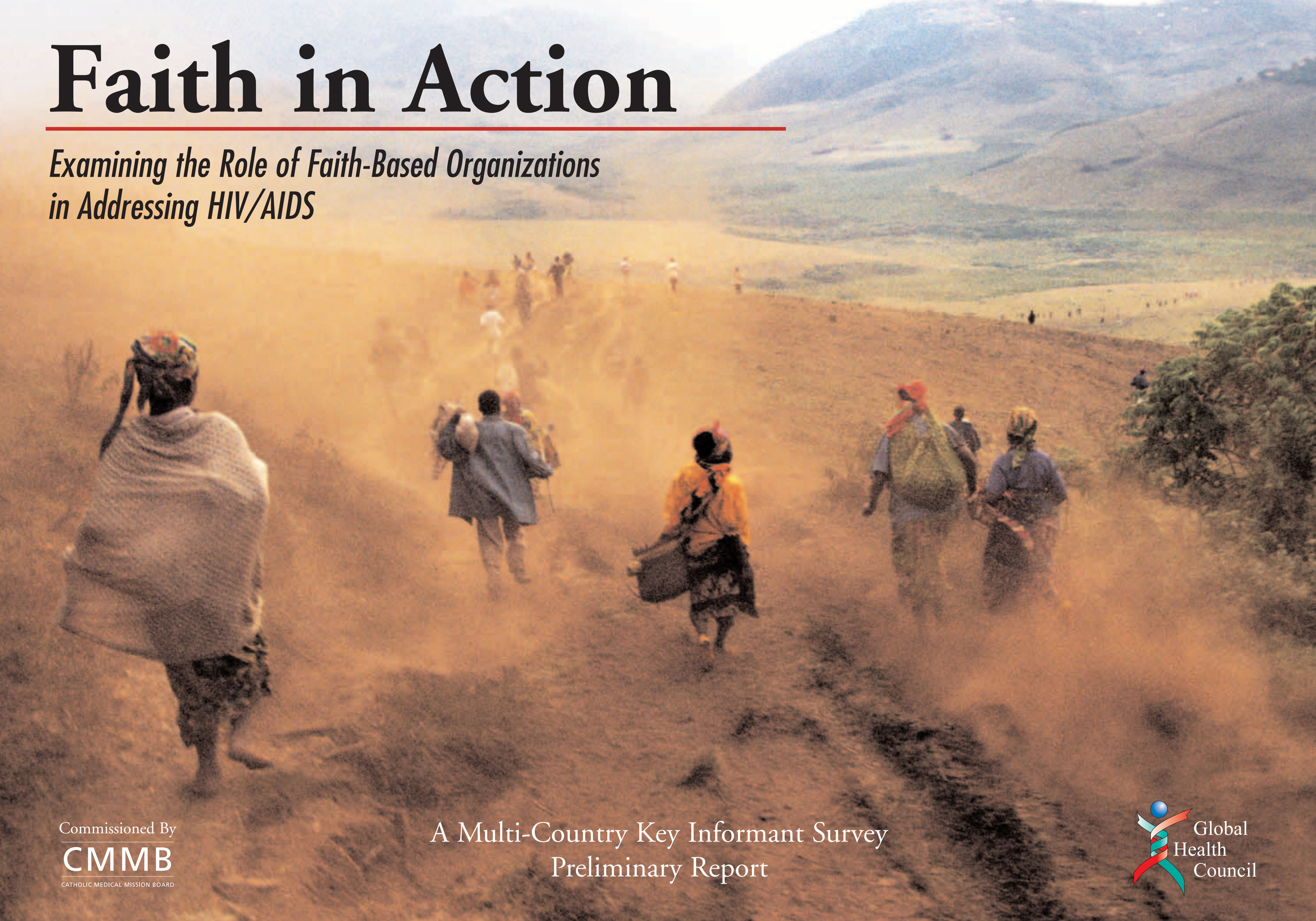
Faith in Action

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



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A Multi-Country Key Informant Survey
Preliminary Report

Global Health Council

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Introduction

HIV/AIDS and the Role of Faith

HIV/AIDS is the most devastating epidemic in human history. With 40 million people now living with HIV/AIDS and an estimated 3 million people having died in 2003 alone,[1] the international community is working diligently to identify effective mechanisms to prevent HIV transmission and provide care, support and treatment for those affected by and living with the virus. Human and financial resources are still considerably inadequate to meet the overwhelming level of existing need. It is, therefore, imperative that existing resources be used wisely, based on the best available evidence of what works.

Recently, there has been significant interest on the part of both multilateral and governmental agencies to increase the role of faith-based/religious organizations (FBOs) in mobilizing HIV prevention efforts, as well as in providing care and support services. *The UNAIDS Global Strategy Framework on HIV/AIDS*,[2] in laying out the principles and elements necessary for a coordinated and effective global AIDS response, calls for "partnerships of key social groups, government service providers, nongovernmental organizations, community-based groups and religious organizations." While religious organizations have long delivered social, educational and health services in many countries, their activities have often not been well-documented and independent analyses of their impact is lacking. The increasing involvement of FBOs in delivering HIV/AIDS services warrants a balanced and impartial examination of their contributions to determine their optimal involvement in the future.

Examining Faith in Action

In the interest of contributing to the knowledge base and improving HIV prevention, care, support and treatment efforts, the Catholic Medical Mission Board (CMMB), a faith-based leader in international health care, commissioned the Global Health Council to conduct an independent analysis of the role of FBOs in addressing the HIV/AIDS pandemic. In engaging the Global Health Council to perform this research, CMMB sought to assess the important work of FBOs in meeting the challenge of HIV/AIDS and to identify areas where FBOs can play a role in further development. Through interviews with professionals working in the fight against HIV/AIDS in Haiti, India, Kenya, South Africa, Thailand and Uganda, as well as those at the international level, this qualitative research project aims to explore perceptions of FBO involvement in countries with high or rapidly growing prevalence rates, as well as in countries that have been successful in containing the epidemic. The Global Health Council partnered with university and research-based collaborators in these six countries to conduct 200 interviews with key informants, representing governments, donor agencies, research institutions, pharmaceutical companies, health care facilities, faith-based organizations and community-based organizations, including those representing persons living with HIV/AIDS (PLWA). Key informants were selected to provide informed and diverse viewpoints about the role that FBOs have played and most usefully may play in the future.

> **What is a "Faith-Based Organization?"**
>
> A general term used to refer to religious and religious-based organizations, places of religious worship or congregations, specialized religious institutions, registered and unregistered nonprofit institutions that have religious character or missions.[3]

Conceptually grounded in *The Global Strategy Framework on HIV/AIDS*, interview questions aimed to explore the framework's policy guidance regarding the mitigation of risk, vulnerability and impact of the disease. The questions were designed to investigate perceptions of the extent of leadership, collaboration and community-level contributions that FBOs have made to these strategies. Interview transcripts from our key informants are currently being systematically analyzed across and within each country and sector.

> **Research Methodology Highlights**
>
> *Methods:* Semi-structured interviews with key informants
>
> *Countries:* Haiti, India, Kenya, South Africa, Thailand and Uganda, as well as international arena
>
> *Key informant sectors:* Community-based organizations, donor agencies, faith-based organizations, health care facilities, international governmental organizations, government ministries/national AIDS control programs, nongovernmental organizations, pharmaceutical companies, research institutions
>
> *Number of key informants:* 206
>
> *Analysis:* Verbatim transcripts analyzed using qualitative software (Atlas ti)

Preliminary Report at a Glance

The final report, scheduled for release in early 2005, will be based on the full analysis of the transcripts from the more than 200 key informants. It will address a variety of questions that guided the development of the research instruments, including:

- How have FBOs contributed to addressing HIV/AIDS?
- Are there unique elements to FBO involvement?
- Do perceptions vary among those in the FBO sector and other sectors in society?
- What has the role of FBOs been in relation to issues such as stigma and social/legal barriers to effective change?
- Have FBOs effectively collaborated with other sectors and provided leadership?
- What advice do key informants offer FBOs to maximize their contributions?

This interim report introduces the study and provides preliminary findings from the initial phase of analysis. It addresses one key question: ***From the perspective of key informants working for predominately secular organizations (non-FBOs), how can FBOs be most usefully and constructively involved in addressing the devastating impact of the HIV/AIDS pandemic***? The reported findings are not yet conclusive nor complete; rather, in anticipation of the full report, the goal of this report is to initiate a dialogue among all parties involved in HIV prevention, care and support.

HAITI

Haiti at a Glance

Population (2002)[4]: 8 million

Religion[5]: Christian 96%, Voodoo 50%, other 3%

GNI[i] per capita (2002)[4]: USD 440

Percent living under national poverty line (1987)[6]: 65%

Adult (age 15-29) HIV prevalence rate (end of 2001)[7]: 6.1%

Number of AIDS orphans currently living (end of 2001)[7]: 200,000

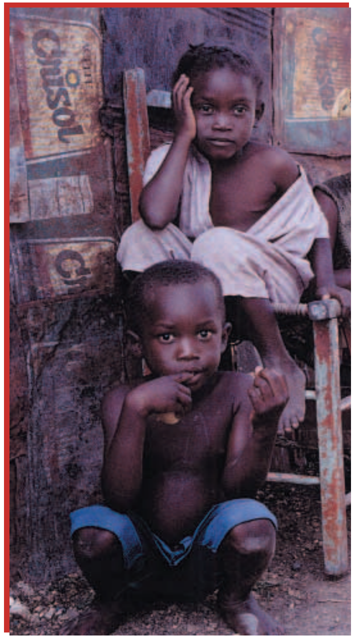

Photo: Keith Mumma

Haiti is home to 8 million people who practice a distinct blend of Christianity and Voodoo. Regardless of its recent celebration of the 200th year anniversary as the world's first black nation to gain independence, Haitians have for generations suffered from an unrelenting mix of civil strife and poverty. In rural areas, two-thirds of the population live under the poverty line, a situation now exacerbated by HIV/AIDS. With more than 250,000[7] people living with the virus, Haiti has the highest adult HIV prevalence rate in the Western Hemisphere. Since the first cases of HIV infection in 1979,[8] the epidemic has now spread throughout the country, especially among those at the most deprived levels of society. With nearly 30,000 lives lost to the disease each year, AIDS has also orphaned 200,000 children.

Public and visible activities of religious organizations involved in combating HIV/AIDS have been relatively recent and uncoordinated. One of the first meetings on HIV/AIDS between Catholic, Protestant and Voodoo religious leaders was held in 1992 without immediate follow-up. In 2003, the Catholic Church convened the National Conference on AIDS, and later that year, World Relief organized the National Conference of Protestant Churches on HIV/AIDS. Under the auspices of UNICEF, more than 50 Voodoo leaders met this same year to discuss their participation in this fight. Since 1999, a Haitian NGO, Promoteurs de l'Objectif Zerosida (POZ), in collaboration with leading religious faiths, has organized an annual Candlelight Memorial as a day of mobilization and awareness-raising around the disease.

> *'The Church here plays an important role by avoiding the exclusion of these persons by saying that the person is the child of God.'*
>
> - Haitian Key Informant

Despite the outbreak of conflict in early 2004 throughout much of Haiti, interviews were conducted with 26 key informants from institutions including multilateral organizations, leading health service providers, bilateral organizations and the Ministry of Health. Most interviewees from outside the FBO sector feel that all groups, whether secular or faith-based, must collaborate in the fight against HIV if progress is to be achieved. The nature of collaboration, as suggested by our study's key informants, includes sharing financial resources, supporting treatment advocacy efforts of community-based organizations, and complementing the work of other HIV/AIDS organizations.

> *'I think that the biggest thing that FBOs could do is speak clearly and on behalf of people living with HIV.'*
>
> - Haitian Key Informant

While faith-based organizations already provide health care in Haiti, several Haitian informants state that the provision of AIDS care and treatment should be the domain of the medical profession. On the other hand, they feel that FBOs should actively engage in prevention activities. The wide 'audience' that FBOs have access to, as demonstrated through their presence and extensive networks throughout Haiti, is seen as a significant asset that should be utilized for disseminating key prevention messages. According to a number of Haitian informants, the fact that tenets of key religious groups in Haiti advocate against multiple sex partners makes FBOs appropriate messengers for promoting faithfulness. Some interviewees state that FBOs should not be expected to promote condoms, as condom promotion may contradict 'abstinence' and 'faithfulness' messaging supported by many churches. However, interviewees recommend that FBOs' efforts should be complementary, rather than in opposition to organizations that promote condoms.

Interviewees also want FBOs to speak up in service of those stigmatized by HIV/AIDS. As religious leaders and their respective institutions have a large audience in Haitian society, their voice would facilitate the inclusion of those affected by and infected with HIV and help to mitigate stigma within the community-at-large.

[i] *GNI: Gross National Income.*

निष्ठा कृति में

INDIA

Home to more than a billion people at the end of 2003, India is a diverse country in which six major religious communities are represented. Hinduism, practiced by a large majority of Indians, has an important influence on the public and personal lives of most Indians. Although it is the largest democracy in the world, nearly 80% of all Indians lived on USD 2 or less per day in 2002.[6] The HIV/AIDS epidemic promises to further compound the burden of a population already suffering from a host of poverty-driven problems.

> *Faith-based organizations definitely have a very strong role to play in the community, but it also should be a very tempered, balanced approach.*
>
> \- Indian Key Informant

Since the first reported case of AIDS in 1986, the estimated number of HIV infections in India has increased sharply to 4 million at the end of 2001.[7] While current prevalence rates are relatively low, the potential magnitude of an unchecked HIV epidemic in a country that has more people than the whole of Africa is staggering. Globally today, India is second only to South Africa in the number of people living with the infection. The pattern of HIV infection in India is as diverse as the country itself. At present the epidemic is greatest in a few southern states, with heterosexual intercourse being the predominant mode of transmission spreading the epidemic to the general population, while injecting drug use is the main mode of transmission in eastern India.[9]

Soon after the reporting of the first HIV/AIDS case in the country, the National AIDS Committee was constituted and a National AIDS Control Programme (NACP) was launched a year later.[10] Today, despite the National AIDS Control Organisation's (NACO) multi-sectoral strategy for the prevention and control of HIV/AIDS, India faces an upward battle complicated by a paucity of health funding, limited political commitment, and a diverse and embattled populace that may be difficult to mobilize around one issue.[11,12]

We interviewed 27 individuals in India, representing key sectors including national and state AIDS control boards, international donor agencies and generic antiretroviral drug manufacturers. In India, some informants believe that FBOs (including Hindu, Christian and Muslim) have large infrastructures and networks that should be utilized for scaling up HIV prevention efforts and integrating treatment for those with AIDS. Many individuals state that religious leaders are ideal prevention educators as they are "in charge of conduct, ethics and morality." These informants feel that people would listen to their advice if given within the context of their existing belief systems. As most prominent Indian religions promote faithfulness, interviewees believe that FBOs are well poised to actively create awareness about high risk behaviors. In fact, some interviewees think that in order to be effective, religious leaders have the moral responsibility to talk openly about sex and sexuality.

In contrast to our other study countries, a number of informants do not think that Indian FBOs have been significantly active in addressing HIV/AIDS and do not see a clear participatory role for them in the future. One reason offered by interviewees to explain this perception is that the majority of Hindus do not regularly visit temples. The interaction between Hindu religious leaders and individuals provides limited opportunity for Hindu FBOs to influence members of their communities.

> *You know, Hinduism talks of tolerance.*
>
> \- Indian Key Informant

India at a Glance

Population (2002)[4]: 1.05 billion

Religion[5]: Hindu 81%, Muslim 12%, Christian 2%, Sikh 2%, other 3%

GNI per capita (2002)[4]: USD 480

Percent living under national poverty line (1999-2000)[6]: 29%

Adult (age 15-29) HIV prevalence rate (end of 2001)[7]: 0.8%

Number of AIDS orphans currently living (end of 2001)[7]: not available

Photo: Annmarie Christensen

KENYA

Kenya at a Glance

Population (2002)[4]: 31 million

Religion[5]: Christian 78%, indigenous beliefs 10%, Muslim 10%, other 2%

GNI per capita (2002)[4]: USD 360

Percent living under national poverty line (1997)[6]: 52%

Adult (age 15-29) HIV prevalence rate (end of 2001)[7]: 15%

Number of AIDS orphans currently living (end of 2001)[7]: 890,000

Photo: Carmen Cristina Urdaneta/MSH

A multi-party democracy since 1992, Kenya is a diverse country with multiple ethnic groups. While most Kenyans are Christians, Islam also plays a significant public role in Kenyan society. Kenya is considered by many as the gateway to East Africa, and the region's financial and trade center. However, with nearly one-quarter of the population living on less than USD 1 a day, Kenya is a low-income country by all standards.[6] For instance, Kibera, the largest squatter settlement in Africa, has little or no infrastructure and houses nearly 60% of Nairobi's residents.[13]

Kenya is ill prepared to care for the 2.5 million Kenyans currently living with HIV/AIDS and will feel the impact for generations to come. Since the first case of HIV was reported in 1984, HIV incidence has steadily increased until the mid 1990s.[14] By the year 2000, more than 50% of hospital beds were occupied by AIDS patients.[15] At present, there are nearly a million HIV/AIDS orphans, and 1.4 million women are infected with the virus. The cost of treatment is still beyond the means of the average Kenyan, and the government has not yet managed to make generic drugs available to the public on a large scale. The government of Kenya is implementing a national strategic plan that calls for HIV/AIDS prevention programs in all ministries. However, the lack of financing and a weak economy are hampering real progress.[16]

> *‘People listen to pastors. No matter what religion you are talking about. They will listen.’*
>
> \- Kenyan Key Informant

We interviewed 26 individuals throughout Kenya, representing a diversity of organizations including interfaith, Islamic and Christian FBOs, academic research institutions and leading PLWA organizations. Nearly all interviewees feel that FBOs are essential in the fight against HIV/AIDS. Many consider FBOs as having a duty to be involved as their mission is to "to reach out and provide moral and compassionate support to the most vulnerable and disenfranchised." A majority of informants also believe that key aspects of FBOs' daily work, including counseling and spiritual support, makes them well-suited to contribute to this field.

> *‘There is no way we can go to 'B' and 'C' without touching on 'A' and any politician or leader who stands up to say "abstain," he faces a lot of challenges because the next question will be, "does he abstain himself?"’*
>
> \- Kenyan Key Informant

Our interviewees identify a number of assets that make FBOs critical partners in the fight against HIV/AIDS; FBOs have the infrastructure and audience base that can be used for implementing policies, as well as delivering and scaling up services; faith-related groups have the ability to mobilize at a grassroots level as they are highly respected and people listen to them; religion influences people's everyday lives (including the difficult times that characterize the HIV/AIDS pandemic), giving FBOs opportunities to actively engage with their faith communities. Because of these attributes, respondents believe that FBOs have power in Kenyan society to influence policies – and have already done so. For all these reasons, informants think that FBOs should be involved in nearly all aspects of care, support and prevention.

SOUTH AFRICA

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

While South Africa's gross national income per capita of USD 2600 makes it significantly wealthier than most sub-Saharan nations, poverty and inequity are still widespread. South Africa's development efforts have been greatly impaired by the HIV/AIDS epidemic. With 5 million people living with the disease, South Africa has the highest prevalence of any country worldwide.

> *'I'd like to see FBOs be more clear in their prevention messages and not undermine the work being done by those that try to provide adolescents and young people with guidance to responsible sexuality.'*
>
> \- South African Key Informant

Until recently, the South African government had received criticism from a number of national-level advocacy groups and members of the international community for its approach to mitigating the epidemic. In a major shift in its treatment policy, the government announced, in 2003, a plan to roll out antiretroviral drugs to 1.2 million people – or about 25% of the country's HIV-positive population – by 2008. The government has also formulated a multisectoral national strategic framework for the period of 2000 – 2005 that involves 17 sectors, including persons living with HIV/AIDS, faith-based groups and traditional healers.[16]

We interviewed 35 individuals from a wide range of sectors in South Africa including representatives from national and provincial governmental institutions, community-based organizations, Christian churches and traditional healers. Most interviewees feel that it is critical to involve FBOs when addressing the HIV/AIDS epidemic because of the valuable and diverse assets they 'bring to the table.' As religion figures prominently in South African life and as South Africans have a high respect and trust for religious leaders, key informants also believe that FBOs have credibility because they are entrusted with "the good of society." Faith-related organizations have large networks and places where people can congregate periodically. Many respondents believe that FBOs have immediate and open access to their faith communities, which can facilitate mobilization activities.

A significant number of South African informants think that FBOs should use their influence to raise awareness and encourage openness and inclusiveness. In fact, some respondents feel that FBOs' audience base should be expanded through government-sponsored media campaigns. While informants promote the involvement of FBOs in prevention work, views on condom promotion vary. Some interviewees believe that FBOs could be silent, while others believe that if they cannot talk about prevention comprehensively, effectiveness of FBO prevention programs would be very limited.

Another important role envisioned for FBOs is the care and support of affected and infected communities. There is, however, a division in the perspectives of informants in terms of FBOs' role in treatment activities. While some feel faith-related groups should use their infrastructure to deliver treatment, others think that the provision of treatment is best left to the government. In general, regardless of the type of role, the consensus among South African informants is that FBOs should be involved in addressing and mitigating the impact of HIV/AIDS.

> *'If you're going to a rural area, there may not be a school but there'll probably be a church. So it's a question of how you best engage the faith-based sector around HIV and AIDS.'*
>
> \- South African Key Informant

South Africa at a Glance

Population (2002)[4]: 44 million

Religion[5]: Christian 68%, Muslim 2%, Hindu 1.5%, indigenous beliefs and animist 28.5%

GNI per capita (2002)[4]: USD 2600

Percent living under national poverty line[6]: not available

Adult (age 15-29) HIV prevalence rate (end of 2001)[7]: 20.1%

Number of AIDS orphans currently living (end of 2001)[7]: 660,000

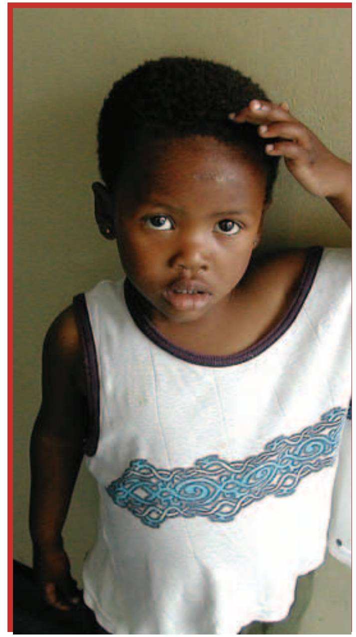

Photo: Colleen Murphy

THAILAND

กระทำโดยศรัทธา

Thailand at a Glance

Population (2002)[4]: 62 million

Religion[5]: Buddhist 95%, Muslim 3.8%, Christian 0.5%, Hindu 0.1%, other 0.6%

GNI per capita (2002)[4]: USD 1980

Percent living under national poverty line (1992)[6]: 13%

Adult (age 15-29) HIV prevalence rate (end of 2001)[7]: 1.8%

Number of AIDS orphans currently living (end of 2001)[7]: 290,000

Photo: Annmarie Christensen

A Buddhist county in Southeast Asia, Thailand has a growing economy and is doing relatively well on the United Nations' Human Development Index (HDI), which combines measures of life expectancy, school enrollment, literacy and income to reflect a country's level of development.[17] A favorite tourist destination, Thailand is also known for its booming commercial sex industry, which has significantly contributed to its AIDS epidemic.

The first case of AIDS in Thailand was reported in 1984.[9] Poised on the brink of an HIV/AIDS disaster in the early 1990s, Thailand has been credited with implementing a successful national campaign focused on, among other things, a "100% condom use programme" for the close to 100,000 sex workers in Thailand.[18] At present, the focus of the Ministry of Public Health (MOPH) is on ensuring that 50,000 PLWAs will have access to low-cost antiretroviral (ARV) treatment (USD 30 per month). To date, an estimated 20,000 PLWAs have access to ARV drugs. However, the shifting interest of the MOPH means the budgets used for free condoms and prevention have been severely cut.

> *'We really hope that the religious organization[s] will get involved because it is clear that they can help.'*
>
> \- Thai Key Informant

While there are Buddhist faith-based institutions such [as] the Buddhist Monk University (*Mahachulalongkornrajaviyalaya*) and the Young Buddhists Association, their activities have usually been restricted to more traditional roles. More recently, Buddhist nuns and monks have become actively involved in HIV/AIDS work.[19, 20]

In Thailand, we interviewed 28 individuals from a variety of sectors including Buddhist, Christian and Islamic FBOs, governmental ministries, and organizations representing PLWAs. Since the majority of Thais considers themselves Buddhist, key informants tend to focus primarily on Buddhist organizations in their responses. While most informants see a very useful role for monks, many contradictions and tensions exist in the interviews, highlighting the complexities of involving monks in HIV/AIDS work. For instance, the respect that Thai society has for monks appears to work in unexpected ways than in the other societies that we examined. On the one hand, informants think that monks, who are commonly held in high esteem, may be able to lead by example in mobilizing communities and discouraging stigma. On the other hand, interviewees tell us that monks are traditionally perceived to be "outside" society. Therefore, society expects them not to get involved. If lay people see monks getting too involved in "worldly matters" such as HIV/AIDS and sex, they start questioning the monks' morality and lose respect for them.

> *'Both lay people and monks should adjust themselves to be more open to one another.'*
>
> \- Thai Key Informant

A related obstacle to monks getting involved in addressing HIV/AIDS is internal: key informants state that monks have many rules to follow (227 precepts) that may hinder them in everyday activities. There is also a possibility of rejection from among their own ranks. For instance, several interviewees mention a small group of somewhat controversial "development" monks that have recently become active in the community.

Despite these obstacles, informants think that monks could use Buddha's teachings to advocate for prevention. However, even this is seen as problematic since monks are traditionally not supposed to talk about sex, which presents a problem in a country where a main determinant of the epidemic is the social acceptance of commercial sex.

UGANDA

Uganda is one of Africa's most stable democracies and has one of the fastest growing economies on the continent. Yet, despite a healthy GDP growth rate (6.3% in 2001),[4] Uganda continues to be a country with very high poverty levels and ranks a low 150 out of 173 countries on the United Nations Human Development Index. Life expectancy at birth is 44 years (compared to developing countries' average of 64.7 years); and combined primary to tertiary school enrollment is 45% (low-income countries' average 61%).[17]

> *We must recognize their [FBOs] comparative advantage. So do not, as I said, expect the bishop to go and start demonstrating how to use a condom, if you know it is against his whatever. Use him for what he is best able to deliver.*
>
> - Ugandan Key Informant

Quoted by many as the "HIV/AIDS success story," Uganda is internationally recognized and exemplified for having taken effective action in the early days of its HIV epidemic. Ugandan President Yoweri Museveni demonstrated unprecedented leadership by making HIV/AIDS a national priority, effecting remarkable reductions in HIV prevalence; for example, prevalence rates among antenatal clinic attendees in Kampala were reduced from 29% in 1992 to 11% in 2000.[21] Uganda is also credited with the widespread promotion of the "ABCs of HIV" – Abstain, Be faithful, or use Condoms.

Despite its successes, Uganda still requires significantly more resources to mitigate the impact of HIV/AIDS. In response, the government is promoting public-private partnerships as well as community-based responses to the epidemic.[16] Even though Uganda is a predominantly Christian country, nearly all major Christian and Islamic institutions have been publicly active in Uganda's struggle with HIV/AIDS.[22, 23]

In Uganda, we interviewed 30 individuals from a variety of sectors including, among others, ministries of health and education, Catholic, Islamic and Anglican groups, as well as nongovernmental organizations who focus on care, treatment and support. Most informants feel that FBOs from all major denominations in the country should be key players in Uganda's HIV/AIDS strategy. Nearly all respondents expect FBOs to be a part of the national policy process and believe that they are currently active on many political levels.

A chief reason that informants raise to explain the high level of FBO involvement in the public arena is that religion plays a central role in nearly all aspects of life in Uganda, and, therefore, FBOs symbolize the multisectoral approach deemed necessary for effective action against the virus. Informants stress that FBOs have a key role to play in addressing stigma because they can mobilize their followers and change social norms "from the pulpit"; people trust religious leaders and are viewed as a regular Friday/Sunday audience.

Some informants strongly believe that FBOs should be involved in prevention by reminding people of "norms and values" that reinforce protective behaviors. Interviewees seem divided between believing that FBOs should advocate for "A" and "B" of the ABCs of prevention and avoid the promotion of condoms, to believing that if they cannot provide a balanced message, FBOs should not talk about prevention at all. With regard to treatment, some informants think that FBOs have done well and should continue to provide treatment and care through their networks of faith-based hospitals that they perceive as providing better care than government facilities. According to a number of secular Ugandan respondents, FBOs have developed good models of health care that can be utilized for scaling-up and providing examples for other public health efforts.

> *They [FBOs] provide the service and they have a large following. So, I think they cannot be left out.*
>
> - Ugandan Key Informant

Uganda at a Glance

Population (2002)[4]: 23 million

Religion[5]: Christian 66%, Muslim 16%, indigenous beliefs 18%

GNI per capita (2002)[4]: USD 250

Percent living under national poverty line (1997)[6]: 44%

Adult (age 15-29) HIV prevalence rate (end of 2001)[7]: 5.0%

Number of AIDS orphans currently living (end of 2001)[7]: 880,000

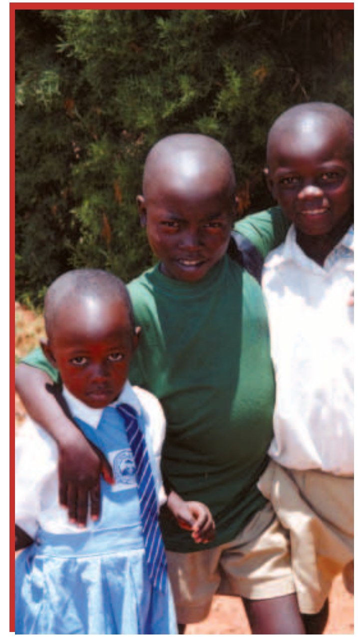

Photo: Annmarie Christensen

Conclusions

Faith in Action is an exploration of issues surrounding the role of faith-based organizations in the fight against HIV/AIDS in a variety of contexts that may require different types of action from FBOs. The analysis is based on the perceptions of key informants and can, therefore, be expected to include a wide range of viewpoints. We envision that these perspectives will provide a basis for policy dialogue and decision-making that will ultimately lead to improved prevention efforts, and will positively expand the care, support and treatment of persons living with HIV/AIDS and others affected by the disease.

' *Perception is reality.* '

We anticipate that the findings will also be of significance to FBOs entering or working in the HIV/AIDS field. The findings will enable them to have greater insight into how they are perceived, and how those in a variety of sectors believe that FBOs can most usefully collaborate, contribute and provide leadership. The study is not an evaluation of the role that FBOs have played, nor is it a comparison of the effectiveness of services provided by FBOs and secular groups. Rather, our hope is that the lessons learned will spur and inform future research regarding unanswered questions about FBOs' roles within the context of HIV/AIDS, including evaluation of the effectiveness of interventions that utilize FBOs and analyses of policies that promote FBO involvement in HIV/AIDS prevention and treatment efforts.

Reference List

1. UNAIDS. AIDS Epidemic Update 2003. Geneva: Joint United Nations Program on HIV/AIDS, 2003.

2. UNAIDS. The Global Strategy Framework on HIV/AIDS. Geneva: Joint United Nations Program on HIV/AIDS, 2002.

3. Africa Strategic Research Corporation. Faith-based Responses to HIV/AIDS in South Africa: Summary of Findings. CDC, Department of Health, ASR, 2002.

4. World Bank. Selected World Development Indicators 2004. World Development Report 2004: Making Services Work for Poor People. Washington D.C.: World Bank, 2004.

5. CIA. World Factbook [Web Page]. 2003; Available at http://www.odci.gov/cia/publications/factbook /.

6. World Bank. World Development Indicators (WDI): Table 2.5 Poverty [Web Page]. 2004; Available at http://www.worldbank.org/data/databytopic/poverty.html#pdf.

7. UNAIDS. Report on the Global HIV/AIDS Epidemic. Geneva: Joint United Nations Program on HIV/AIDS, 2002.

8. National Institute of Allergy and Infectious Diseases. The Relationship Between the Human Immunodeficiency Virus and the Acquired Immunodeficiency Syndrome [Web Page]. 1995; Available at http://www.niaid.nih.gov/publications/hivaids/hivaids.htm.

9. UNAIDS. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: India [Web Page]. 2002; Available at http://www.unaids.org.

10. National AIDS Control Organization (NACO). National AIDS Prevention and Control Policy [Web Page]. Available at http://www.naco.nic.in/nacp/ctrlpol.htm.

11. The Economist. Special Report - AIDS In India: Abating, or Exploding? United Kingdom: 2004:21-3.

12. The Economist. AIDS in India: When Silence is Not Golden. United Kingdom: 2004:10.

13. UN-HABITAT. The Slum Challenge: The Global Report on Human Settlements [Web Page]. 2003; Available at http://www.unhabitat.org/mediacentre/presskits.asp.

14. UNAIDS. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: Kenya [Web Page]. 2002; Available at http://www.unaids.org.

15. National AIDS Control Council. The Kenya National HIV/AIDS Strategic Plan 2000 -2005. Office of the President, 2000.

16. UNAIDS. UNAIDS National Responses [Web Page]. 2004; Available at http://www.unaids.org.

17. UNDP. Human Development Report 2002: Deepening Democracy in a Fragmented World. New York and Oxford: Oxford University Press: United Nations Development Program, 2002.

18. WHO. STI HIV: 100% Condom Use Programme in Entertainment Establisments. World Health Organization, 2000.

19. UNICEF. Buddhist Monks and Nuns Fight against HIV/AIDS (Press Release) [Web Page]. 22 August 2003;

20. UNICEF. The Mekong Partnership and Beyond: The Regional Buddhist Leadership Intiative [Web Page]. Available at http://www.unicef.org/eapro-hivaids/regpro/buddhist_response.htm .

21. UNAIDS. Epidemiological Fact Sheets on HIV/AIDS and Sexually Transmitted Infections: Uganda [Web Page]. 2002; Available at http://www.unaids.org.

22. UNAIDS. Islamic Medical Association of Uganda. AIDS Education through Imams: a Spiritually Motivated Community Effort in Uganda. UNAIDS, 1998.

23. Green EC. Faith-Based Organizations: Contributions to HIV Prevention. USAID: The Synergy Project. 2003.

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