

A Firm Foundation

The PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS



PEPFAR

U.S. President's Emergency Plan for AIDS Relief

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For further information or questions, contact:

John Blevins
The Interfaith Health Program
Rollins School of Public Health
1518 Clifton Road, NE
CNR 8043
Emory University
Atlanta, GA 30322
404.727-6338
john.blevins@emory.edu

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Report Authors

JOHN BLEVINS, ThD

Associate Research Professor

Interfaith Health Program, Emory University

STEPHANIE DOAN, MPH

Public Health Analyst

U.S. Centers for Disease Control and Prevention

SANDRA THURMAN, MA

Director, Interfaith Health Program, Emory University
and Senior Advisor, U.S. Centers for Disease Control and
Prevention

THOMAS WALSH, JD, MPH

Deputy Coordinator for External Relations

Office of the Global AIDS Coordinator, Department of State

WARREN (BUCK) BUCKINGHAM

Director, Office of Global Health and HIV

U.S. Peace Corps

VERONICA DAVISON, MA

Public Health Advisor

U.S. Centers for Disease Control and Prevention

KARYN DELUCA, BA

Communications Specialist

Interfaith Health Program, Emory University

MIMI KISER, DMin, MPH

Program Director

Interfaith Health Program, Emory University

CHAD MARTIN, MPH

Senior Public Health Advisor

U.S. Centers for Disease Control and Prevention

MIKE MUGWERU

Secretariat Officer

Africa Christian Health Associations Platform

ESTHER MOMBO, PhD

Deputy Vice Chancellor for Academic Affairs

St. Paul's University

PETER OKAALET, MD, MDiv, MTh

Executive Director

Okaalet and Associates, Limited



United States Department of State

Washington, DC 20520

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Without the contributions of our faith-based organization (FBO) partners, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) could not have achieved the extraordinary impact on the HIV/AIDS epidemic of the past decade. Supporting antiretroviral treatment for nearly 4 million people living with HIV, interventions to prevent mother-to-child transmission that allowed approximately 200,000 infants to be born HIV-free in 2011 alone, care for over 4 million orphans and vulnerable children — FBOs have been central to all of these achievements. These partners work with us in areas of the world that have been hardest hit by AIDS. In sub-Saharan Africa, it is estimated that 40 percent of health care services are provided by FBOs, many of which serve the most rural areas and the most marginalized people. FBOs have long histories and strong community roots, and a deep reservoir of trust on which to draw. Robust participation of FBOs is not optional — it is essential for an effective response to AIDS.

In its second phase, PEPFAR has focused on supporting expanded country leadership of HIV responses — the key to sustainability. The contribution of FBOs to this is sometimes overlooked, but it is essential. For many people in severely affected countries, a visit to a local FBO is their primary interaction with their country's health system and their lifeline to care and treatment. In our work with partner governments, we emphasize the need to recognize the essential contributions of the faith sector to the national response, and this dialogue was part of the PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS.

FBOs have long been symbols of hope to millions of people. For years, HIV-positive individuals have often found it difficult to speak to their loved ones about their status because of the stigma associated with being HIV-positive. More and more, those barriers are coming down as FBOs join the conversation and help create an atmosphere of acceptance for HIV-positive individuals.

FBOs have saved countless lives from AIDS. I thank the Consultation participants for their engagement, and I look forward to their continued partnership with PEPFAR as we move toward an AIDS-free generation.

Sincerely,

A handwritten signature in black ink, appearing to read "Eric Goosby".

Ambassador Eric Goosby, MD
United States Global AIDS Coordina

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**PREFACE**

Faith-based responses to pressing health and social needs of communities are hardly new in Africa or the United States. In fact, they have been part and parcel of the development of health, education, and social service infrastructure here at home and in Africa since the nineteenth century. If you are hospitalized in the United States today, the chances are one in six that your hospital traces its origins to Catholic nuns.

Long before the first feature story on AIDS in Africa appeared in USA Today in 1999 and brought the global epidemic to American consciousness, the Salvation Army in South Africa was already caring for dozens of AIDS orphans, a Jesuit priest had established a home for abandoned HIV positive children in Nairobi and mission hospitals were providing palliative care to thousands of AIDS patients often with little or no resources. As the magnitude of the AIDS crisis unfolded, faith-based institutions were firmly planted in communities with existing relationships of trust, resources, and networks that enabled them to mobilize in the face of a disease that sparked fear, denial, stigma, and discrimination, and inspired myth and misinformation. In the absence of treatment and external support, they created a continuum of compassionate care. Thankfully, with scientific advances and the support of the President's Emergency Plan for AIDS Relief (PEPFAR) and other partners, the work of FBOs, a cornerstone of the foundation of AIDS prevention, care, and treatment in Africa and other parts of the developing world, has expanded dramatically.

Practitioners in health and faith have partnered throughout history to alleviate suffering and disease and improve the health of communities. In fact, the father of modern public health, Dr. John Snow, partnered with the Reverend Henry Whitehead, a trusted local clergyman in the Soho neighborhood of London, during an 1854 cholera outbreak. Snow believed that cholera was spread through water contaminated by human waste, and he worked with Reverend Whitehead to engage with the local community to map the households where cholera had occurred. The exercise led them to the Broad Street water pump that had been contaminated by a faulty cesspool, which proved to be the source of the local infections. Following a consultation with the elders of the local parish, the pump handle was removed and the outbreak subsided. Their research and interventions became the basis for modern-day epidemiology. In the end, the goals and objectives of the scientist and the clergyman were the same — to identify the cause and intervene to stop the spread of deadly disease. This legendary collaboration had little to do with religion per se. Rather, it reflected a shared commitment to the health and well-being of all people, the common good of communities, and an appreciation of the value of trusted relationships and community support in affecting the change, both individual and collective, that could save lives. The same holds true today.

This Consultation comes at a pivotal time in the AIDS epidemic. After decades of hard work we are finally seeing the tide begin to turn. With support from PEPFAR and others, we have millions of people on treatment and are preventing thousands of new infections each year; however, to sustain the momentum and build on the foundation of AIDS prevention and care, we must leverage and strengthen community and country partnerships as never before. Faith-based organizations with deep roots and enduring commitments to their communities are a prime partner going forward. The faith leaders and other partners who participated in this extraordinary gathering are exemplars of best practice and willingness to adapt to address new challenges to protect and care for those they serve. This report provides a snapshot of their work, the challenges and opportunities it offers, and recommendations for how partnerships with FBOs can be strengthened to most effectively leverage the unique and critical part they can play to support a comprehensive response to epidemic into the future.

Sandra L. Thurman

Director, Interfaith Health Program, Rollins School of Public Health, Emory University
Senior Advisor, Division of Global HIV/AIDS, Centers for Disease Control and Prevention

Glossary

AIDS Acquired Immunodeficiency Syndrome

ARHAP See IRHAP

ARV/ARVs Antiretrovirals—the medications used to slow replication of the HIV virus in the body.

BAKWATA National Muslim Council of Tanzania

BUFMAR Le Bureau des Formations médicales Agréées du Rwanda. A Rwandan FBO that purchases and distributes medicines and supplies to faith-based health programs.

CHAK Christian Health Association of Kenya

CHAs Christian Health Associations

CPR The Protestant Council of Rwanda

CSSC Christian Social Services Commission

ECFA Evangelical Council for Financial Accountability

EDARP Eastern Deanery AIDS Relief Program

Faith Communities see FBOs

Faith Networks see FBOs

FBOs Faith-based organizations. An organization that is influenced by stated religious or spiritual beliefs in its mission, history, and/or work. In this report, the term includes three distinct types of organizations: 1. faith communities (religious bodies at local levels such as mosques or churches as well as local bodies of Christian or Muslim religious orders such as Sufis, Jesuits, or Sisters of Loreto), 2. faith-based NGO (non-governmental organizations that are related to one or more religious traditions that provide health, development, or social support services), and 3. faith networks (groups of faith communities or faith-based organizations working together under a shared organizational structure). For further discussion of the types of FBOs and their functions, see “Faithful Response: Understanding the Work of Various Faith-based Organizations” in the report below.

HIV Human Immunodeficiency Virus

HTC HIV Testing and Counseling

IHP Interfaith Health Program (of the Rollins School of Public Health at Emory University)

INERELA+ International Network of Religious Leaders Infected with or Affected by HIV and AIDS

IRHAP International Religious Health Assets Programme

JMS Joint Medical Supplies

MARP Most at-risk populations. Also known as key populations at elevated risk.

MEWA Muslim Education and Welfare Association

MEDS Mission for Essential Drugs and Supplies

Glossary (continued)

MOU Memorandum of Understanding

NGO Non-governmental organization

Nyumbani Also known as Children of God Relief Institute; includes the Nyumbani Village, Nyumbani Home, and Lea Toto

OGAC Office of the Global AIDS Coordinator, Department of State

OVC Orphans and vulnerable children

PACANet Pan African Christian AIDS Network

PASADA Pastoral Activities and Services for people with AIDS Dar es Salaam Archdiocese

PEPFAR U.S. President's Emergency Plan for AIDS Relief

PLWHA Person or People living with HIV/AIDS (also known as PLWH or PLHIV)

PMTCT Prevention of mother-to-child transmission [of the HIV virus]

RCLS Rwanda Interfaith Network

RRP+ Rwandan Network of People Living with HIV/AIDS

RWANERELA+ Rwanda Chapter of INERELA+

SSDDIM Stigma, Shame, Denial, Discrimination, Inaction, and Misaction

SAVE Safe(r) practices; Access to treatment and nutrition; Voluntary, routine, and stigma-free counseling and testing, and Empowerment of children, youth, men, women, families, communities, and nations most vulnerable to, at-risk of, living with, and affected by HIV and AIDS.

SUPKEM Supreme Council of Kenya Muslims

TACAIDS Tanzania Commission for AIDS

TAIFO Tanzania AIDS Interfaith Forum

UNICEF United Nations Children's Fund

USAID United States Agency for International Development

WHO World Health Organization

Executive Summary

This moment in time presents unprecedented opportunities and challenges in the ongoing effort to defeat AIDS globally. Drawing on their established networks, capacity to reach rural and hard-to-reach populations, and respected and trusted status in local communities, faith-based organizations (FBOs) are well positioned to leverage the work of local, national, and international donors.

In May 2012, The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) convened The PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS. This East African regional forum was held to examine the critical capacity of FBOs for HIV prevention, care, and treatment and to generate recommendations for collaborative, sustainable impact. Based on the dialogue and outputs from the Consultation, this report summarizes the insights and on-the-ground experience of 98 leaders from 58 different FBOs in Kenya, Rwanda, Tanzania, and Uganda, joined by partners from government agencies in these countries and the United States.

FBOS IN THE FIGHT AGAINST HIV/AIDS

With a legacy of providing health, education, and social services in East Africa for more than a century, FBOs already play a central role in caring for orphans and vulnerable children (OVC), preventing transmission of HIV from mother-to-child and among adults, and ensuring that people with HIV receive the treatment and care needed for living healthy lives. FBOs can be a powerful force to prevent HIV transmission by making information relevant to community members and replacing stigma and discrimination with acceptance, love, and commitment.

HIGHLIGHTS:

- * In the face of financial and health systems challenges, Faith-based organizations (FBOs) are well positioned to leverage the work of local, national, and international partners in the fight against HIV/AIDS.
- * Over a century before the first cases of HIV were reported, FBOs were active in local communities.
- * In Tanzania and Kenya, FBOs provide more than 40 percent and 60 percent of health care services, respectively.
- * FBOs already play a central role in caring for orphans and vulnerable children, preventing the transmission of HIV from mother-to-child, and ensuring that people with HIV receive the care and treatment needed for living healthy lives.
- * FBOs possess unique functions and capabilities that can be mobilized:
 - › Well-established health service delivery networks and infrastructure.
 - › Clear commitments to serve local communities.
 - › A wide range of programs, skills, experiences, and knowledge that contribute to a strong, sustainable, multi-sectoral response.
 - › The abiding trust of local communities.
 - › A capacity to mobilize an army of volunteers in any corner of the globe.

FAITHFUL RESPONSE: UNDERSTANDING THE WORK OF VARIOUS FAITH-BASED ORGANIZATIONS

A work group of Consultation participants identified and defined six distinct types of FBOs, each accomplishing different activities relevant to the HIV/AIDS response. Efforts to build sustainable, effective partnerships will be improved by understanding the unique contributions of these structures and functions.

FAITH-BASED HEALTH SYSTEMS AND SUSTAINABILITY THROUGH PARTNERSHIPS

In Tanzania and Kenya, FBOs provide more than 40 percent and 60 percent of health services, respectively. Additionally, faith-based supply chain organizations serve 40% of the population in both of these countries. In the midst of financial and health-system challenges, governments and donors are looking for the most effective and efficient ways to provide quality and affordable HIV services. FBOs are responding to these changing dynamics and assuming expanded leadership roles in building sustainable systems for HIV/AIDS service delivery.

RECOMMENDATIONS FOR ACTION

Consultation participants developed recommendations to maximize the capacities of FBOs in a coordinated, sustained response to HIV/AIDS, including:

Leverage the unique role and function of FBOs

- Capitalize on the trust that has developed between FBOs and local communities to build stronger, more comprehensive, integrated HIV prevention efforts built not on stigmatization but on unconditional love.
- Develop the capacity for FBOs to advocate for improved healthcare for all citizens and hold governments accountable.
- Maximize the existing organizational infrastructure of faith-based health systems to reach communities impacted by HIV, including vulnerable, hard-to-reach, and most at-risk populations (MARPs).
- Develop the capacity to communicate in ways that are relevant and meaningful to religious communities, donors, and governments.
- Strengthen communities' input and investment into FBO administration and programming.

Build the capacity of FBOs, their employees, and volunteers

- Develop and make widely available mechanisms to support the organizational development of FBOs.
- Increase FBOs' capacities to develop and implement effective programs or to strengthen existing programs.
- Expand FBO networks by bringing in new or previously unaffiliated FBOs and engaging other religious traditions.
- Hold ineffective FBOs accountable.
- Offer leadership development initiatives to better equip the next generation of leaders.

HIV and other diseases continue to threaten our communities, our nations, and our world. But effective responses have been developed and innovations continue to emerge. FBOs have long been key partners in those coordinated responses, and they always will be.

Four years ago, Esther¹ gave birth to a healthy baby girl. Tears of joy well in her eyes and her smile widens as she shares the story of how the holistic health services she received at Coptic Hospital, a health facility run by the Coptic Orthodox Church, helped her deliver a baby born HIV-free, despite her HIV-positive status. Several years earlier, the 27-year-old had a very different experience.

At 15, Esther went to another hospital for what she thought was a nagging cough, but she was stunned to learn that she was five months pregnant—and HIV-positive. When she gave birth to a baby boy who was also HIV-positive, she vowed not to have any more children because she did not want to bring another HIV-infected baby into the world. Soon Esther began to receive care at Coptic Hospital. Through the HIV education and counseling services she received there, she learned that it was possible to live a long, healthy life with HIV and that she could have an HIV-negative baby despite her HIV-positive status—as hundreds of thousands of women across Africa are now doing each year with support from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR).

Esther proudly shares she has a healthy CD4 count.² Her two children—one HIV-positive and one HIV-negative—are thriving and continue to receive care at Coptic Hospital. She is now earning a certificate in HIV counseling so she can educate other women about HIV prevention. Esther’s experience is shared by thousands of HIV-positive mothers who have given birth to HIV-negative babies as a result of Coptic Hospital’s efforts. Their stories give testimony to the important role of faith-based organizations in bringing hope to communities living in the shadow of AIDS.

Like many other FBOs, Coptic Hospital combines high-quality health care, strong organizational structures, and vital partnerships with both governmental and non-governmental organizations (NGOs). And, like other FBOs, Coptic Hospital also brings unique resources and capacities to bear in the ongoing response to HIV. It has long-standing relationships with the communities it serves—the people Coptic Hospital serves come there because they trust the organization and its staff. Its workers are motivated by the conviction that the work they do is important and by a commitment to the people they serve. This combination of strong service delivery capacity and long-standing commitments to local communities has allowed Coptic Hospital to make a vast difference in Esther’s life and in the lives of her children.

The *PEPFAR Consultation on the Role of Faith-Based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS* was convened in May 2012 to provide a forum for highlighting the information, ideas, recommendations, model practices, lessons learned, and next steps for FBOs engaged in HIV/AIDS programs. The participants’ insights are being shared through this report so that the particular contributions and capacities of FBOs are maximized as we move forward in the ongoing fight against HIV/AIDS.

¹ Name changed to protect confidentiality.

² CD4 cells are one type of white blood cells that make up the immune system. HIV destroys CD4 cells as it replicates, leaving an HIV-infected person vulnerable to infections. Esther’s CD4 cell count is equivalent to that of someone HIV-negative, thanks to the antiretroviral medications she receives at Coptic Hospital.

Faith-based Organizations in the Fight Against HIV/AIDS

The success of PEPFAR to date has been achieved in large part because of the contributions of faith-based organizations to country efforts on HIV/AIDS, across the entire spectrum of prevention, treatment, and care.

After a decade of extraordinary progress, this moment in time presents both unprecedented opportunities and tremendous challenges in the ongoing effort to reach the goal of an AIDS-free generation. With effective antiretroviral (ARV) treatment, people infected with HIV can lead full, long, productive lives—as PEPFAR has demonstrated, supporting nearly 4 million people on treatment in 2011. In addition, over the last decade many African nations have seen dramatic declines in new HIV infections. HIV prevention programs have become more comprehensive, increasing their scope by adding powerful new biomedical tools to existing behavioral approaches and by addressing broader cultural factors and the harmful effects of stigma and discrimination.

Even as progress is made in these areas of prevention and treatment, other challenges remain. With financial resources stretched thin in the wake of the ongoing global economic crisis, the need to identify and replicate proven, effective, and efficient service delivery and prevention models is greater than ever. Resources must be marshalled for the fight, not only from external partners but also from country governments and other sources. As part of PEPFAR's effort to promote sustainability in the fight, support for country leadership is now a central focus. In support of this, improved coordination between funding sources and service providers is a priority, especially at the country level.

As governments and donors face ongoing economic challenges, efforts to maximize resources and build sustainable programs become increasingly urgent. FBOs are well positioned to leverage the investments of local, national, and international donors due to their respected and trusted status in local communities¹, established networks, and access to rural and hard-to-reach populations.² However, a better understanding of the impact of FBOs on health outcomes is needed, as well as realistic and effective methods for measuring that impact.³

FBOs already provide a substantial proportion of both general health services and HIV-specific services in sub-Saharan Africa (an estimated 40% of health care services in sub-Saharan Africa are provided by the faith-based sector).⁴ Faith-based health systems play a key role in getting life-saving HIV treatment and care to the people who need them and in building the service delivery networks that can reach from the most densely populated urban center to the most remote village.⁵ Religion is a powerful social force that can help replace stigma and discrimination with acceptance, love, and commitment. FBOs empowered by these expressions of faith have unique capacities to reach vulnerable, marginalized, and other at-risk populations.

While countless FBOs in sub-Saharan Africa work tirelessly to meet the needs of the people they serve, their work is often undocumented.⁶ This has a direct impact on funding, as both national and international donors push for more evidence-based programs. Moreover, while the range of partners can be quite vast for many FBOs, coordination and collaboration across religions and geographical boundaries are still limited in many instances.⁷ Although the United States has been and will continue to be a key partner, strong, sustainable, effective, and coordinated responses to the HIV epidemic must continue to strengthen and support the leadership of affected countries. FBOs are certainly key stakeholders in these efforts. They have a particular capacity and clear responsibility as their countries work to further the gains made in the last decade against this epidemic and to meet the challenges ahead.

Faith-based Organization (FBO): an organization that is influenced by stated religious or spiritual beliefs in its mission, history, and/or work.

In this report, the term FBO includes three distinct types of organizations: **1. faith communities** (religious bodies at local levels such as mosques or churches as well as local bodies of Christian or Muslim religious orders such as Sufis, Jesuits, or Sisters of Loreto), **2. faith-based NGOs** (non-governmental organizations) that are related to one or more religious traditions that provide health, development, or social support services) and **3. faith networks** (groups of faith communities or faith-based organizations working together under a shared organizational structure).

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SNAPSHOT

UGANDA

Population: 35.8 Million

Religions: Roman Catholic (41.9%), Protestant (42), Muslim (12.1%), Other (3.1%), None (0.9%)

State of the HIV Epidemic: 1.2 million people aged 15-49 (6.5%) live with HIV. 47% ART coverage.^A 1.2 million children orphaned by AIDS.^B 5.9% of GDP spent on health.

Contribution of FBOs to health service delivery: More than 1/3 of clinical care in Uganda is provided by FBOs^C (including the Uganda Catholic Medical Bureau with 27 hospitals and 235 health centers and the Uganda Protestant Medical Bureau of Uganda with 17 hospitals and 273 health centers). More than 40% of all hospitals are run by FBOs.^D

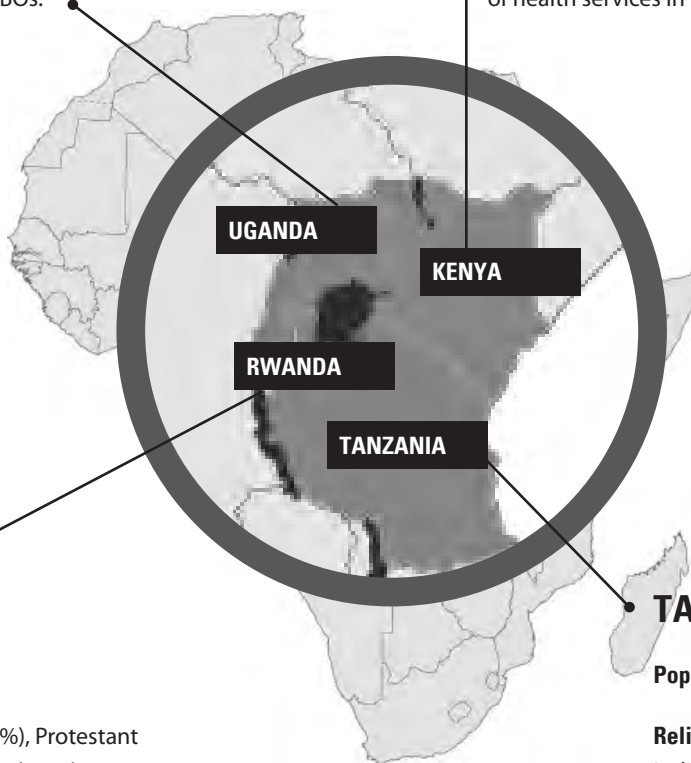
KENYA

Population: 43.0 Million

Religions: Protestant (45%), Roman Catholic (33%), Muslim (10%), Indigenous beliefs (10%), Other (2%)

State of the HIV Epidemic: 1.5 million people aged 15-49 (6.3%) live with HIV. 61% ARV coverage.^A 1.2 million children orphaned by AIDS.^B 12.1% of GDP spent on health.

Contribution of FBOs to health service delivery: The Kenya Episcopal Conference (KEC) and the Christian Health Association of Kenya (CHAK) provide health services in 17 referral hospitals, 59 mid-level hospitals, 133 health centers and 675 dispensaries. Together, CHAK and KEC provide about 65% of health services in the country.^{G,H,I}



RWANDA

Population: 11.7 Million

Religions: Roman Catholic (56.5%), Protestant (26%), Adventist (11.1%), Muslim (4.6%), Indigenous beliefs (0.1%), None (1.7%)

State of the HIV Epidemic: 170,000 people aged 15-49 (2.9%) live with HIV. 88% ART Coverage.^A 130,000 children orphaned by AIDS.^B 9% of GDP spent on health.

Contribution of FBOs to health service delivery: FBOs administer approximately 40% of health services in Rwanda.^F The Government of Rwanda has a unique partnership with faith-based health facilities, counting them among the government facilities and providing equal funding and health personnel.

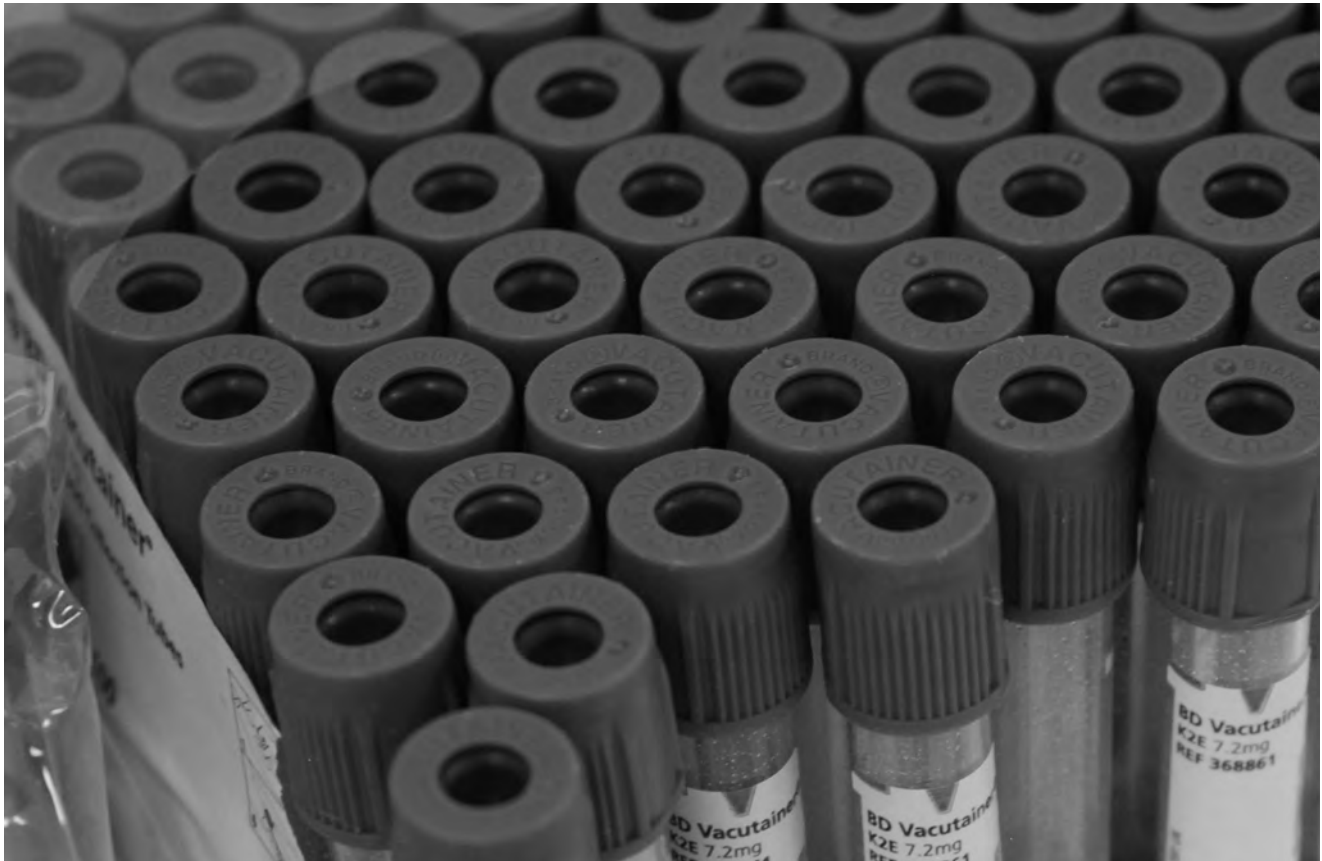
TANZANIA

Population: 43.6 Million

Religions: Christian (30%), Muslim (35%), Indigenous beliefs (35%)

State of the HIV Epidemic: 1.4 million people aged 15-49 (5.7%) live with HIV. 42% ART Coverage.^A 1.3 million children orphaned by AIDS.^B 5.9% of GDP spent on health.

Contribution of FBOs to health service delivery: The Tanzania Christian Social Services Commission provides approximately 40% of health services in Tanzania.^I If the contribution from other FBOs and networks is included, this number would be even higher.



CITATIONS FROM THE GRAPHIC

Unless otherwise cited, all statistics in the graphic box are from the CIA World Factbook. Available at: <https://www.cia.gov/library/publications/the-world-factbook>. Accessed July 3, 2012.

^A World Health Organization/UNAIDS/UNICEF. (2011). *Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access: Progress Report 2011*. Retrieved on July 3, 2012, from http://www.who.int/hiv/pub/progress_report2011/en/index.html.

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^F Mwenda, S. (2012, May) *Faith based organizations and the health system: Opportunities and challenges for sustainability in the HIV/AIDS response*. Paper presented at PEPFAR Consultation on the Role of Faith-Based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS.

^G Mokua, Moses. (2006). *Cost analysis of essential curative health services in church health facilities*. Nairobi: Christian Health Association of Kenya.

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Engaging Faith-based Organizations: PEPFAR Consultation Overview

On May 28–30, 2012, PEPFAR organized a regional consultative forum in Limuru, Kenya in collaboration with the U.S. Centers for Disease Control and Prevention (CDC), St. Paul’s University, and the Emory University Interfaith Health Program. Entitled the *PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS*, the Consultation included 98 participants representing 58 different FBOs, along with partners from Ministries of Health and U.S. Government Agencies, in Kenya, Rwanda, Tanzania, and Uganda (see Appendix 1 for full list of participants and organizations). Designed to identify examples of effective FBO contributions to country HIV service delivery and develop recommendations for strengthening partnerships between FBOs, governments, and other partners, the Consultation provided opportunities for participants to share their stories and experiences through thoughtful dialogue and spirited discussion.

Based on the feedback of the Consultation Planning Committee (see Appendix 1 for committee members), the Consultation included panel presentations and work group sessions on topics related to the role of FBOs in sustaining community and country-led responses to HIV/AIDS (see Appendix 2 for the Consultation agenda). Over the course of three days, attendees shared examples of innovative and effective responses to the HIV epidemic and highlighted best practices, challenges, and lessons learned in their ongoing efforts to address the needs of individuals and communities affected by HIV/AIDS.

The insights shared at the Consultation illustrated the unique role and value added by FBOs in the fight against HIV/AIDS. The Consultation underscored the commitment of FBOs to working with national and local governments, international donors, and other partners to ensure that their efforts are locally-led, effective, and sustainable.

The HIV/AIDS epidemic has evolved over the last few decades to become one of the greatest challenges in global health,¹ and it is incumbent upon all stakeholders to carefully examine how to leverage their successes through effective programs and partnerships. This report summarizes the key areas of focus during the meeting and profiles several FBOs whose partnerships have enabled them to implement programs that are impacting the lives of people living with HIV/AIDS (PLWHA), their families, and their communities.

Consultation Goals and Objectives:

- * Examine and highlight the distinctive role of FBOs in sustaining HIV/AIDS efforts.
- * Identify ways in which the faith-based sector provides and/or complements existing public and private HIV/AIDS service delivery.
- * Develop recommendations for strengthening collaborations between FBOs, governments, and other partners.

Selected comments from Consultation participants’ evaluations

“Representation was a good mix of strategic, operational, and technical staff.”

“I have come to appreciate more the role of FBOs in HIV/AIDS responses at all levels.”

“The role of FBOs in response to HIV is very important. I will use my organisation’s resources to build capacities of religious leaders to use their powers and achieve their roles.”

“It was a great relief to learn that the FBO contribution in responding to HIV/AIDS pandemic is appreciated by PEPFAR and that through effective collaboration, we can be more effective.”

“Three conditions are required for people to feel responsible for the future — and faith groups foster each of them. Kinship. Equity. Continuity. In faith groups, we understand a tradition that goes backward and a responsibility that goes forward.”

—William Foege, MD, in “Faith & Health,” Summer 1996

¹ De Cock, K.M., Jaffe, H.W., & Curran, J.W. (2012). The evolving epidemiology of HIV/AIDS. *AIDS*, 26(10), 1205-13.

What Makes FBOs Unique?

Dr. William Foege, former director of CDC and founder of the Interfaith Health Program at The Carter Center, is an internationally-known leader in global health. He was an early advocate for the important role of FBOs, recognizing the long, deep commitments of FBOs in communities around the world: “In faith groups we understand a tradition that goes backward and a responsibility that goes forward.”¹Foege’s words remind us that FBOs have been offering medical, educational, development, and psychosocial support services in East Africa for over 150 years. Over a century before the first cases of HIV were reported, FBOs were active in local communities.²They still are. And they will continue to be long after the clinical file is closed on the last case of HIV.

These organizations have demonstrated their long-standing commitment to local community needs; over time, they have developed vital relationships with residents that are built on trust, compassion, and dedication. As stewards of that trust, FBOs lower barriers to health services, communicate community priorities to national bodies, and serve as messengers to make health information relevant to the public by putting it into language that people understand and value.

FBOs have a unique and broad reach in societies. FBOs include primary, secondary, and tertiary hospitals; comprehensive health centers; schools for the education of health professionals; community health programs; outreach initiatives to vulnerable communities; and national networks that support health, development, and social services. From the largest cities to the smallest villages, FBOs maintain an established, long-term presence that is interconnected and comprehensive. Members of religious organizations contribute tens of thousands of volunteer hours in their local communities through efforts that address both local contexts as well as the varied needs of far-flung communities. By connecting national networks with grassroots programs, FBOs can respond quickly to pressing needs.

1 Foege, W. (1996). *Faith & health: A newsletter of the Interfaith Health Program of The Carter Center*

2 Ssewamala, F., & Ismayilova, L. (2008). Faith-based Institutions as project implementers: An innovative economic empowerment intervention for care and support of AIDS-orphaned and vulnerable children in rural Uganda. In Pamela Joshi, Stephanie Hawkins, and Jeffrey Novey (Eds.), *Innovations in Effective Compassion: Compendium of Research Papers for the White House FBO Conference*. U.S. Department of Health and Human Services.

FBOs on the Ground

FBOs have played a key role in a multi-faceted and multi-sectoral response since the beginning of the global HIV/AIDS epidemic. The Consultation of East African leaders showcased the central role of FBOs in such varied areas as care for orphans and vulnerable children (OVCs), care and treatment, and prevention of adult and mother-to-child transmission (PMTCT).

ORPHANS AND VULNERABLE CHILDREN (OVC)

In fiscal year 2011, PEPFAR directly supported more than 4.1 million orphans and vulnerable children worldwide,¹ including a significant contribution to meeting the needs of an estimated 12 million children in sub-Saharan Africa who have lost one or both parents to AIDS.²

FBOs provide a significant proportion of services in response to the vast needs of OVC. In a study exploring FBOs' response to OVC, the United Nations Children's Fund (UNICEF) noted that FBOs with OVC activities were widespread throughout Africa, with many establishing programs and services in the 1990s. These services include providing medical and social support services for children and extended family members, strengthening extended family networks so that orphans can live with their families, establishing holistic home-based programs for long-term care and support of OVC, and running orphanages where sufficient family- and community-based options are not available. UNICEF's study also states that FBOs have responded to the HIV/AIDS epidemic by adapting and developing new approaches to address community needs.³

Holistic Care at Children of God Relief Institute

The Children of God Relief Institute, known widely as Nyumbani, is a Nairobi-based FBO that has a high standard for quality, comprehensive, cost-effective services for HIV-positive children and children orphaned by HIV/AIDS. The FBO runs three separate programs, Nyumbani Home, Lea Toto, and Nyumbani Village.

Named for the word "home" in Kiswahili, Nyumbani Home has been a refuge to more than 250 HIV-positive children since it was established 20 years ago. In addition to providing medical care, Nyumbani Home embraces a child-centered, holistic approach that includes education, stigma reduction, self-reliance, and familial and community reintegration. Nyumbani is among many FBOs whose efforts have a direct impact on the quality of life, morbidity, and mortality of one of sub-Saharan Africa's MARPs.

Recognizing the need for different approaches to support the growing number of HIV-positive children in the Nairobi area, the organization launched the Lea Toto Program. Swahili for "to raise the child," Lea Toto provides services to HIV-positive children and their families in several Nairobi communities. This community-based outreach program enables children to continue living with their caregivers without uprooting them from the community. Lea Toto provides basic medical care to children along with a range of services to their caregivers and families, including counseling and psychological support, spiritual guidance, financial support, and HIV prevention education.

In response to the rising number of OVC who are left behind by the "lost generation" of the HIV/AIDS epidemic, Nyumbani also established Nyumbani Village, which provides a family-like setting for orphaned children cared for by their grandparents. The Village is a self-sustaining community that seeks to create new blended families that foster healing, hope, and opportunity. With one thousand acres of land, the Village can accommodate approximately 1,000 orphans and 100 grandparents and has implemented a number of income-generating projects including organic farms and hardwood timber forests that are moving the Village toward its goal of long-term sustainability. Taken together, the many dimensions of Nyumbani provide a window into the many efforts FBOs are undertaking to address the needs of children affected by HIV/AIDS.

1 PEPFAR. (2012). *Using science to save lives: Latest PEPFAR results*. Retrieved June 1, 2012, from <http://www.pepfar.gov/results/index.htm>.

2 Mmbando, P., Hartwig, K.S., Hofgren, B., Disorbo, P., Smith, S., & Hartwig, K.N. (2009). Care for the most vulnerable children in Tanzania: A faith-based model of care and support for children affected by HIV. *Journal of Health Care for the Poor and Underserved*, 20(sup4), 13-21.

3 Foster, G (2004). *Study of the response by faith-based organizations to orphans and vulnerable children*. Nairobi: UNICEF

CARE AND TREATMENT

Many can still recall what life was like in African countries hardest hit by HIV/AIDS before care and treatment became as widespread as they are today. Entire families died as fathers, mothers, and their children went untreated. Despite great progress, AIDS remains an urgent issue today. More than two-thirds of all people living with HIV/AIDS worldwide live in sub-Saharan Africa, and in every year since 1998, AIDS has claimed more than 1 million lives in the region.¹ Despite these numbers, effective care and treatment services offer those infected a chance to live healthy lives. Essential for improving quality of life, sustaining life, and stabilizing communities, care and treatment services have changed outcomes for PLWHA. While just a decade ago a death from AIDS was almost certain for people who contracted HIV, today treatment is saving millions of lives and is contributing to the decline in new infections and AIDS-related deaths.²

Care and Treatment at Bomu Hospital

In the late 1970s, Mrs. Hayati Anjarwalla approached some private donors and friends at the Rotary to open a small dispensary to cater to the needs of the poor and underprivileged. Today, Bomu stands out as the largest NGO serving the community in the Coast Province, particularly in the area of HIV/AIDS.

With the help of PEPFAR funding, Bomu currently provides free comprehensive medical services to more than 26,500 PLWHA from all over Mombasa through its Hospital, Medical Centers, and clinical outreach programs for those who cannot afford transport to Bomu.

The success of Bomu's comprehensive program is evident in the story of one patient who says, "To be honest, it's difficult to express myself — I am so happy because when I think back to the first time I came here, my condition was so bad. I met the doctor who treated me like a brother and who has helped me a lot. I normally receive free medication here. Sometimes I also get a free meal. They also give me fare for my transport home. I am so happy."

Mrs. Anjarwalla says that, "people come to Bomu to get quality health service and at the end of their exercise they feel at the bottom of their hearts that they were treated humanly. That is the basic human right of every individual — to be treated with dignity and respect."

PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (PMTCT)

Each year, an estimated 370,000 babies are born with HIV, primarily in sub-Saharan Africa.³ One of the great success stories in HIV prevention, however, is the progress that has been made in ensuring that children born to HIV-positive mothers are themselves HIV-negative. Continued success in PMTCT is essential to achieving an AIDS-free generation and is thus a central PEPFAR priority.⁴

In 2011, PEPFAR supported HIV testing and counseling for more than 9.8 million pregnant women and provided prophylaxis medications to 660,000 HIV-positive pregnant women, allowing approximately 200,000 children to be born free of HIV.⁵

With comprehensive antenatal care and ARV treatment, HIV-positive mothers have a high likelihood of giving birth to HIV-negative children. Strong and sustained community health systems are essential in these efforts. Mothers-to-be need to know their status, necessitating HIV testing as an important part of antenatal care. Women who test positive need comprehensive antenatal services and ARVs to prevent transmission of the virus from mother to child. The need for strong community systems does not end when a mother takes her child home; she needs ongoing support and services to keep from transmitting HIV to her newborn through her breast milk. As long-standing, trusted institutions that offer both clinical care and community-based support services, FBOs often play a unique role in bringing these PMTCT services to women and families in local communities.

1 UNAIDS. (2011). How to get to zero: Faster. Smarter. Better. *World AIDS Day Report, 2011*.

2 PEPFAR. (2012). *Treatment*. Retrieved June 19, 2012, from <http://www.pepfar.gov/about/c19384.htm>.

3 Centers for Disease Control and Prevention. (2012). *Mother-to-child transmission of HIV and syphilis globally*. Retrieved June 1, 2012, from <http://www.cdc.gov/winnablebattles/Mother-to-ChildTransmission>.

4 Clinton, H. (2011, November 8). *Creating an AIDS-Free Generation*. Address at the National Institutes of Health, Bethesda, MD.

5 PEPFAR. (2012). *Using science to save lives: Latest PEPFAR results*. Retrieved June 1, 2012, from <http://www.pepfar.gov/results/index.htm>.

Rwanda's Collaborations to Prevent Mother-to-Child Transmission In 2002, faith leaders organized the Interfaith Network of Rwanda, a group representing a broad spectrum of faiths and denominations coordinated for a unified response to HIV/AIDS. This network serves as an intermediary for the faith community, government, and other stakeholders to discuss and implement programs and policies. These efforts have helped 85 percent of health facilities in Rwanda provide HTC and PMTCT services. Additionally, male participation in PMTCT has risen dramatically, with 84 percent of female participants bringing their male partners with them for treatment.¹ In Rwanda, the government recognizes the unique capabilities faith leaders have in facilitating community mobilization in very remote areas that are difficult for the government to reach but where churches and mosques are present.

The success of this FBO-government collaboration is evident in the story of Beatrice Kagoyire, an HIV-positive woman in Rwanda. Because of the PMTCT programs in her community, Mrs. Kagoyire was able to give birth to two children since 2003, both of whom are HIV-negative. She is now the Chairperson of the Rwandan Network of People Living with HIV/AIDS (RRP+),² a group established in 2003 with only two members that now has 175 members working with many partners. The combined efforts of RRP+, the Rwandan government, and other stakeholders have helped drastically reduce number of new infant infections in the country.

PREVENTION AS CARE

While religious organizations have played a role in articulating and developing behavioral HIV prevention models, Consultation participants were clear that prevention efforts need to be more comprehensive, addressing both individual behavior change and the broader socio-cultural factors that contribute to HIV risk.

Consultation participants described the importance of multilevel programs that target both individual behaviors and community dynamics. By addressing individual, family, congregation, and community levels more comprehensive prevention program are possible. Although such programs have been developed by FBOs, additional efforts with the following characteristics could contribute to reductions in new infections.

- **DYNAMIC AND AUDIENCE-FOCUSED PREVENTION MESSAGES.** Participants noted that some FBOs have used materials and information developed years ago for their prevention programs, while others are using information that incorporates new knowledge. Effective prevention must be dynamic, changing in light of new information, and it must be population-focused, reflecting the issues and concerns of each particular audience rather than a “one size fits all” general prevention message. Even when FBOs develop and implement strong prevention programs, a lack of marketing capacity sometimes limits their reach. FBOs should explore a variety of media (e.g., posters, radio programs, Twitter, Facebook, and YouTube) in order to expand the reach of effective prevention programs.
- **SSDDIM REDUCTION.** SSDDIM (Stigma, Shame, Denial, Discrimination, Inaction, and Misaction) were described as key factors in HIV vulnerability. FBOs can contribute to SSDDIM but they also possess unique capacities for the fight against it. Specifically, FBOs can combat SSDDIM with SAVE (Safe(r) practices, Access to treatment and nutrition, Voluntary, routine, and stigma-free counseling and testing, and Empowerment of all communities and societies to fight HIV).

“The church’s first missiological challenge in the HIV/AIDS era is to rethink the gospel in the light of contemporary cultures-especially cultures that promote death rather than life.”

–Esther Mombo, Deputy Vice-Chancellor of Academic Affairs, St. Paul’s University, Limuru Kenya

In 1989, seventy women from around Africa gathered in Accra, Ghana to form the Circle of Concerned African Theologians. Historically, the voices of women were not heard. Religious leaders were talking about women rather than talking with them. Some never even considered that women might be powerful voices of revelation of God’s work in the world and that women could contribute new theological perspectives in their own right. But women knew it. And they worked to be sure that their voices would be heard.

Today, the Circle is comprised of hundreds of women from around the world contributing their voices and their testimonies to a growing chorus of women from various religious traditions telling the world about God’s love. The Circle speaks at length about HIV/AIDS, challenging theologies that promote stigma and discrimination that hamper the response with a clarion-like call of God’s love and grace.

¹ Kagoyire, B. (2012, May). Best Practices from FBOs: Sustained Community-Level HIV/AIDS Response in Rwanda. Presentation at *PEPFAR Consultation on the Role of Faith-Based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS*. Limuru, Kenya.

² The original name of RRP+ was French, *Reseau Rwandais des Personnes Vivant Avec le VIH/SIDA*. This acronym RRP+ comes from this name. For further information, see the organization’s website at www.rppplus.org.

- **BREAK THE SILENCE ON SEX, SEXUALITY AND SEXUAL HEALTH.** Participants noted that effective prevention programs sometimes challenge the silence that is the norm within some FBOs in regard to sexuality and gender. They do so in ways that combine accurate and comprehensive information, sensitivity, and theological perspectives that complement sexual health education. Faith leaders should talk about those topics that have long been ignored: defilement, rape, pornography, and sexual violence. In doing so, these prevention programs challenge myths, misconceptions, and misinformation.
- **LIFE SKILLS AND VALUES FOR CHILDREN.** Religious communities are important sites for teaching young people about life skills, values, and commitments to living faithful lives. HIV prevention can be integrated into such programs.
- **PEER-TO-PEER PROGRAMS.** Peer-led programs targeted to peers can be powerful prevention initiatives that both increase individual perceptions of risk and increase collective power to avoid infection. This quality of collective action and responsibility takes prevention programs out of one-on-one counseling and moves them into the community.
- **PARTNERSHIPS TO MAXIMIZE EXISTING COMMUNICATION FORUMS.** Participants agreed that FBOs do not always collaborate with one another and faith-based NGOs do not always work in local religious communities. However, effective partnerships are a necessity in the current environment in which organizations are being asked to do more even as resources grow tight. Church, mosque, and temple services and related activities provide an opportunity to extend prevention and health messages.
- **CHALLENGE READILY AVAILABLE SEXUALLY EXPLICIT MATERIAL.** In this age of digital media, participants noted that sexually explicit material can be readily accessed from the Internet any time of the day in both urban and rural communities. FBOs could develop Internet-based media that offers theological resources to help people know how to respond when they encounter such material.
- **CHALLENGE LIFE-THREATENING THEOLOGICAL PERSPECTIVES ON AIDS.** At times, theological language is used to justify stigma, fear, discrimination, and hatred. Faith-based prevention programs that offer unconditional love in response to the HIV epidemic contribute to alternative theological perspectives that speak clearly of God's love and compassion and call people of faith to overcome SSDDIM with love. In addition, prevention programs such as these are grounded in commitments to stand against social injustice, poverty, economic inequality, trade injustices, political instability, conflicts, violence, and displacements. These issues are important to a theological commitment to social justice in general and to a social structural approach to HIV prevention specifically.
- **ADDRESS DISCRIMINATION AND POWER IMBALANCES.** People are often marginalized and excluded from information, skills, and services due to age, gender, disability, sexuality, marital status, and nature of profession or trade. FBOs need to develop prevention programs and materials specifically for those communities most at-risk for HIV infection rather than supporting ongoing exclusion. Populations at risk should be part of the staff and advisory structures of FBOs. FBOs should develop prevention programs targeted toward and staffed by these populations.

Prevention among At-Risk Populations in Mombasa

The Muslim Education and Welfare Association (MEWA) in Mombasa, Kenya is a community-based program that was established in 1986 to help improve the educational, economic, and social welfare of Muslims. Funded by the contributions of individual Muslims and Muslim organizations, MEWA has now built a hospital, drug treatment center, library, and computer center.

In 1993, MEWA began to focus on drug treatment in response to the growing addiction problem in the community, particularly among the youth abusing heroin. A study conducted in collaboration with the University of Nairobi showed that almost 50 percent of injection drug users tested were HIV-positive. Abdalla Badrus, the Director of MEWA's Drug Rehabilitation and Resource Center, began volunteering with them in 1997. A former drug user himself, Abdalla is representative of MEWA's volunteers, most of whom are recovering addicts. The MEWA volunteers and staff perform interventions in drug dens, armed with alcohol swabs, water, condoms, clean needles, and educational materials. Because over 75 percent of injection drug users in the area abuse heroin and require detox, they also educate the users' family members about the side effects of detox, provide peer counseling, and escort clients to comprehensive care centers.

Funded in part by PEPFAR in 2011, MEWA currently has five different centers close to drug dens and has seen over 8,000 patients for clinical detox in the center, where inpatient treatment is only \$150 per month and outpatient treatment is free. With over 26,000 drug users in the Coast Province alone, MEWA currently has over 5,000 clients in Mombasa and is actively reaching out to younger IDUs in villages. This community-based program is providing "health, hope, and healing" to drug users, their families, and the broader community.



Faithful Response: Understanding the Work of Various Faith-based Organizations

FBOs are diverse in both their functions and structures. Efforts to build sustainable, effective partnerships that support country leadership in coordinated responses to HIV can be improved by understanding the specific contributions of these structures and functions.¹ A diverse group of Consultation participants worked together to define different types of FBOs and describe the unique roles each type performs in order to mobilize the diverse capacities of FBOs in more effective, efficient, and sustainable responses to HIV. The participants identified six different types of FBOs:

- **NATIONAL AND INTERNATIONAL RELIGIOUS BODIES:** Participants described national religious bodies as centralized organizations comprised of local religious communities. National religious bodies bring together individual religious communities in broader networks of synods, presbyteries, dioceses, or archdioceses. Religious orders (e.g., Jesuits, Franciscans, Sufis, or the Sisters of Loreto) are a part of local communities that are organized through national and international religious bodies. These religious order bodies often provide extensive health care and social services in local communities both urban and rural. In addition, many of these national religious bodies are connected to international bodies.

National religious bodies provide an important organizational capacity that connects local religious communities to a national body. National religious bodies can help create and sustain support networks that provide targeted, population-specific services and reach some of the most vulnerable and marginalized members of local communities. They provide mechanisms for financial and programmatic accountability and for the dissemination and implementation of best practices. They provide avenues for communication and administrative support through which resources can be mobilized and channeled to the places where they are most needed. Finally, national religious bodies provide a “critical mass” at a national level, allowing the wisdom, ideas, perspectives, and priorities of people at the local level to be heard. This capacity to make diverse local voices heard means that national religious bodies are important vehicles for advocacy around sound, ethical policies and practices at national and international levels.

- **NATIONAL OR INTERNATIONAL ECUMENICAL NETWORKS:** National or international ecumenical networks are similar to national religious bodies in terms of their functions but differ in terms of their structure because these networks are not formal organizations of religious traditions. Rather, they relate to national or international religious bodies as faith-based organizations that were founded specifically to provide services to people in local communities. Faith-based health systems or health education facilities are examples of such networks. These networks are comprised of scores of far-flung health centers, dispensaries, training institutes, hospitals, community outreach programs, social services, and colleges that together represent a significant proportion of the health service delivery and health education capacity at the country level. Organizations affiliated with such ecumenical networks work directly with people at local levels, and the networks make visible the needs and capacities of these local communities. The networks have the responsibility and capacity to advocate to both governmental and non-governmental funders on local needs and to bring that funding to the local level through service provision. In these ways, the wide variety of national or international ecumenical networks serve as intermediaries between funders and local programs, providing support at the local level and articulating the on-the-ground challenges and best practices to national and international funders and partners.

The Sisters of Loreto, a Roman Catholic religious order of women, describe their work eloquently, “We stand below the cross as we strive to bring the healing spirit of God into our world and commit ourselves to improving the conditions of those who suffer from injustice, oppression, and deprivation of dignity.” For over 200 years, deep faith has compelled the sisters into ministries around the world with a vision grounded in social justice. The Sisters of Loreto is only one of scores of religious orders providing a broad range of HIV services.

¹ Casale, M., Nixon, S., Flicker, S., Rubincam, C., & Jenney, A. (2010). Dilemmas and tensions facing a faith-based organization promoting HIV prevention among young people in South Africa. *African Journal of AIDS Research* 9(2), 135-45.

- **NATIONAL INTERFAITH NETWORKS:** Sometimes, the perspectives of distinct religious traditions need to be voiced, and shared perspectives of various religious traditions need to be heard. National interfaith networks provide a mechanism for sharing such perspectives. However, these networks do more than articulate perspectives. They also create and sustain coordinated service delivery programs that span the divisions that sometimes occur in local communities between members of different religious traditions. They provide a structure to educate religious leaders from a variety of backgrounds on issues of common concern. They use religious language and ideas to translate HIV treatment and prevention information into messages that people in local communities understand and value. Finally, these interfaith networks capitalize on the trust that many people place in their religious traditions and religious leaders, creating a context for local communities to discuss issues that they would never share with representatives of governmental or NGOs.
- **INTERNATIONAL NGOS:** Some FBOs are quite large, with programs and staff in countries around the world. These FBOs are international NGOs that bridge both geographic and cultural divides around the world, bringing people of faith together in shared commitments to addressing HIV. International NGOs serve as key partners in national FBO programs, bringing organizational support, well-established networks, and financial resources to the table. Examples of FBOs that function as international NGOs include World Vision, Aga Khan Health Services, World Relief, and Tearfund.
- **AFFILIATE NGOS:** Like ecumenical networks, affiliate NGOs are related to but distinct from national religious bodies. Affiliate NGOs often arise in response to a local community need that is not being met by national religious structures. For example, affiliate NGOs may be created to work with people stigmatized in their local communities. At times, religion itself can contribute to people being stigmatized and national religious bodies are not well-equipped to address such stigmatization. At the same time, religion can also build trust and foster compassion in local communities and people who are stigmatized may themselves feel deep religious conviction. Affiliate NGOs offer an ideal structure for negotiating through this complexity because they operate in collaboration with national religious bodies while also maintaining flexibility to tailor the nature of their response to the local context. In this way, affiliate NGOs are key institutions for reducing stigma and revealing the human dimensions of people in need. By bringing such capacities to the table, affiliate NGOs can be effective faith-based organizations for working with MARPS.

The **Islamic Medical Association of Uganda (IMAU)** brings together hundreds of health providers from across the country to offer health services through hospitals and nursing homes and to offer a wide variety of health education initiatives, with an emphasis on HIV prevention. Beginning in 1998, IMAU began to partner with other Muslim medical organizations to convene the International Muslim Leaders' Consultation on HIV/AIDS. Dr. Elizabeth Marum (CDC) worked with IMAU on an initiative to provide HIV education to communities in Uganda through imams: "IMAU has inspired communities to accept persons living with AIDS, and to offer practical support and compassionate care to individuals and families affected by the epidemic. What have been the keys to IMAU's success? One crucial element has been IMAU's excellent record of accountability, not only to the donors, but more importantly, to the community."

"You can learn from each other. If you are Muslim then you can learn from Christians—"What do you do to fight HIV/AIDS?"—and they can learn from us."

—Aisha Mohammed, Mufti's Office of Zanzibar

"Partnership" is more than a word in the title of The **Tanzania Interfaith Partnership (TIP)**—it guides the organization. Through funding from PEPFAR, TIP brings together the Tanzania Episcopal Conference, Christian Council of Tanzania, Bakwata (Muslim Council of Tanzania), and the Office of the Chief Mufti of Zanzibar to provide inter-religious education and programs on HIV prevention, treatment, and support. TIP is an example of ongoing strategic collaboration between the U.S. government, the government of Tanzania, local in-country partners, and a US-based FBO (Balm in Gilead). Together they are building the capacity of FBOs to develop programs that align with Tanzania's National AIDS Service Plan and create an infrastructure to channel service to over 80 FBOs working at the local level.

- **LOCAL GRASSROOTS RESPONSES:** The final organizational structure identified by participants was the local grassroots response. These responses address local needs. National bodies may not even be aware of these needs or see them as a priority. Local grassroots responses create a structure both to address the need and to advocate for national bodies to respond. On a functional level, they also provide key capacities: a space for gathering and a group of willing volunteers. Because they respond quickly to local needs, the grassroots responses are trusted. Because they work directly with those whose needs are not being addressed by national networks or religious bodies, local grassroots responses are incubators for innovation. If these responses can relate to national structures with flexibility, they offer mechanisms by which innovation can be known and replicated. Additionally, local grassroots responses are key organizations for sustainable and effective programs because they mirror local communities' priorities and offer high value services to people at the local level. Finally, local grassroots response are—or should be—prophetic, in that they work with broader governmental and religious systems to challenge those broader systems to act responsibly to those in need.

The **Eastern Deanery AIDS Relief Program (EDARP)** was founded in 1993 by Roman Catholic priests in response to people dying in the slums of Eastern Nairobi. The priests in Eastern Deanery created a program structured on a nurse-driven community based model of care, which still exists today.

At EDARP's inception, one nun helped train 50 community volunteer health-care workers (CHW) who went into the communities with four nurses from EDARP to provide palliative care so that people could die with dignity.

The current Managing Director of EDARP, Alice Njoroge, says, "In my life, even as a nurse, I had never seen the number of deaths that I saw when I was caring for HIV/AIDS when I began working [with EDARP]." In the early days EDARP did not have the funding to provide access to ARVs and focused its work on palliative care. In 2001 that work transitioned from caring for those dying into early identification of people with HIV disease through HTC. The high rate of HIV disease and significant access of EDARP made it eligible to receive PEPFAR funding in 2004. The PEPFAR funding allowed EDARP to expand their services to include care and treatment. Today, EDARP offers care in 13 different slums in Eastern Nairobi. All of these sites offer integrated care so patients are able to easily access whatever services they need. In the first half of 2012 alone, 28,433 people accessed testing, 17,780 adults received basic HIV care and support, and 4,233 received voluntary male circumcision.

Mrs. Njoroge sums up the success of this community-based model by saying, "The face of AIDS has changed tremendously for [our patients]. We used to have patients who were dying within two, three weeks. Now, our patients are living for many years. We used to have many children who were brought to us every Monday morning because their mother had just died and we had to take these children and try to link them with their extended families. That is history. We don't see these children anymore because their parents are alive and they are able to care for them. Working with the community and working with the community health-care workers has a lot of impact. And as a faith-based organization, the very fact that we were not discriminating, we were very compassionate, we accepted everybody regardless of their situation – that helps people and the communities to trust us. I want to thank PEPFAR for making the ARVs available because, as I always tell my patients, we have come from death to life."

Faith-based Contributions to the Health System

FBOs and governments working to provide quality and affordable HIV services face a myriad of health systems challenges, including health care worker shortages, parallel and unlinked programming, insufficient financial management systems, and inadequate infrastructure and capacity in local facilities.

These challenges have come to the forefront at a time when financial resources have been stretched to their limits in the wake of the global economic downturn. In addition to these external challenges, FBOs are also responding to changing dynamics with their international partners as PEPFAR and others are asking country governments to assume greater leadership in overseeing national strategies for fighting HIV/AIDS.

“In partnership with our partner countries ... we move forward together to respond to the needs of the populations — not as primary implementers, but as a supporter to the effort that is reflected and defined by the partner country leadership, which includes civil society and faith-based organizations, to develop a continuum of services that will continue to respond to the needs of the HIV-infected populations for many years to come. The United States sees this as a long-term commitment.”

– Ambassador Eric Goosby, June 4, 2012

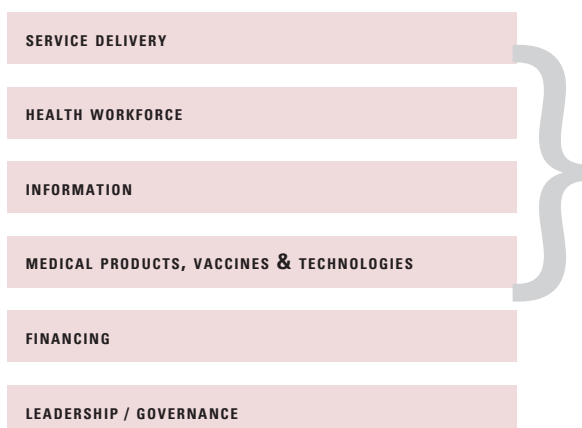
PEPFAR and other external partners are now giving priority to in-country organizations as primary program implementers. While offering opportunities for FBOs and other NGOs in the long-term, this change adds to the numerous issues that FBOs must address at this point in time. As the details of the transition to in-country leadership evolve, national governments, FBOs, and their partners need to develop solutions and plans for the coming changes in the short, medium, and long term.

Throughout the Consultation, participants discussed the health systems challenges facing East Africa. They identified both recommendations for strengthening their systems as well as model practices that FBOs are already using to build management, finance, and infrastructure capacity.

Figure 1: Consultation participants identified health systems components that align with those described by the World Health Organization (2007).

THE WHO HEALTH SYSTEM FRAMEWORK

SYSTEM BUILDING BLOCKS



OVERALL GOALS / OUTCOMES



HUMAN RESOURCE PLANNING

Kenya, Rwanda, Tanzania, and Uganda were identified by the World Health Organization (WHO) as 4 of 57 countries facing a health workforce crisis.¹ An estimated 2.4 million doctors, nurses, and midwives are needed to overcome these health worker shortfalls worldwide. The human resource capacity of the health system in East Africa is hampered by migration of trained workers, poor geographical distribution, skill imbalances, poor distribution of workers by geography, and a weak knowledge base on human resource management.² FBOs have a rich history of providing quality opportunities for people to grow and develop and can often draw on strong staff commitments to retain competent and trained health workers and managers.³ By taking a longer-term perspective on human resource planning, FBOs can be effective at alleviating the health worker shortage in East Africa. Recognizing serious workforce challenges, the Tanzania Ministry of Health convened a Human Resources for Health (HRH) technical working group, which includes multiple members from the faith-based sector. The group supports the implementation of an HRH strategic plan supported by multiple donors through the Global Workforce Initiative. The Ministry recognizes the contribution of FBOs in healthcare worker training and their ability to retain health workers in remote areas.

SERVICE DELIVERY AND SUPPLY CHAIN INFRASTRUCTURE

Access to clean, safe, health facilities where community members can receive quality care is an essential part of HIV/AIDS service delivery. Many of the local health facilities in the most remote parts of East Africa are run by FBOs. These clinics and hospitals operate as a key element of national health systems, often serving a clientele that are outside the reach of public health facilities.

Additionally, people living with HIV depend on the timely delivery of quality and affordable antiretroviral drugs and other medications. Faith-based supply chain organizations provide medicines and pharmaceutical products for 40 percent of the population in the four countries highlighted in this report.⁴ In support of many faith-based and public sector health facilities, these faith-based supply chain organizations are working to ensure that a reliable supply of commodities reaches the people most in need.

The **Lokichogio Health Center**, managed through the Africa Inland Church, provides healthcare services to the nomadic people and refugees living in Turkana, the remote northwest corner of Kenya near the borders of Uganda, Ethiopia, and Sudan. Communities in Turkana face multiple health challenges due to their remote location, poor access to healthcare, food insecurity, and persistent violence. The Lokichogio Health Center provides a beacon of hope amid the arid landscape, working to provide basic healthcare, laboratory services, and HIV/AIDS counseling, testing, and treatment. The health center also works to reduce the transmission of the virus from mother to child.

A member organization of the Christian Health Association of Kenya, the Africa Inland Church Health Ministry provides quality health services to rural and remote communities across Kenya in 5 hospitals and 52 health units similar to the one in Lokichogio.

1 World Health Organization. (2006). *The world health report 2006: Working together for health*. Geneva: World Health Organization.

2 Chen L., Evans, T., Anand, S., Boufford, J.I., Brown, H., Chowdhury, M., . . . Wibulpolprasert, S. (2004). Human resources for health: Overcoming the crisis. *Lancet*, 364(9449), 1984-90.

3 Lipsky, A.B. (2011).

4 Banda, M., Ombaka, E., Logez, S., & Everard, M. (2006).

FINANCING AND PROGRAM INTEGRATION

As governments and FBOs are asked to do more with available resources, FBOs must begin to streamline HIV/AIDS services into their organizations' core service portfolio and diversify funding streams away from singular, large donor subsidies. Using existing structures and resources, many FBOs have continued to provide service and care despite shifting external funding and priorities. Some FBOs are making the decision to incorporate HIV/AIDS programming into their denominational or institutional budgets. For example, the Evangelical Alliance of Kenya has dedicated more than 20 percent of the organization's budget to HIV/AIDS and is working to mainstream HIV/AIDS efforts into its core business practice.

Donors, FBOs and governments must continue to invest in efforts to strengthen the core capacity of organizations in the fundamentals of budgeting, quantifying costs, and financial planning. They must explore ways to gain greater efficiencies by integrating programs and services both within and across organizations and institutions. By working together to identify synergies within the health system, FBOs will be well situated to work more effectively and efficiently. For example, faith-based partners in Uganda have begun building collaborations around integrated service delivery using new technologies like video conferencing. By reducing travel costs, the trainings can be delivered to managers and staff in smaller, indigenous organizations to help build management and technical knowledge needed to manage, expand, and integrate programs.

Joined together by the **Ecumenical Pharmaceutical Network**, supply chain FBOs in Kenya, Tanzania, Rwanda and Uganda provide affordable, life-saving medicines to 40% of the people living in those countries.

Established in 1979 as a joint venture between the Uganda Catholic Medical Bureau and the Uganda Protestant Medical Bureau, **Joint Medical Supplies** (JMS) works to supply medicines, medical equipment and related healthcare services and training of assured quality to the people of Uganda at an affordable price. Supporting 54 direct staff, JMS produces and procures medicines for more than 500 hospitals and health centers with medicines and other supplies.

Working alongside JMS, the **Mission for Essential Drugs and Supplies** (MEDS) in Kenya, **Le Bureau des Formations Médicales Agréées du Rwanda** (BUFMAR) in Rwanda, and **Christian Social Services Commission** (CSSC) in Tanzania support strong and viable health systems in East Africa.

MONITORING AND EVALUATION

Doing more with existing resources will require finding innovative ways to harness and focus the energies of communities, FBOs, governments, and other partners.¹ Governments and donors are increasingly relying on the evidence base to make decisions about investing in programs that will result in the greatest health outcome improvements in communities.

FBOs are working to demonstrate that they offer quality services that make a measurable difference in people's lives. Participants in the Consultation described both the rapidly growing capacity of their organizations to evaluate the impact of the services they deliver and the need for technical support to build their monitoring and evaluation capacity.

Faith-based organizations have also argued that their programs offer a number of unique qualities that make them valuable assets in HIV prevention and treatment. Those unique qualities are less tangible and more difficult to describe: commitment, compassion, trustworthiness, abiding relationships, and motivation for the work that they do that is grounded in deep faith and respect.² Finding ways to describe these intangible qualities has required FBOs to become more adept at understanding the complexities of monitoring and evaluation and not merely to describe the work they do using theological perspectives or the language and values of their faith traditions. The International Religious Health Assets Programme (IRHAP), a network of practitioners and academics in religion and public health, has laid the groundwork for ongoing collaborations to better describe and measure the unique, intangible assets that FBOs can mobilize to fight the HIV/AIDS epidemic. Research in this field is ongoing and the correlations between these qualitative characteristics and measurable outcome indicators are only beginning to be explored. FBOs will play a key role in this emerging research.

MAP International is a large faith-based organization with offices in eight countries around the world, including Kenya and Uganda. MAP receives significant support from the private sector through a diverse group of funders, individual donations, and government grants. MAP is committed to strong monitoring and evaluation of its programmatic activities and to strong fiscal oversight of its finances. This commitment makes a difference. In regard to administrative efficiency and accountability, MAP has scored 99 out of 100 for charitable commitment and efficiency from Forbes. MAP has received a four-star rating (the highest rating) from Charity Navigator, an independent charity evaluator. Finally, MAP is charter member of the Evangelical Council for Financial Accountability (ECFA), an accreditation agency that works to ensure that faith-based charities are accountable to their donors and the public-at-large. In its programmatic work, MAP directs its program directors to complete all monitoring and evaluation protocols required by its funders and provide detailed narratives of the work that MAP is doing on the ground that makes a difference in local communities in the countries it serves. This multi-faceted approach to monitoring and evaluation in both administration and programming makes clear the impact of MAP's work through quantitative measures and through a description of the qualities that MAP relies on as an effective, trusted, faith-based partner in local communities.

¹ World Health Organization. (2006).

² ARHAP. 2006. *Appreciating assets: The contribution of religion to universal access in Africa*. Cape Town: Report for the World Health Organization, African Religious Health Assets Programme.

Sustaining Efforts Through Partnerships: The Christian Health Association of Kenya

The Christian Health Association of Kenya (CHAK) is a national network of more than 140 Protestant health facilities and programs that collectively provide about 40% of health services to Kenyans. Member organizations contribute significantly to HIV/AIDS treatment, care, and prevention efforts.

Established in 1946 by the National Council of the Churches of Kenya, CHAK's activities include health service delivery, health systems strengthening, research, advocacy, health care financing, and advocacy. Through member facilities, CHAK provides comprehensive HIV/AIDS prevention and care and treatment services spanning from PMTCT to management of opportunistic infections.

To maximize impact, CHAK joined the Kenya Episcopal Conference of the Catholic Church and the Supreme Council of Kenya Muslims in a partnership with the Government of Kenya. In 2009, the three FBOs and government officials signed a memorandum of understanding (MOU) aimed at improving the quality of health service delivery and sustainability. Recognizing the importance of accountability, the MOU also accounts for monitoring and evaluation. Some MOU accomplishments include:

- › Staff secondment- With Medical Officer interns and with Medical Officer consultants.
- › Support with in-kind supplies: Dispensary drug kits to FBO dispensaries, FP commodities, ARVs, vaccines.
- › Supervision of FBO facilities by MOH
- › Upcoming Health Sector Services Funds.
- › Good working relationships with ministry- inclusion in technical working groups, various committees
- › Inclusion in training opportunities

CHAK has also worked tirelessly to help meet the health worker shortage challenge. CHAK operates 16 schools for training health professionals in Kenya.¹

In each of these training programs, CHAK provides pre-service HIV/AIDS education for nurses, reducing needs for re-training once the nurses have finished school.

“Besides just primary level of services, we are [seeing] faith-based institutions develop into more specialized referral and training services. For example, we have one mission hospital . . . that is now providing specialized open-heart surgery through a partnership with some US institutions and it has become a training institution for surgeons and other health workers.”

– Dr. Sam Mwenda, Executive Secretary, Christian Health Association of Kenya

¹ Barnes, J., O'Hanlon, B., & Feeley, F. (2010). World Bank working paper 193: Private health sector assessment in Kenya. Washington, DC: The World Bank.

Strengthening Sustainable HIV/AIDS Programs through Partnerships

Faith-based systems cannot build their capacity entirely on their own. By working together, governments, FBOs, and other partners can develop creative solutions to the challenges of building sustainable systems for HIV/AIDS service delivery.

HEALTH SYSTEMS PARTNERSHIPS

The scope and depth of the partnerships between governments and FBOs can vary greatly. In Kenya, Rwanda, Tanzania, and Uganda, the countries represented in this Consultation, there are numerous examples of strong, sustained, long-lasting partnerships. In each of these countries, FBOs function as key elements of national health systems, providing a significant proportion of health services. For example, in Tanzania, the Christian Social Services Commission, an umbrella network of Protestant and Roman Catholic health systems, provides approximately 40 percent of health services in the country and actually administers more hospitals (98) than does the Tanzanian government (95).¹

The most effective of these partnerships are mutually beneficial, both for governments and FBOs, with faith-based health facilities helping ensure that citizens receive care and government programs providing financial and/or administrative support for FBOs. Still, the nature of the partnerships between national governments and FBOs varies widely from country to country, requiring country-specific responses to strengthen and sustain programs. For example, the Government of Rwanda noted that it supports faith-based facilities alongside other government facilities and provides equal support and standards to all health facilities by supporting a certain number of staff salaries in both FBO and government facilities. Participants in Uganda noted that FBOs often provide health services without receiving funding or support from the government.²

COMMUNITY-BASED PARTNERSHIPS

FBOs also make important contributions to HIV/AIDS prevention, treatment and care by working outside formal health systems. For example, a study by UNICEF in six African countries found that 97 percent of congregations studied were providing support to OVCs. On average, these communities were each supporting over 400 children.³ These activities occurred outside of identified OVC service delivery networks. Instead of developing new programs that may not effectively address the nuances of communities, in-country and international donors can partner with FBOs and help build capacity that allows these established organizations to broaden their services and, potentially, their reach. Collaboration and coordination among FBOs—within and across religious faiths—is essential as well. Providing technical assistance, sharing resources, and establishing faith networks can have far-reaching benefits.⁴

In small group discussions, participants again pointed out the strong connection between FBOs and communities, reminding leaders that FBOs should maintain a nature of being “community-owned, community-managed and community-led.” Additionally, participants recommended that creation of working groups and other mechanisms to facilitate the flow of information between FBOs, Ministries of Health, and other partners at the both the local and national level could help build accountability, buy-in, and participation at the community level for reaching goals and commitments.

“The fight against this disease is going to be won or lost at the community level because people don’t live in hospitals— they live in the communities. That’s where we need to focus our actions, that’s where we need to focus our investments....[Hospital-based care and treatment] is good, keep it, but move out of the hospitals, invest in the community, and you will see that the results will be fantastic in the short-term.”

– Salvador de la Torre, Catholic Medical Mission Board, Consultation Participant

1 Kigadye, F. (2012, May). *Faith Based Organizations and the Health System: Opportunities and Challenges for Sustainability in the HIV/AIDS Response*. Paper presented at PEPFAR Consultation on the Role of Faith-Based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS

2 Mwenda, S. (2012, May). *Faith Based Organizations and the Health System: Opportunities and Challenges for Sustainability in the HIV/AIDS Response*. Paper presented at PEPFAR Consultation on the Role of Faith-Based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS.

3 Foster, G. (2004).

4 Marshall, K., & Van Saanen, M. (2007). *Development and faith: Where mind, heart and soul work together*. Washington, DC: The World Bank.

Recommendations and Next Steps

Consultation participants developed a number of recommendations to maximize the particular capacities of FBOs in a coordinated, sustained response to HIV/AIDS. Those recommendations were clustered around two broad categories: capitalize on the unique role and function of FBOs and build the capacity of FBOs, their employees, and volunteers.

A number of concrete, specific, and actionable recommendations geared to governments, donors, and FBOs themselves were offered for each category:

LEVERAGE THE UNIQUE ROLE AND FUNCTION OF FBOs

1. *Capitalize on the trust that has developed between FBOs and local communities to build stronger, more comprehensive, integrated HIV-prevention efforts built not on stigmatization but on unconditional love.*

Those efforts should move beyond a focus on individual behavior to include family, congregational, and community based-initiatives. Further, they should advance theological perspectives grounded in human rights and social justice. Specific HIV-prevention initiatives should be targeted toward people entering into and within marriage rather than assuming that marriage insulates people from risk of HIV. Finally, marginalized, hard-to-reach, and MARPs should be included in program design, implementation, monitoring, and evaluation.

2. *Develop the capacity for FBOs to advocate for improved healthcare for all citizens and hold governments accountable.*

FBOs should draw on the moral power of their religious traditions to ensure that governments build and sustain adequate health facilities, distribute resources equitably for all citizens, and develop sound, long-term strategies for improving health systems—both in the faith-based and government sectors.

3. *Maximize the existing organizational infrastructure of faith-based health systems to reach communities impacted by HIV, including vulnerable, hard-to-reach, and MARPs.*

Faith-based health systems provide a significant proportion of the health services in East Africa. Those systems have a capacity to reach both urban and rural communities that can surpass that of other health systems.

4. *Develop the capacity to communicate in ways that are relevant and meaningful to religious communities, donors, and governments.*

FBOs should be equipped to understand the language, perspectives, and priorities of funders and other partners so that they can make a stronger case for funding. This should include building a stronger evidence base on the contribution of FBOs to service delivery. Additionally, FBOs should work to ensure that HIV awareness and prevention messages are integrated into religious life and practice by referencing HIV in corporate liturgies prayers, and sermons. This will encourage local religious communities to see HIV prevention and care not as the specialized work of health or social service professional, but as the shared responsibility of people of faith gathered together.

5. *Strengthen communities' input and investment into FBO administration and programming.*

The work of FBOs can be sustained and strengthened when it aligns with community priorities. Such alignment can be encouraged by soliciting community involvement in program administration through community advisory boards. Additionally, faith-based health systems should build or foster strong community ties in order to put referral mechanisms into place. These mechanisms should lower barriers to accessing service for people coming *from* the community into the health system and for people going *back into* the community from the health system.

BUILDING THE CAPACITY OF FBOs, THEIR EMPLOYEES, AND VOLUNTEERS

- 1. *Develop and make widely available mechanisms to support the organizational development of FBOs.***
FBOs would benefit strongly from greater participation in organizational and technical support services provided by funders and other partners. This is particularly true in the areas of human resources, supply chain management, financial accountability and development, and training.
- 2. *Increase FBOs' capacities to develop and implement effective programs or to strengthen existing programs.***
Capacity-building should not focus only on organizational capacity. Rather, FBOs should be part of mechanisms to improve the quality and scope of their programs. These mechanisms should include: providing skills-building and training; disseminating best practices with support to replicate them; prioritizing evidence-based, sustainable initiatives; and developing and supporting more robust monitoring and evaluation mechanisms that tie indicators to service improvement.
- 3. *Expand FBO networks by bringing in new or previously unaffiliated FBOs and engaging other religious traditions.***
Grassroots FBOs are sites for innovation. However, opportunities for replicating this innovation are often limited because these FBOs remain isolated and unconnected. In addition, a number of interfaith HIV initiatives across East Africa are limited to Muslims and Christians. By expanding interfaith initiatives to include other traditions, FBOs can work together to reach a greater number of people in their respective countries. By mapping local communities, unknown FBOs doing good work can be identified and connected into networks to allow for mutual support and learning among member FBOs.
- 4. *Hold ineffective FBOs accountable.***
Not all FBOs are effective in their work. Some lack capacities and resources to do the work they aspire to; others use religion to promote stigma and shame rather than care and compassion. Mechanisms should be developed to address these circumstances. The capacity-building recommendations listed above could be offered to FBOs lacking capacity and resources. FBOs that actively use religion to promote stigma and shame should be held accountable by FBOs endeavoring to offer strong HIV prevention, treatment, and support service.
- 5. *Offer leadership development initiatives to better equip the next generation of leaders.***
Leadership development is as important as organizational development. Therefore, it is critical to provide platforms for current leaders to share their knowledge, expertise, and wisdom and to create mechanisms at both individual and organizational levels for mentoring. At the individual level, mentoring would allow emerging leaders to work with well-respected and highly effective senior leaders for an extended period of time. At the organizational level, mentoring would pair established, successful FBOs with new and/or promising FBOs in order for staff to share best practices.

Conclusion

Breakthroughs in HIV treatment and prevention have allowed us to hope for an AIDS-free generation. However, many challenges remain. Given those challenges, all resources must be identified, mobilized, and maximized to make the hope of an AIDS-free generation a reality. FBOs' assets have not always been counted among those resources; they must be.

The race to defeat HIV has shifted from a sprint to a marathon—we have moved from an emergency response and are working to develop long-term sustainable priorities, practices, and programs that can lower the number of new infections and decrease prevalence and incidence rates over time. FBOs are essential in this race. This report reflects the unique contributions they offer: well-established and deep-rooted service delivery networks; clear commitments to serve local communities; a wide range of programs, skills, experiences, and knowledge that contribute to a strong, sustainable, multi-sectoral response; the abiding trust of local communities; and a capacity to mobilize an army of volunteers in any corner of the globe.

In addition to HIV, a number of other challenges confront the health of communities around the world. The U.S. Government has pledged to draw on the best practices and lessons learned in the ongoing HIV response to redouble our efforts to address those challenges. FBOs are essential partners in that work, as Lois Quam, Executive Director of the U.S. Global Health Initiative, eloquently described: “Faith-based organizations are particularly effective in their work in global health in part because of the unique capabilities and resources that they bring to the table....I look forward to a robust and enduring partnership between the U.S. Government and the faith community in our global health work.”

HIV and other diseases continue to threaten our communities, our nations, and our world. But effective responses have been developed and innovations continue to emerge. Faith-based organizations have long been key partners in those coordinated responses, and they always will be.

Acknowledgments

PEPFAR acknowledges with gratitude the invaluable assistance of a number of organizations and individuals without whom the Consultation would not have been possible.

The members of the Consultation Planning committee provided valuable insights into the design of the meeting, participant invitation lists, and desired goals and outcomes. The meeting would not have been successful without their hard work. We are particularly grateful for the generous and thoughtful efforts of Dr. Peter Okaalet, Dr. Esther Mombo and Mike Mugweru, who went above and beyond in their contributions to the Consultation.

The Consultation moderators—Reverend Gideon Byamugisha, Dr. Esther Mombo, Reverend Pauline Wanjiru, and Dr. Peter Okaalet—summarized presentations, highlighted key points, addressed and paraphrased participants' questions, and assured that the Consultation process adhered to the schedule.

A number of faculty and students of Saint Paul's University in Limuru, Kenya played key roles in Consultation. Dr. Joseph Galgalo, Vice Chancellor at Saint Paul's, offered leadership on content and graciously offered the university's resources to help make the Consultation a success. Dr. Esther Mombo, Deputy Vice Chancellor for Academic Affairs, worked tirelessly to craft the Consultation content and agenda, identify participants and speakers, and address countless logistics related to this event. We are also grateful for the participation of Dr. Maryann Mwangi, Dr. Lillian Kimani, and Rev. Christopher Peter and for the tireless efforts of six Saint Paul's students—Rahab Wanjiru Kariuki, Magdaline Chepkirui Koech, Esther Kwamboka, Kirienye Maina, Ruth Kerubo Mombo, and Ritah Otindo.

The Interfaith Health Program at the Rollins School of Public Health at Emory University has been at the forefront of applied research, teaching, and practice in religion and public health for almost two decades. IHP faculty were involved in the Consultation planning and design, helped to frame themes and content, facilitated breakout sessions, and worked to produce this report. Special thanks to Susan Landskroener, Paul Livingston, and Anne Hardison-Moody for their assistance with editing and research.

We appreciate all of the assistance from the staff in the U.S. Centers for Disease Control and Prevention (CDC) Country Offices as well as staff in the PEPFAR Country Offices in Kenya, Rwanda, Tanzania, and Uganda. We also thank them for their ongoing dedication day in and day out; the Consultation would not have been possible without the long-standing partnerships they have fostered. In addition, we offer a special thanks to CDC staff from the Division of Global HIV/AIDS in Atlanta for their expertise and insights.

The Consultation was held at the Jumuia Conference Center in Limuru, Kenya. The staff at Jumuia were gracious and welcoming, providing superb conference facilities and welcoming accommodations. Special thanks to Mr. James Gitanjua, Manager at Jumuia, for his tireless assistance with Consultation planners on all the aspects of the event.

We are grateful to all of the participants and organizations interviewed and/or videotaped who provided background information and compelling examples of the important work of FBOs. Without their insights and stories, this document would only consist of empty statistics.

The Rwanda Ministry of Health, Tanzania Ministry of Health and Social Welfare, Uganda Ministry of Health, Kenya Ministry of Medical Services, and Kenya Ministry of Public Health and Sanitation have all offered collaboration and support for the faith-based organizations in their respective countries, contributing to the health of their citizens. Key staff from these various ministries participated in the Consultation, offering their expertise and perspectives.

Last, but certainly not least, we are grateful to the Consultation participants for their active participation, lively discussions, contributions, and insights; just as importantly, we are grateful for their long-standing commitments to the communities they serve.

Appendix 1: Consultation Participants and Organizations

NAME	ORGANIZATION
Dr. Willis Akwhale	NASCOP, Government of Kenya.
Mr. Lubowa Ali Ali	Islamic Medical Association of Uganda
Ms. Pamela Amugozo	Friends Theological Institute
Mr. Joseph Ochieng Anyango	MAP International Kenya
Father Mena Attwa	Coptic Orthodox Church
Pastor Samuel Kizito Bamweyana	Uganda Union of Seventh Day Adventist Church
Mr. Edward Baralemwa	PACANet
Mr. Stanley Bii	USAID Kenya
Dr. John Blevins*	Emory IHP
Mr. Warren (Buck) Buckingham	U.S. Peace Corps
Rev. Dr. Gideon Baguma Byamugisha*	FOCAGIFO; Christian Aid
Mr. Omar Yahaya Chambo	TACAIDS
Rev. Alinikisa Felick Cheyo	Moravian Church in Tanzania, South West Province
Ms. Hanna Dagnachew*	PEPFAR – United States Mission to Kenya
Ms. Veronica Davison*	Division of Global HIV/AIDS, CDC
Dr. Salvador Garcia de la Torre	Catholic Medical Mission Board
Ms. Karyn DeLuca*	Emory IHP
Ms. Stephanie Doan*	Division of Global HIV/AIDS, CDC
Dr. Jennifer Galbraith	Division of Global HIV/AIDS, CDC Kenya
Mr. Ahmed Ali Hassan	Supreme Council of Kenya Muslims (SUPKEM)
Dr. Willy Mtamakaya Hyera	Tanzania AIDS Interfaith Forum (TAIFO)
Dr. Tina- Monique James	Catholic Relief Services / AIDSRelief
Dr. Daniel N. Kabira	Kenya Episcopal Conference-Catholic Secretariat
Dr. Magid Kagimu*	Islamic Medical Association of Uganda
Mrs. Beatrice Kagoyire	Rwandan Network of People Living with HIV/AIDS
Dr. Ida Kankindi	Rwanda Ministry of Health
Mr. Phares Karani	Nyakundu Disabled Project
Rev. Francis Karemera	Anglican Church of Rwanda
Rev. Dr. Charles Kibicho Kariuki	Presbyterian University of East Africa
Mr. Silver Richard Karumba	USAID Rwanda
Mrs. Jackie Katana	Inter-Religious Council of Uganda
Ms. Alice Maryam Wanubi Kibunja	Mothers Programmes Foundation
Dr. Fredrick Chubwa Kigadye	Tanzania Episcopal Conference
Mr. Joel Kigenyi	PACANet
Dr. Lillian Kimani	St. Paul's University
Sister Pauline N. Kimeu	Catholic Archdiocese of Mombasa
Dr. Mimi Kiser*	Emory IHP
Rev. William Andrew Kopwe	Christian Council of Tanzania
Mr. John Abraham Laiser	Selian Lutheran Hospital
Mr. Sammy Ikeny Loyelei	AIC Lokichoggio Health Centre
Rev. Nicta Lubaale Makiika	Organisation of African Instituted Churches
Mr. Michael N. Machaka	Nazareth Hospital
Mr. Peter Maduki	Christian Social Services Commission (CSSC)
Mr. Chad Martin*	Division of Global HIV/AIDS, CDC
Ms. Veronica K. Mathano	Ecumenical Disability Advocates Network
Mrs. LoeRose Bartholomew Mbise	Young Women's Christian Association of Tanzania
Dr. Deborah McFarland	Rollins School of Public Health, Emory University
Dr. Esther Mombo*	St. Paul's University
Dr. Debra Mosure	Division of Global HIV/AIDS, CDC
Mr. Michael Mugweru*	Africa Christian Health Associations Platform
Dr. Lorna B. Muhirwe	Uganda Protestant Medical Bureau
Ms. Speciose Mukagahima	The Protestant Council of Rwanda (CPR)
Mr. Godfrey Geoffrey Mukalazi	Uganda Joint Christian Council
Dr. Barbara Namata Mukasa	Mildmay
Rev. Dr. Wellington Kiilu Mutiso	Evangelical Alliance of Kenya

Appendix 1: Consultation Participants and Organizations

NAME	ORGANIZATION
Mr. Robert Solomon Mwandishi	Division of Global HIV/AIDS, CDC Tanzania
Mrs. Maryann Nyambura Mwangi	St. Paul's University
Ms. Catherine Wanjiku Mwayonga	Ecumenical Disability Advocates Network
Dr. Sam Mwenda	Christian Health Association of Kenya (CHAK)
Dr. Henry Mwesezi	Uganda Episcopal Conference
Dr. Gerald Aaron Mwima	Division of Global HIV/AIDS, CDC Uganda
Mr. Simon Mwima	AIDS Control Program, Uganda Ministry of Health
Dr. Nuru Nakintu	Uganda Muslim Medical Board
Ms. Sarah Kaye Nansasi	Islamic Medical Association of Uganda
Mr. Simon Yohana Ndevuzabure	PASADA
Rev. John Kamau Ndirangu	Organisation of African Instituted Churches
Mrs. Jane N. Ng'ang'a*	INERELA+ Kenya
Dr. Lucy Wanjiku Ng'ang'a	Division of Global HIV/AIDS, CDC Kenya
Mr. Stephen Wangongu Ngugi	Christian Aid
Ms. Nkatha Njemi	Catholic Medical Mission Board
Rev. Pauline Wanjiru Njiru	World Council of Churches
Mrs. Alice W. Njoroge	Eastern Deanery AIDS Program (EDARP)
Mr. Innocent Ntagara	Barakabaho Foundation
Mr. Justin Lazaro Nyamoga	Tanzania Interfaith Partnership
Mrs. Rebecca Nthenya Nzuki	The Salvation Army
Dr. Peter Okaalet*	Okaalet and Associates Limited
Mr. Peter Paul Opat	Uganda Catholic Secretariat
Sister Mary Margaret Owens	Children of God Relief Institute - Nyumbani
Rev. Christopher Benjamin (CB) Peter	St. Paul's University
Rev. Sam Lawrence Ruteikara	Parliament of Uganda
Mr. Ernest Rwagasana	BUFMAR
Rev. Amin Andrew Sandewa	TANERELA+
Ms. Renee Saunders	Division of Global HIV/AIDS, CDC
Mrs. Imelda Namayi Sembe	National Council of Churches of Kenya
Mr. Lattif N. Shaban	Supreme Council of Kenya Muslims
Ms. Asina Ali Shenduli	National Muslim Council of Tanzania
Mr. Ignace Singirankabo	Rwanda Interfaith Network (RCLS)
Rev. Ernest Sumisumi	Baptist Convention of Tanzania
Mr. Dean Surbey	Rollins School of Public Health, Emory University
Dr. Stella Alamo Talisuna	Reach Out Mbuya Parish HIV/AIDS Initiative
Ms. Sandra Thurman*	Emory IHP & Division of Global HIV/AIDS, CDC
Dr. Isaya Kitula Tosiri	Muhimbili National Hospital
Mr. Eric Willy Uwimana	RWANERELA+
Mr. Tom Walsh*	OGAC, U.S. Department of State
Rev. Fr. Vincent Wambugu	Kenya Episcopal Conference
Dr. John G. Wasonga*	Catholic Medical Mission Board-Kenya

* Member of the Consultation Planning Committee

Appendix 2: Consultation Agenda

Day 1: Monday, 28 May, 2012

- 18:00 – 18:30 Welcome, Prayer and Opening Remarks
- 18:30 – 19:00 Keynote Address: Building Sustainability through Government and Faith-based Organization Partnership

Day 2: Tuesday, 29 May, 2012

- 09:00 – 09:15 Welcome, Prayer and Meeting Framing
- 9:15 – 10:45 Plenary Panel—Faith-based Organizations and the Health System: Opportunities and Challenges for Sustainability in the HIV/AIDS Response
- 11:15 – 13:00 Plenary Panel — Best Practices from Faith-based Organisations: Building a Sustained Community-level HIV/AIDS Response
- 14:30 – 17:00 Breakout Group Discussions
1. Strong and Sustained Commitments: The Role of Faith-based Organisations toward Country Leadership and Sustainability in the Response to HIV/AIDS
 2. Faithful Response: Understanding What Makes Faith-based Organisations Work
 3. Prevention as Care: The Role of Faith-based Organisations in HIV Prevention Initiatives
 4. What Can Be Counted and What Counts: Monitoring and Evaluation for Faith-based Organisations
 5. Investing in Sustaining Systems: Demystifying Financing and Program Integration
- 17:30 – 18:15 Interfaith Service—Honoring Our Traditions, Those We Care For, and Our Commitments to Action

Day 3: Wednesday, 30 May, 2012

- 08:30 – 09:00 Welcome, Prayer and Recap of Day 1
- 09:00 – 10:30 Plenary Panel: Report Back and Discussion around Breakout Sessions
- 11:00 – 12:45 Closing Plenary Panel—Charting a Way Forward: Partnerships and Sustainability in the HIV/AIDS Response
- 12:45 – 13:00 Closing Remarks

Appendix 3: Selected Bibliography

The following bibliography contains citations of all of the peer-reviewed literature referenced in this report along with selected peer-reviewed publications relevant to topics or geographic areas represented in the report. The website of the Interfaith Health Program at the Rollins School of Public Health, Emory University contains a larger bibliography of materials on religion and health with a specific focus on HIV and AIDS. See <http://www.interfaithhealth.emory.edu>

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