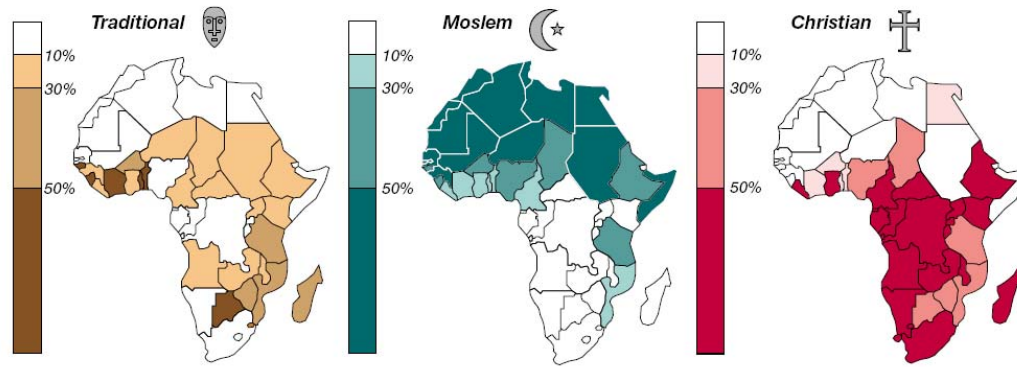


## Chapter 3

### Context to partnership and collaboration



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Figure 3.1: Major religions in Africa<sup>22</sup>

#### Chapter overview

This chapter rapidly appraises the state of current literature which speaks of the religious-health landscape in SSA, and specifically of REs' engagement in HIV and AIDS. Many of the concepts raised here will be addressed again in the country case-studies that follow.

#### 3.1 Surveying secondary literature at the intersection of religion, health and HIV and AIDS

Reviews of secondary literature at the intersection of religion and health in Africa, including the sub-category of HIV and AIDS, have most commonly found a glaring lack of information in this area. The staple of academic literature searches - i.e. peer-reviewed studies and articles - are virtually non-existent. The majority of documentation that does exist emerges from what is commonly termed 'grey literature' - organizational reports, news articles and internet-housed reports.<sup>23</sup> While there are a few key studies and reports emerging, this secondary literature usually has a narrow focus, is often of unknown quality, is more frequently qualitative than quantitative, and is rarely based on data which makes it comparable across countries or the African continent. As a result, a recent landscaping study of religious-health literature in SSA strongly calls for more research in nearly every area of investigation.<sup>24</sup>

It is in this research context, and based on such literature, that this study provides here a brief overview of some of the key themes and concepts relevant to the presence and collaboration of CREs in Kenya, Malawi and the DRC. The aim here is not to present a survey of the entire literature, but rather to briefly acknowledge the body of knowledge - 'grey' or otherwise - upon which this research builds its argument, and upon which the further country case-studies can be tested.

<sup>22</sup> Parry 2005

<sup>23</sup> See Olivier et al 2006, Schmid et al 2008

<sup>24</sup> See Schmid et al 2008

### **3.2 HIV and AIDS in sub-Saharan Africa**

*In 2007 ... Sub-Saharan Africa continues to be the region most affected by the AIDS pandemic ... More than two thirds (68%) of all people HIV-positive live in this region where more than three quarters (76%) of all AIDS deaths in 2007 occurred. It is estimated that 1.7 million [1.4 million-2.4 million] people were newly infected with HIV in 2007, bringing to 22.5 million [20.9 million-24.3 million] the total number of people living with the virus. Unlike other regions, the majority of people living with HIV in sub-Saharan Africa (61%) are women.<sup>25</sup>*

We will not provide here a full description of the HIV and AIDS epidemic in SSA. Briefly, however, we note that despite some successes and declining infection rates (such as can be seen in Kenya and Malawi), the AIDS epidemic continues to hit SSA the hardest.<sup>26</sup> Furthermore, in SSA, the AIDS epidemic is based in a context of broader complexities - of competing issues such as development, poverty and co-existing diseases such as TB and malaria.<sup>27</sup> This results in a population facing inter-related risk factors. What this highlights is that CREs, their partners and the communities they serve are dealing with an epidemic in a broader and more complex context with competing priorities.

### **3.3 The religious-health landscape in SSA**

There has been a recent boom of interest in the potential of religious entities in establishing effective HIV and AIDS interventions. This interest usually reflects a strongly positive attitude towards working with religious entities - and simultaneously some cautionary note, based on perceptions of the potential negative effects of religious messages.<sup>28</sup>

Despite some negative perceptions of their role and impact, faith-based organizations are among the most viable institutions at both local and national levels and have developed experience in addressing the multidimensional impact of AIDS ...<sup>29</sup>

International agencies have only recently acknowledged the important role of faith communities as a legitimate partner in responding to HIV ...<sup>30</sup>

This interest emerges from organizations including international agencies such as the WHO, UNAIDS, PEPFAR and The Gates Foundation - and is balanced by a realisation that little is known about these religious entities, who they are, what they can do, what assets they hold that can be leveraged for good health, and how they function.<sup>31</sup> Much of this interest has been centered around the idea of aligning or integrating religious entities in the broader national efforts or health systems.<sup>32</sup>

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<sup>25</sup> UNAIDS 2007

<sup>26</sup> UNAIDS 2007

<sup>27</sup> See Schmid et al 2008. For example, it was recently reported that efforts to combat the spread of TB in the DRC have slowed down because of patients co-infected with HIV. See Plusnews 2008a

<sup>28</sup> See Birdsall and Kelly 2007, PEPFAR 2008, Taylor 2005a, Taylor 2007, UNFPA 2004

<sup>29</sup> Foster 2003

<sup>30</sup> Christian Aid 2004

<sup>31</sup> See ARHAP 2006

<sup>32</sup> See ARHAP 2006

### 3.3.1 Religious entities working in health in SSA

#### A. The problem of classifying religious entities

There have been substantial difficulties in finding appropriate nomenclature that properly depicts the huge variety of entities that have a faith-aspect to their work or character and are commonly grouped as 'the religious/faith sector'. For example, consider the following list of a few of the types of AIDS-engaged religious entities in Zambia: mission hospitals running complex ART programs, grass roots community organizations spontaneously getting together to run home-based care and OVC efforts, congregations running youth training programs, national religious coordinating bodies and health desks, groups of religious leaders with HIV and AIDS, a Muslim community financially supporting an HIV program in a government hospital, a traditional healer (who is also a Christian pastor) running HIV treatments and referrals to government hospitals.<sup>33</sup> To call all of the above 'FBOs' - as is commonly found in secondary literature - vastly undermines the variety within the faith-response to the AIDS epidemic. Some of the current trends in 'FBO-nomenclature' include the following:

- *Religious entity*: seeking to capture the broad range of tangible RHAs, incorporating religious facilities, organizations as well as practitioners, both bio-medical and traditional.<sup>34</sup> In a previous mapping study of Zambia and Lesotho, ARHAP undertook to develop a more concise typology that would contribute to a better understanding of the role and contribution of religious entities to health. The ARHAP WHO report (2006) provided a detailed multi-level categorisation, differentiating between the *type* of RE (congregation, clinic, support group), its primary *activity*, its geographic *reach* (local up to international) and the *time* it has been active.<sup>35</sup>
- *Faith based organization*: variously used to describe all religious entities, but more commonly used to describe organizations of the 'NGO-variety'. The WCC further differentiates between faith-related organizations, faith-background organizations, faith-centered organizations and faith-saturated organizations.<sup>36</sup>
- '*FBOs as CBOs*': Increasingly common is the use of 'FBO' to specifically denote community-based organizations with a faith element. For example, PEPFAR material says: "the Emergency Plan prioritises the development of partnerships with FBOs and CBOs as a key strategy for increasing access to services and building sustainability ..."<sup>37</sup>
- *Facility-based FBOs and non-facility based FBOs*: Used to create a distinction between religious entities which provide health services from a facility (such as hospitals, clinics, surgeries, dispensaries), and those that are taking place in communities and homes and are usually informal and less dependant on external expertise and funding (such as support groups, home-based care, health education).<sup>38</sup>
- Also common is the differentiation between types of 'FBOs' by using other *commonly used sub-categories*. For example, this can be seen in a WCRP-UNCEF report, namely: congregation (local

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<sup>33</sup> All religious entities found in the ARHAP 2006 study

<sup>34</sup> See the glossary in Appendix 2.

<sup>35</sup> ARHAP 2006

<sup>36</sup> See Doupe 2005

<sup>37</sup> PEPFAR 2008

<sup>38</sup> Schmid et al 2008

gatherings of believers that meet on a regular basis, e.g. churches, mosques); religious Coordinating Bodies (RCBs, responsible for coordinating or supporting congregations or other RCBs); non-governmental organizations (NGOs, faith-based organizations that employ staff and are accountable to a group other than a congregation or RCB); community-Based Organizations (CBOs, faith-based groups that rely on volunteers and are accountable to a group other than a congregation or RCB.)<sup>39</sup>

All such typologies are limited, and there is an urgent need for continued investigation and consultation in this area. This is not just a matter of nomenclature, but evidence of the struggle to better understand the nature of religious entities, and the work they do.<sup>40</sup>

## **B. Problems of generalisation across SSA**

In the same way, it has been highlighted in several recent studies that context is critically important when seeking to better understand the religious-health landscape in Africa. There is enormous diversity in social, economic, cultural and religious profiles. However, there are several attempts to describe and plan for the African situation generally, or for 'the AIDS epidemic in Africa'.<sup>41</sup>

Making summary statements or generalisations about the religious-health landscape (is) not usually meaningful ... great care should be taken when applying or interpreting generalisations about the religious-health context, which may not accurately reflect many situations in SSA.<sup>42</sup>

Of course, this does not mean that plans and recommendations cannot be made on a broader scale, but is simply a warning that regional differences in Africa (even within national borders) can be extreme.<sup>43</sup> The variety and inconsistency of the secondary literature and data relevant to the religious-health landscape, and more specifically religious entities' involvement in the HIV and AIDS epidemic, adds to awareness that, based on the current body of knowledge, it is difficult to make generalisations within countries, and across SSA.<sup>44</sup>

## **C. Religion in SSA**

When considering the religious-health landscape in Africa, what is often forgotten is that religion is ubiquitous to the African context - but often hidden from the modernist view.<sup>45</sup> This demands that a better understanding of religious entities and practices be sought.

When seeking to understand the place of 'religion' in SSA health systems, it is critical to understand the complexities within the African religious context. For example, while the 'religious statistics' that are shown in the following three country case-study chapters all indicate that Christianity dominates

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<sup>39</sup> Foster 2003

<sup>40</sup> As described in chapter 1 and 2, this research has chosen to use the broader term 'religious entity' - and in this case 'Christian religious entity' to capture the range of organizations, networks and 'religious coordinating bodies' that participated in this study

<sup>41</sup> See Olivier et al 2006

<sup>42</sup> Schmid et al 2008

<sup>43</sup> Indeed, the literature review that follows in this chapter attempts to speak of 'generalizations' across the broad category of 'religious entities'

<sup>44</sup> This study seeks to address this lack of knowledge by running the research in three SSA different countries, and thereby getting some basis for cross-country understanding

<sup>45</sup> See ARHAP 2006

in these countries, it is necessary to reflect that plural religious affiliation is to be expected.<sup>46</sup> In the religious-health landscape and the context of HIV and AIDS, plural religious affiliation can be most effectively seen in the case of plural health seeking behavior. Here, people turn - very commonly and often in unacknowledged ways - to different sources or systems of health, sometimes sequentially, sometimes simultaneously, all of which significantly impacts on the implementation and sustainability of health interventions.<sup>47</sup>

- This highlights that in the African context there are several 'health systems' in place - just as there are several types of healing.
- *African traditional healing* addresses the physical, spiritual and psychological body. A range of specialists including medicine doctors, royalty, herbalists, rainmakers, priests, birth attendants can be involved. *Spiritual healing* is often characteristic of many African Independent Churches, especially those known in southern Africa as 'Zionist', but also newer forms of local Pentecostal churches. *Islamic healing* is an ancient form of healing, incorporating Galen's 2<sup>nd</sup> Century CE understanding of the body. *Western biomedicine* expanded in Africa initially in response to the health care needs of colonial missionaries and administrators. In time, mission health services became a key form of outreach, especially in rural areas.<sup>48</sup>
- This study has focussed on CREs, and therefore participants express a range of understandings of what is 'healing'.<sup>49</sup>

#### **D. The contribution of religious entities to health in SSA**

*It is generally accepted that religious entities have long engaged in health-related activities such as providing educational interventions and caring for individuals affected by disease. In many locations around the world, such REs have been in the forefront or alone in the struggles to ameliorate suffering and provide support, and have often been doing so with little attention or documentation from public health authorities.*<sup>50</sup>

As stated above, there are severe gaps in our knowledge about the resources and nature of religious entities working in health.<sup>51</sup> A common, but not particularly helpful statement is that religious entities are said to provide 25-70% of health care in SSA.<sup>52</sup>

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<sup>46</sup> See ARHAP 2006, Thomas et al 2006.

<sup>47</sup> See Thomas et al 2006

<sup>48</sup> Schmid et al 2008

<sup>49</sup> See Chapter 5, Malawi, for a particularly strong participant response on the various understandings of 'healing' in the context of HIV and AIDS

<sup>50</sup> Olivier et al 2006

<sup>51</sup> See ARHAP 2006 which mapped REs working in HIV/AIDS in locations in Zambia and Lesotho. Several other mapping studies are also currently underway, see Schmid et al 2008

<sup>52</sup> Schmid et al 2008. See Asante 1998, Baer 2007, Benn 2003, DFID 2006, IDT 1998, Nussbaum (ed) 2005, PACANet 2002, Robinson & White 1998

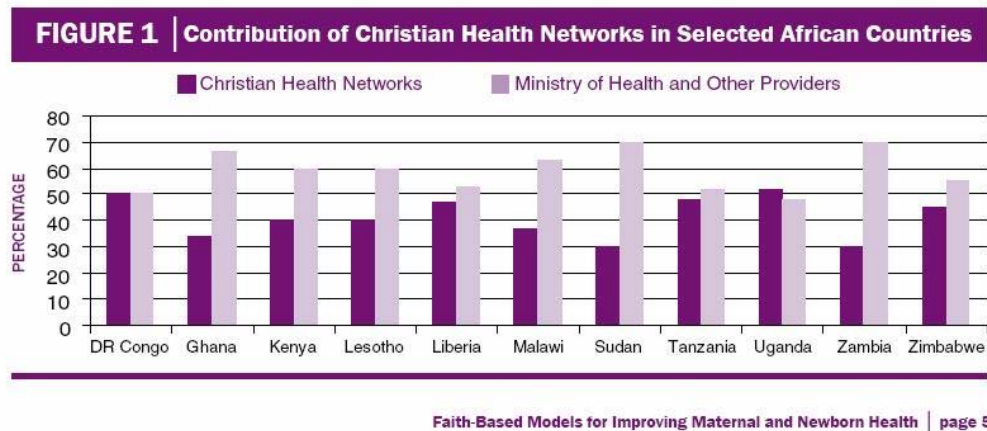


Figure 3.2: Contribution of Christian health networks - Chand & Patterson 2007

What data there is, such as depicted in the table above, is mainly focused on facility-based religious entities providing health services. What is more difficult to measure and understand are the multitude of religious entities who run programmes and initiatives which work to improve health - many of whom are not 'registered NGOs' or facility-based programmes.<sup>53</sup> Indeed, ARHAP mapping undertaken in Lesotho and Zambia in 2006 revealed that while the larger, facility-based entities such as hospitals are (sometimes) visible on public health maps, the mass of smaller non-facility based programmes and initiatives are rarely visible to the public view.<sup>54</sup> Nevertheless, based on secondary literature, what can be said with certainty is that religious entities are widely present in SSA, and have been for a long time, and they are present differently in different parts of SSA, (see box 3.1 below with findings from the Schmid et al 2008 landscaping study.)<sup>55</sup>

**Box 3.1: The contribution of religious entities to health in SSA**

- Religious entities (REs) make a significant and unique contribution to health services
- Faith-based health services in SSA show great variety in type and extent
- National faith based health networks (NFBHNs) play a crucial role in enabling facility-based services, which yet have a contested place within national health systems
- There have been significant shifts in ownership/funding/responsibility regarding faith-based health facilities over recent years from the historic mission model to local and agency funding, leaving huge discrepancies
- Faith-based health services work under severe constraints, especially regarding their workforce
- A wide range of non-facility-based services in response to immediate local needs are provided by REs, playing a very important role under serious constraints
- Mixing of multiple healing modalities (African traditional, bio-medical, faith healing, alternative therapies) is a common reality across SSA with mostly very little mutual acknowledgement and collaboration
- While the important potential of religious leaders for health promotion has been channelled into some creative initiatives, it is generally underutilised

Source: Schmid et al 2008

<sup>53</sup> ARHAP 2006

<sup>54</sup> ARHAP 2006

<sup>55</sup> Schmid et al 2008

## **E. Areas of critical concern for religious entities working in health and AIDS**

It is perhaps necessary to briefly mention that while generalisations are difficult, there are a few key challenges that REs face that are highlighted in the recent secondary literature.

The African health systems in which religious entities are working are mainly weak and dysfunctional, and most SSA health care systems are coming under increasing pressure from HIV and AIDS in particular, and a wider complex of health crises in general.<sup>56</sup> Many REs are struggling in these increasingly trying circumstances, as many have to work under the constant strain of having to do more with less. An example is the dilemma faced by many facility-based REs, where their 'mission' to serve the poor and marginalised comes into direct conflict with financial survival in these strained contexts.<sup>57</sup>

This is a critical time in the history of some of these facility-based health providing FBOs<sup>58</sup> - as they are being pushed to weigh their organizational culture and reason for being, against the realities of financial support and survival.<sup>59</sup>

Of particular concern is the workforce crisis which threatens all aspects of health provision - including HIV and AIDS work.<sup>60</sup> Another challenge (particularly since the DRC and Kenya are two of case-study countries), is that REs in SSA are frequently working in conflict situations, and frequently in the regions in which conflict is most heavily felt. Such conflict situations have a heavy impact on health delivery, infrastructure and outreach.<sup>61</sup>

### **3.3.2 The strengths and weaknesses of religious entities**

Little in-depth case study research has been done on religious entities involved in health, and virtually nothing which compares religious entities with secular organizations involved in the same work.<sup>62</sup> This remains one of the key areas needing further investigation. However, there is a great deal of anecdotal material which speaks of the perceived strengths and weaknesses of religious entities involved in health and in HIV and AIDS.

#### **A. The strengths of religious entities**

The secondary literature that posits religious entities as viable partners for HIV and AIDS work, frequently state a series of perceived strengths. The most commonly stated are:<sup>63</sup>

- Religious entities have unique and extensive reach and access: are found in all communities, and frequently in inaccessible and rural areas.
- Religious entities have access to dedicated volunteers and educated leadership.

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<sup>56</sup> See Schmid et al 2008.

<sup>57</sup> Benn 2002

<sup>58</sup> Please note that in-quote 'FBO' terminology will be left as per the original quotation so as not to lose any significant nuance.

<sup>59</sup> Schmid et al 2008.

<sup>60</sup> See Schmid et al 2008.

<sup>61</sup> See ARHAP 2006, Dimmock 2008, Olivier et al 2006, Lusey-Gekawaku 2003, Parry 2008, Schmid et al 2008.

<sup>62</sup> There are a few interesting exceptions to this broad trend. See for example, CHAK 2007 which is a comparison of faith-based health services vis-a-vis the Kenyan government health services, Thomas et al 2005, Reinikka & Svensson 2003

<sup>63</sup> This summary is from Schmid et al 2008. For more detailed material and referencing see Birdsall & Kelly 2007, DIFAEM 2005, Olivier *et al.* 2006, Parry 2003, Reinikka & Svensson 2003, Taylor 2005, Taylor 2006, Taylor 2007, Thomas et al 2006, UNFPA 2005, World Bank 2004

- Religious entities have unique credibility and acceptance in communities, and therefore a particular potential to change behaviour.<sup>64</sup>
- Religious entities have well-developed networks extending from international to grassroots communities.
- Religious entities also provide an element of 'added value' to their work: intangible factors such as motivated and committed volunteers and workers, spirituality, trust, hope, resilience or durability.

## **B. The weaknesses of religious entities**

Of course, these stated strengths are balanced by the knowledge that REs have not always responded helpfully to the HIV and AIDS epidemic, and in fact have sometimes been harmful.

- **Unhelpful religious attitudes:** Of great concern is the way certain religious beliefs or attitudes have had a negative impact on the fight against HIV and AIDS. Areas include issues of sexuality, cultural practices, the prohibition of condom use, discouraging education of adolescents on reproductive health; limitation of open discussion on sexuality, gender relations, and intergenerational relations; an increased sense of fatalism and increased stigmatisation of people living with HIV and AIDS.<sup>65</sup>
- **Religious attitudes in conflict with biomedicine and public health:** It must be cautiously said that several studies have noted the problematic that occurs when a particular religious attitude comes into conflict with a biomedical perspective - a most obvious example concerns church leaders claiming to cure HIV with prayer.<sup>66</sup> "A pastor in southern Malawi recently hit the headlines when he told five HIV-positive people in his church to stop taking antiretroviral (ARV) medication because they had been treated by prayer ... the government has drawn up legislation, currently before parliament, to muzzle anyone claiming they can cure AIDS."<sup>67</sup> Such attitudes can place some religious entities in conflict with 'mainstream' responses to HIV and AIDS, and endanger collaboration.
- **Religiosity both as an aid and an obstacle to behaviour change:** Secondary literature contains several dialectics - such as this one that religiosity both prevents and engenders risky behaviour; REs' focus on abstinence is a strength, and a weakness; that religious leaders should talk about sex, and that they cannot; that preaching is a moralising process that leads to stigma and a method with potential to provoke healthy behaviour change.<sup>68</sup>

While religious organizations have sometimes reinforced stigma by too readily associating AIDS with religious teachings about 'sin', there are notable examples where they have worked to foster tolerance and social solidarity using approaches that are non-judgmental and not based on fear. UNAIDS 2002

In stark contrast to the position that argues that religions enhance stigma, is the opposite position that argues that religion, and therefore REs, are ideally situated to intervene against stigma. Olivier et al 2006

<sup>64</sup> A controversial point in public health circles, see below regarding the weaknesses religious entities.

<sup>65</sup> Schmid et al 2008. See Green 2003, Liebowitz 2002, Olivier et al 2006, Tiendrebeogo & Buykx. 2004, UNFPA 2005.

<sup>66</sup> We say 'caution' since it is not the place of this study to make claims either way.

<sup>67</sup> See Plusnews 2008b

<sup>68</sup> See Olivier et al 2006, Schmid et al 2008

- **Condom promotion and distribution:** The above challenges have resulted in REs being seen to be particularly weak in the area of condom promotion and distribution - around which controversy and conversation continues.<sup>69</sup>
- **Women disadvantaged by gender - and religion:** While many REs run programs that seek to intervene in gender issues, the effect of religion on gender has been highlighted as an area of concern - e.g. when patriarchal systems bestow privilege on men while encouraging submissiveness in women, and therefore make women more vulnerable to HIV and sexually transmitted infections (STIs).<sup>70</sup>
- **Religious entities have a particular lack of capacity in the area of documentation:** Secondary literature has noted that REs tend to have a *particular* lack of capacity in the areas of technical and financial support, administration and documentation.<sup>71</sup> As Chand and Patterson say, "even though FBOs have been providing health care for over a century, little has been written about them. FBOs should become proactive in writing, publishing and sharing, through various channels, their knowledge, successes and challenges."<sup>72</sup> Again, this is an area requiring further investigation (see box 3.2 below) - especially as this lack of capacity around documentation seems to result in a related lack of capacity in monitoring and evaluation (M&E) - as one study says, "community based organizations are weak at evaluation, but FBOs within this category are even worse."<sup>73</sup>

**Box 3.2: Religious entities' lack of capacity in the area of documentation**

Literature on REs' lack of capacity around documentation tends to focus on five main points:

- REs perceive themselves to be implementers: they are the 'doers' with an attitude of 'getting on with the work' - that is, they perceive themselves as to be 'too busy saving lives' in critical conditions to spend time on documentation.
- REs efforts have grown spontaneously and organically from community needs, and frequently either do not have formal NGO status, or have grown into organizations without information planning.
- The documentation that *is* happening is often 'vertical' reporting on specific activities to donors that does not get used in other ways within the programme.
- REs lack knowledge of specific donor requirements, and the capacity to handle a variety of such requirements from multiple donors (for example, project proposals, monitoring, evaluation and reports).
- Staff working in REs, which are often based on a large volunteer base, often do not have the technical skills required to meet the documentation requirements of overseeing agencies or funders.

Therefore, a recommendation that emerges from the secondary literature is that REs, especially the smaller community-based organizations would benefit from support through technical assistance or 'incubation' of their organizational capacity in the area of documentation and technical skills.

*Source: Schmid et al 2008*

<sup>69</sup> See Byamugisha 1998, Olivier et al 2006

<sup>70</sup> See Soloman 1996

<sup>71</sup> See Birdsall & Kelly 2005, Chand & Patterson 2007, Lusey-Gekawaku 2003, Munene 2003, Parry 2002, Taylor 2005b & 2006, Woldehanna et al 2005

<sup>72</sup> Chand & Patterson 2007

<sup>73</sup> Birdsall & Kelly 2005

### 3.4 The nature of religious responses to HIV and AIDS in Africa

*Churches were largely silent in the first years of the AIDS epidemic ...*<sup>74</sup>

While there is variation in the speed and intensity with which REs responded to the HIV and AIDS epidemic in SSA, there has been a notable boom in REs responding to the epidemic since around 2000. This can be seen both in the birth of new organizations and programs and in programmatic shift of older established religious entities.<sup>75</sup>

Especially over the last five years, there has been a largely spontaneous and often locally funded explosion of congregation and community level activity to respond to the HIV/AIDS crisis in many countries.<sup>76</sup>

It is still largely unknown whether this response is a result of community-level need, an increased availability of funding, or a combination of such elements.

Secondary literature says that REs are (differently) involved in *all* aspects of the response to the HIV and AIDS epidemic.<sup>77</sup> However, the AIDS-related work of REs is often embedded within broader service portfolios and studies, making it difficult to disentangle purely 'AIDS-related services' from the total range of services provided.<sup>78</sup>

#### **Box 3.3: Religious entities' responses to HIV and AIDS**

The ARHAP literature review noted several generalisations made in secondary literature - in relation to REs responses to HIV and AIDS in SSA - some of which are:

- REs' responses are more prevalent than is currently recognised, and are making a difference in the communities in which they are based.
- REs' responses range across the continuum of prevention, care and support, treatment and rights, and are often 'holistic' in nature.
- REs' responses do not always fit into the norm or schema of health responses, often employing a variety of strategies at the same time.
- There is still a startling lack of information on REs' activities in the HIV and AIDS sector, particularly in relation to small-scale or community initiatives which remain undocumented.
- Much remains to be understood about the nature, scale and scope of these contributions and the way in which they supplement and interface with more centralised responses to the HIV and AIDS crisis.
- There appears to be a crucial lack of alignment between health systems and religious resources.
- OVC are a primary focus of REs, and they are well suited to this work.
- REs are also particularly focused on care, often at a home-based or community level.
- In some cases an element of 'special care' has been attributed to religious interventions.

*Source: ARHAP 2006*

<sup>74</sup> See Doupe 2005

<sup>75</sup> See ARHAP 2006, Birdsall 2005

<sup>76</sup> Birdsall 2005

<sup>77</sup> See Schmid et al 2008.

<sup>78</sup> Birdsall 2005. See Schmid et al 2008

### **3.5 Multisectoral collaboration in the context of HIV and AIDS**

*Collaboration, dialogue and partnership should be on an ongoing basis, rather than for a single programme or event. Mature relationships and partnerships would then mature, and create possibilities for other joint activities.*<sup>79</sup>

A multisectoral response to HIV and AIDS has been recommended since the very early stages of the epidemic. Since then, and as the epidemic has been revealed to be a multiplex crisis - touching on multiple elements of health and society - this call for multisectoral collaboration has been strengthened to a point where it is one of the key strategies worldwide, and “nearly all national plans are now multisectoral in design”.<sup>80</sup> This strategy calls for a coordinated response from all the elements of government, civil society and business sectors in that country, as well as an internationally coordinated strategy. We will now briefly consider some of the collaborative relationships in which secondary literature shows REs to be involved.<sup>81</sup>

#### **3.5.1 Collaboration with governments**

Little comparative research has been done on RE's collaboration with governments in SSA in the context of HIV and AIDS (hence the case-studies that follow). What little secondary literature there is points to two main vehicles or structures through which this collaboration happens. The first, is governments' collaboration with religious health (service) sectors such as national faithbased health networks (NFBHNs), or the Christian health associations (CHAs) - most commonly managed through Ministries of Health. The second is governments' collaboration with REs that are perceived to be part of 'civil society' - this relationship managed (on the governments' side) through national AIDS Commissions or Councils and multisectoral committees.<sup>82</sup> The level of success of these collaborative strategies (with REs in particular) is largely unknown. An interesting recent development has been at the *United Nations High-Level meeting on HIV and AIDS*

... (which) ended on 12 June with civil society groups complaining over the lack of true partnership with governments in the fight against the pandemic. 'Greater involvement of civil society has been identified by the UN as a critical strategy to combat AIDS ... The involvement of civil society in official national delegations must be effective, not just tokenistic,' stated a Civil Society Declaration signed by some 100 groups. 'Real partnership between donors, governments, civil society, UN agencies and affected populations requires a balance of power in making decisions. Only through genuine partnership can we overcome the challenges and achieve universal access to prevention, treatment, care and support for all people by 2010' ...<sup>83</sup>

Several pieces of secondary literature call for REs to be increasingly accountable to governments,<sup>84</sup> for example, to become part of national M&E systems and strategies as part of the Three Ones strategy. However, a review of progress on the Three Ones found that civil society is not an equal partner - particularly when it comes to reviewing and updating national plans - “and that people

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<sup>79</sup> UNFPA 2004

<sup>80</sup> CADRE 2007

<sup>81</sup> This brief review does not cover all elements of multisectoral collaboration - for example, collaboration with the business sector, women's groups, networks of medical professionals, or community partnership are not mentioned here.

<sup>82</sup> See Schmid et al 2008 - country profiles

<sup>83</sup> PlusNews 2008c

<sup>84</sup> See Doupe 2005, NACC 2005

with HIV, women's groups and FBOs are particularly under-involved."<sup>85</sup> Just as AIDS is rooted in a wider socio-political context, so the question of collaboration between REs and governments is rooted in a wider context - where issues such as the historical role of civil society in that country, the strength of the state, and the underlying power dynamics upon which the collaborative relationships are built become key. There is a great deal yet unknown about what 'genuine' partnership means in these power-driven collaborative situations, and in particular where REs stand in this collaboration.

### **3.5.2 Interfaith collaboration**

*There are signs that, more and more, different faiths are working together. Slowly, religious leaders, spurred by the tragedy they see all around them, are feeling compelled to respond to the crisis and even to take a lead in their countries. Although it is too early to see concrete results, there is some evidence of a growing and constructive strategy across the divides of faith.*<sup>86</sup>

The above quote from the WCC reflects what a large body of anecdotal evidence states - namely that the HIV and AIDS epidemic has in fact been a 'driver' for increased interfaith collaboration.<sup>87</sup> However, inter-religious tensions are still dominant factors in international politics and in communities in Africa today.

It can be said in the same breath that FBOs have a strong historical tradition of ecumenical co-operation (e.g. between Protestant and Catholic health facilities), and that collaboration between religious groups historically has been marred by suspicion and disassociation (e.g. between Christian and Islamic groups, or between 'mainline' churches and the charismatic movements).<sup>88</sup>

The ARHAP study of 2006 found little inter-religious collaboration or cooperation around AIDS at a community level in Zambia.<sup>89</sup> Therefore, while the literature may reflect increased inter-faith collaboration in the context of HIV and AIDS, perhaps a more realistic statement might be this one from UNAIDS, that "collaboration is often possible on AIDS even in situations of significant inter religious tension and conflict."<sup>90</sup>

### **3.5.3 'Ecumenical' collaboration<sup>91</sup>**

Of great concern is how little is known of the nature of collaboration between CREs in the context of HIV and AIDS - for example if particular collaboration is easier or more difficult between particular types of CREs. This may be as a result of the tendency to group all REs together in studies on multisectoral collaboration, rather than seeking the variety within this 'religious sector'. The WCC notes that almost all REs (or 'churches') have experience in building partnerships - many having decade long partnerships with sister churches. Furthermore, that many of these partnerships, particularly the 'North-South' ones, have "often been unbalanced with power over finances and

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<sup>85</sup> CADRE 2007

<sup>86</sup> Doupe 2005

<sup>87</sup> See Olivier et al 2006

<sup>88</sup> Schmid et al 2008

<sup>89</sup> ARHAP 2006

<sup>90</sup> UNAIDS 2008

<sup>91</sup> Here meaning collaboration between CREs

direction residing in northern churches ... Partnerships between churches on HIV/AIDS offer an opportunity to redress this imbalance, to create an equitable relationship.”<sup>92</sup>

Liebowitz argues that within most of the REs involved in his study on REs involvement in HIV and AIDS in South African and Uganda, “a strong associational infrastructure (exists) at the national and local levels.”<sup>93</sup> The Catholic Church is an obvious example, with links between denominational bodies, episcopal councils, international agencies (such as Caritas, CAFOD or Catholic relief) and local structures. Liebowitz gives the example of the Anglican Church of Uganda, which forms an associational infrastructure that includes the Mothers’ Union, Fathers’ Union, youth groups and other church-related associations, and argues that this provides an advantage to organizations within this umbrella, particularly in rural areas where religious groups are often based.<sup>94</sup> It would seem that such ecumenical collaboration provides support and access to broader networks and resources for local organizations, while the national level structures gain (further) access to local communities.

#### **A. National Faith-based Health Networks (NFBHNs)**

Special mention must be made of a particular type of RE, namely the National Faith-Based Health Network (NFBHN): country-level providers of health services, or networks of health service providers such as the Christian Health Associations (CHAs).<sup>95</sup> Based on the available secondary literature, it can be said that these NFBHNs have played a critical role in drawing together the efforts of REs for health in Africa.

(They are) national or regional networks of church health facilities and programmes which have come together to create a stronger voice in advocacy and facilitate technical support, networking, communication and capacity building ... Although the CHAs and their members face various critical challenges such as financing and workforce concerns ... it would appear that these associations are exemplars of the positive impact of collaboration, networking and resource sharing. Indeed, it would seem that in countries that do have such national faith-based health networks, there is stronger collaboration between FBOs, as well as between FBOs and secular groups - in particular a stronger advocacy role with government. The NFBHN appears to be a valuable type of FBO that draws together different faith-health activities, and provides support in a variety of ways, from technical to emotional.<sup>96</sup>

Such umbrella networks clearly play a critical role in the development and maintenance of collaborative frameworks. They forge and maintain partnerships between their own members, between other NFBHNs (in their own countries and beyond), with the broader spectrum of secular and non-profit actors, and between their members and the government.<sup>97</sup>

However, there are still challenges - even to this collaboration between NFBHNs and governments. For example, reporting on a CHA meeting, Mandi lays out the main challenges as being: lack of co-ordination among REs when lobbying since they usually approach governments independently and not as a united front; REs do not have adequate lobbying or negotiating powers; there is a lack of

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<sup>92</sup> Doupe 2005

<sup>93</sup> Liebowitz 2002

<sup>94</sup> Liebowitz 2002

<sup>95</sup> See USAID 2007b

<sup>96</sup> Schmid et al 2008. See CHAK 2006, CSSC 2007a, Dimmock 2007, Dimmock 2005

<sup>97</sup> See Schmid et al 2008

trust between governments and REs; REs fear that if they partner with governments, they will be absorbed and lose their identities; governments view REs as direct competitors rather than partners.<sup>98</sup> Nevertheless, it would appear that in countries in which NFBHNs are functioning properly, there is an improved degree of collaboration between health providing (facility based) REs and governments (specifically government health ministries).<sup>99</sup>

Figure 3.3: National Faith-based Health Networks in the countries of this study<sup>100</sup>

	Organization	% of NHS	Organizational description
<b>DRC</b>	<b>ECC-DOM:</b> Eglise du Christ au Congo - Direction des Oeuvres Médicales	~40%	Established in 1971, created to co-ordinate the health work of the ECC members and to serve as liaison with the Ministry of Health. In 1999, became a major partner in health care in the DRC, currently co-managing 65 of the 515 health zones in the DRC. It has 64 members, 50 hospitals and several hundred dispensaries.
<b>Kenya</b>	<b>KEC:</b> Kenya Episcopal Conference, Catholic Health Commission (CHC)	~20%	Catholic health care provision in Kenya dates back to the early 1900s. The Catholic Health Commission provides oversight and co-ordination of Catholic health facilities: 430 health units: 45 hospitals, 92 health centres, 282 dispensaries and 46 community-based programmes. CHC provides oversight, advocacy, lobbying and representation, capacity building, networking, and management to its members.
<b>Kenya</b>	<b>CHAK:</b> Christian Health Association of Kenya	~20%	Established in 1930, is an umbrella organization of over 296 member health units consisting of 24 hospitals, 43 health centres and 298 dispensaries, and 51 church health programmes owned by Christian denominations or missionary groups providing health services in various parts of Kenya.
<b>Malawi</b>	<b>CHAM:</b> Christian Health Association of Malawi	~37 %	Founded in 1966, members are ecumenical and interdenominational churches that operate health facilities. 30 hospitals and 125 health centres.

### 3.5.4 Collaboration with donors or 'partners'

Donors or funders are also seen as drivers of multisectoral collaboration. In fact, there is an increasing trend to call them 'partners' rather than 'donors' or 'funders'.<sup>101</sup> In terms of collaboration with REs, secondary literature suggests that international donors themselves can act as 'subregional networks'. For example, the Lutheran World Federation provides both support and a collaborative structure for its members, who are mainly Lutheran religious entities. The Catholic Church also appears to be particularly effective in working as a sub-regional network, and facilitating collaboration between its various bodies and organizations.<sup>102</sup> The specific challenges of collaboration between REs and donors in the context of HIV and AIDS is not well documented, and what there is, is frequently an unbalanced report from one perspective or the other. Some challenges mentioned, for example are: that donor funding has a limited period, and binding conditions can be problematic, donor support (mainly through projects) can be highly unpredictable, volatile and unsustainable,<sup>103</sup> and that there is concern over the growing dependence of REs on, not-always-reliable foreign assistance.<sup>104</sup>

<sup>98</sup> Mandi 2006

<sup>99</sup> See Schmid et al 2008

<sup>100</sup> Schmid et al 2008

<sup>101</sup> As found in this research in Malawi and the DRC

<sup>102</sup> Schmid et al 2008. See Olivier et al 2006

<sup>103</sup> UCMB-UPMB-UMMB 2007

<sup>104</sup> Dimmock 2008. See Schmid et al 2008

### **3.5.5 Collaboration with secular civil society**

Secondary literature suggests that there has been an increase in collaboration between REs and secular groups, particularly as a result of the push towards multisectoral HIV and AIDS action.<sup>105</sup> This conclusion is usually based on the fact that more faith-based-AIDS-networks have been formed, and these are seen to act as avenues for secular organizations to increasingly collaborate with REs.<sup>106</sup> However, it does seem that the HIV and AIDS epidemic has pushed REs into new collaborative associations with secular organizations. For example, in the ARHAP research it was found that the majority of REs working in health in Zambia who were invited as participants had met previously on local 'task forces' and 'AIDS working groups' (although a minority, mainly the Traditional Healers Association and Islamic leaders, were not involved in these multisectoral collaborative structures.)<sup>107</sup> Taylor speaks of some of the challenges of collaboration between congregational-type REs and secular organizations, saying:

Many church leaders have failed to engage with secular organizations because they consider their differing values as a threat to the church. They may also have little experience in dealing with the sophisticated bureaucracies of international development agencies, which work within short-term, fixed project cycles, while the church feels unappreciated for its long-term commitment. Secular organizations may in turn doubt the effectiveness of the church, and be uncomfortable about the spiritual emphasis. This lack of trust and understanding can have serious implications in terms of co-ordination and planning around national and local strategies for responses to AIDS.<sup>108</sup>

Much is said in the secondary literature about the importance of REs to work with PLWHA, but little is known of the overall state of this collaboration<sup>109</sup> - for example, of specific partnerships between REs and networks of PLWHA. There are two fast developing areas that should be closely observed. The first is the rapid growth of Anerela+ (the African Network of Religious Leaders Living with or Personally Affected by HIV & AIDS),<sup>110</sup> and the second is the emerging concept of 'decent care' which shifts the focus towards the experience and perceptions of PLWHA, and has an underlying recognition of religion. 'Decent care' is a concept adapted from the world of work, and builds on philosophical and spiritual traditions of dignity, respect, agency and integrity - in this context calling for philosophical and ethical perspectives for decent care which treats people living with HIV and AIDS (PLWHA) as collaborators.<sup>111</sup>

This chapter has presented the current literature which speaks of the religious-health landscape, and specifically of REs' engagement in HIV and AIDS. Many of these concepts will be addressed again in the country case-studies that follow.

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<sup>105</sup> See ARHAP 2006, Schmid et al 2008

<sup>106</sup> Although it is not known whether this is true - that is, the formation of a collaborative organization does not necessarily result in increased collaboration. See Molonzya 2003, Schmid et al 2008

<sup>107</sup> ARHAP 2006

<sup>108</sup> Taylor 2006

<sup>109</sup> See Olivier et al 2006

<sup>110</sup> See ANERELA+ 2008

<sup>111</sup> Karpf et al 2008