. 13% of the population is living with HIV/AIDS. Some 40% of the population has no access to health services, illiteracy rate is at 60% and there are 300 000 orphans.

In the midst of this poverty, the HIV/AIDS Christian Network has taken the bold stand of "Faith as an Instrument of Change" with a declaration, approved by the Council of Churches for Mozambique and the Evangelical Association, that encapsulates such deep commitment to respond to HIV/AIDS. (Oct 2002).

In another initiative, 74 different churches are jointly collaborating in a project called 'Kubatsirana.' Its mission is to work ecumenically through church structures at grass roots by training pastors and volunteers to provide HIV/AIDS awareness, hands-on programmes of care, support, training and follow-up. They are building capacity within the church and the local community to develop and maintain their own programmes.

In Namibia, Catholic AIDS Action is a unique but highly replicable model of a national HIV/AIDS program built on Church structure. With the backing of the Bishops Conference, the programme has slotted into and uses the 90 parishes, 300 Christian communities, hospitals, clinics, schools and hostels as a basis for spreading the message of prevention and care. Home based care, orphan support and support for PLWHA are all based on the Christian values of spiritual and physical care for others. This model served as an inspiration for the Lutheran communities who equally took up the challenge, within their own spheres of influence, and significant collaboration with the Catholics.

### **South Africa:**

The Treatment Action Campaign is courageous, widely supported by the FBOs, as it keeps the international spotlight on the need for ARVs for the country.

Muslims have networks that are replicable models for other countries and regions for example: The Islamic Medical Association is a network which deals with HIV/AIDS health issues. There is an Islamic Leadership Association, and a network for HIV positive Muslims, which has an amazingly useful web-site, and there is a telephone hot-line to support community members in their hour of need.

Examples of collaboration between Muslims, State and other faiths in Senegal have become recognised as UNAIDS 'Best Practices.' Similarly recognised is the example of the Islamic Medical Association of Uganda.

In Botswana, with the government providing everything, it took a long time for Churches to take up the challenge of HIV/AIDS. However, when they did, they formed a collaborative effort between denominations to fill the gaps, to supplement and complement Government efforts, and they established a counselling service and network that is second to none and has now become a regional initiative stretching up to Liberia.

Ethiopia has formed 'The Organisation for Social Service for AIDS in Ethiopia' bringing in religious organisations and HIV/AIDS focused NGOs to support the Ministry of Health. Its training of religious leaders, formation of anti-AIDS clubs, and other services is having considerable impact.

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

Early in the epidemic, the Government of Uganda exhibited a high level of political commitment. The foreign help that Uganda received may have had an impact but this was not the final determinant in turning the tide of HIV/AIDS. The government and the people themselves recognized, from the beginning, that this was their own fight and could only be won if they united against it and took responsibility for it. The Church in Uganda, to its credit, stood side-by-side with the Government and put its full weight behind the campaigns as well. Whilst the secular response was 'condom promotion' and responsible behaviour, the message from the Church was 'abstinence and fidelity.' Alongside the Government education campaign entitled "Love Carefully," the Church developed its own "Love Faithfully" campaign. These two leading bodies agreed not to undermine the efforts of each other, nor the messages, but to do what each could do best within their own spheres of influence. This was a unique response in Africa.

## **CONCLUSION**

Faith-based Organisations are an integral part of life and society in most parts of Africa. They are to be found within every community and hold much credibility with the people because of their presence at grassroots, their involvement with the people at every aspect of their lives and for the many services they offer. They have the

### ***Faith Based Organisations are:***

- / grass roots*
- / people serving*
- / committed*
- / educators*
- / health providers*
- / a voice for the poor*
- / packed with volunteers*

widest network coverage in the continent, the largest constituency of people, and an enviable infrastructure, extending from the international community, to the most marginalized.

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

When government services fail, FBO are increasingly being asked to back up and support previously functioning systems.

However, there is gross inequitable resource allocation. International donors fund governments not usually FBOs. Donors with-hold funds from FBOs because of a perception that they are funding 'a denomination.' **It is time that it is acknowledged that the vast majority of FBO are non- partisan service providers.**

### ***Limiting factors to FBO action***

Moreover, whilst FBOs are encouraged, and expected, to expand their services to meet the growing needs of a multi-dimensional HIV/AIDS crisis, donors seldom provide core funding. FBOs are finding it increasingly difficult to run these expanded programmes looking only to their traditional sources of funds. Many do not receive external support, having to raise their own support locally in resource-constrained settings. Yet they are providing parallel services to government and more.

### ***Too little but not too late***

Without a doubt, FBO are in the forefront of care initiatives especially in Southern Africa. Yet, despite years of experience with HIV/AIDS, and a plethora of responses, the overall sense of urgency and level of response, quality and coverage, is in no way commensurate with the size of this growing epidemic. Numerous factors are contributory not the least being those financial constraints and lack of technical assistance.

### ***They serve through...***

- / pre-schools*
- / schools*
- / training colleges*
- / universities*
- / clinics*
- / hospitals*
- / places of worship*
- / provide skilled manpower*
- / source funds*
- / mobilise communities*
- / justice & peace*
- / development issues*

### ***They have a higher mandate...***

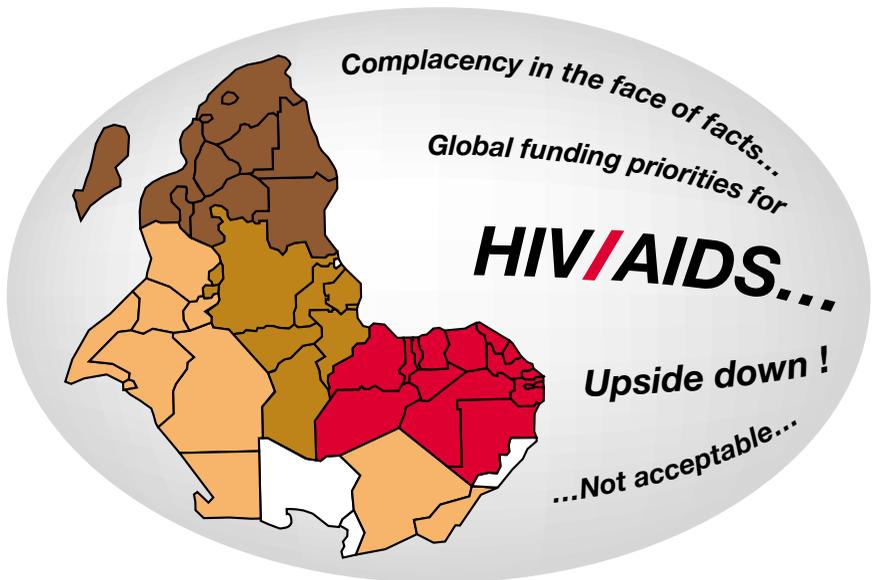
**Policy**

Until very recently, few denominations had actually developed a policy specifically about HIV/AIDS. An official policy denotes commitment, focuses action is motivating and is empowering to the implementers.

Policy Statements, Declarations and Commitments from numerous ecumenical bodies, Denominations and Associations are on the increase which is a hugely encouraging sign of a wave of intensified response to HIV/AIDS.

**Information and Training**

It is not reasonable to assume that religious leaders have all the information, in order to adequately and effectively communicate to their wider audience. These leaders themselves need access to accurate information and training to counteract irrational fears and discrimination. Examples of Uganda and Senegal clearly demonstrate that even the most conservative cleric can become an agent for change when properly informed and involved. Coupled with this, is a great need for theologically based reflections on HIV/AIDS and liturgical material.



## **Advocacy**

This is too muted given the scale of the problem and the injustices that exist. FBO have a responsibility to be the voice of the voiceless and to hold governments accountable to their constitutions and the conventions to which they are signatories. Not only should FBO join their voices with those advocating for justice and more equitable rights but also for other major issues such as debt relief released for social programming, and conflict resolution.

## **Networking**

Of great hope is the way that people of different faiths and seemingly insuperable doctrinal differences respond together. The need for increased coordination and collaboration has never been greater. Some Church leaders have expressed caution about entering into networks with other agencies which advocate AIDS prevention techniques which may be contrary to the Church's moral teaching. Moreover, FBOs are often tagged onto the end of a line of agencies as if to add to degree of inclusiveness and credibility to a program that claims universal consultation and collaboration. Funding for programmes is often linked to the aspects of prevention that might be in conflict to the beliefs of the FBO. To put it more crudely: the dollars come wrapped in condoms.

In primary prevention strategies, FBO should not be required to compromise their doctrines with the secular world. At the same time, the secular partners should not be required to justify their approach from the 'moral high ground' of FBOs. It should be possible to identify different ethical approaches and explore ways of complementing rather than confronting. There are plenty of success examples.

## **Collaboration**

Greater collaboration is needed to maximize efforts, coverage, quality of service delivery and better utilization of resources, both human and financial.

## **Key areas for collaboration**

This collaborative effort could take the form of a tripartite arrangement between the government sector, the multilateral and bilateral agencies / donors and the implementing agencies – civil society, NGOS and, in particular, the FBOs.

## **Limiting Factors to FBO Action...**

- / financial constraints*
- / lack of technical assistance*
- / lack of policy*
- / lack of information & training*
- / lack of networking*

## **Advocacy/muted voice on:**

- / treatment and care (access & equity)*
- / human rights issues & holding governments accountable for the conventions they sign*
- / sexual abuse, domestic violence & gender discrimination*
- / debt relief for social programming*
- / conflict resolution*



Governments have the mandate as the responsible authority of the country, can source bilateral government donor funding and have the strategic plans. If they are unable to implement, they can at least create the enabling environment for those who can.

The multilateral, bilateral agencies and donor/Initiatives have technical expertise, information, training capacity, programmes and the resources.

FBOs have access to the people and commitment as an expression of their faith.

Whether these partnerships are bonded by a Task Force, Commission or the Country Coordinating Mechanisms (CCMs) depends on the individual cases.

Any partnership requires mutual respect and balance. Right now, there is no balance.

**Co-operation means...**

- / Balance
- / Respect
- / Interdependence
- / Trust
- / Empowerment

**SUCCESS**

**Documentation:**

There is a paucity of quality data available. The programmes are there but documentation is a problem. Donor requirements for project proposals, monitoring, evaluation and reports can be extremely onerous and time consuming. FBOs are largely implementers: they are the 'doers.' Few are trained to meet the documentation requirements of major funding agents. If we are serious about

collaborative partnerships, then here is an area for technical assistance either with training or send in trained people to do the job.

FBOs can be data collectors. With their unparalleled coverage and human resources, especially large numbers of committed volunteers, they could collect good data on HIV/AIDS and the social manifestations of the epidemic, such as orphaning, unemployment and psychosocial distress. There is a compelling argument to be made for involving young people in this data collection. It transforms them from passive receivers of HIV/AIDS messages to active participants in the fight against it. As enumerators, they will find the information they gather to be far more compelling than any messages directed at them. And best of all, they could use their natural talents with computers to do something really useful.

### ***Pastors and trained professionals***

We need to bridge the gap between the old and wise and the young and educated. This is on both sides. Sensitivity is needed to overcome the different perspectives with good information and training, and we must not allow prejudices and stigma to stop responses.

### ***Partners or poor relatives***

FBO are major providers and need to be accorded respect as equal partners.

### ***Country Coordinating Mechanisms (CCMs)***

Country coordinating mechanisms are supposed to have balanced representation from the key stakeholders in the responses to HIV/AIDS. Several concerns have been raised that there is need to be a 'politically correct' FBO in order to secure representation on the CCM. It is also difficult to by-pass the system when blocked by Government, an example being the South African attitude toward treatment with anti-retrovirals.

### ***Finally***

Finally, it has long been known that developing countries, where most HIV/AIDS is located have historically received the least global financial support to fight it. Global funding priorities have been up side down. But this also applies to the Faith-based organisations who, without a doubt, are and have been in the fore-front of care initiatives from the outset, but have repeatedly been side-lined from resources. Donors have given funding to corrupt governments and ignored the FBO. Time to rethink!

We are all well aware of the factors that fuel the epidemic and that the medical world is struggling to find a cure or vaccine. In the meanwhile, to reduce the vulnerability of the population to the environment of HIV/AIDS, we need this balanced 'pot of collaboration'. Without balance, the pot tips and the people are exposed.

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