When Religion and Health Align

Mobilising Religious Health Assets for Transformation

James R Cochrane, Barbara Schmid and Teresa Cutts (editors)

Cluster Publications
2011
Contents

Acknowledgements xi
About the Contributors xiii

Preface: The Hope of Alignment xvi

Introduction xvi
From the Past to the Present xvii
The African Religious Health Assets Programme (ARHAP) xix
When Religion and Health Align xxiii

Section 1

Overview and State of the Field

1. The Continued Paradigm Shift in Global Health and the Role of the Faith Community 2

*Christoph Benn*

Introduction 2
Developments in the Last Decade 3
AIDS as a Catalyst for Equity in Global Health 5
A Paradigm Shift In Global Health Ethics? 6
Can the Faith and the Health Communities Find a Common Language? 9
Conclusion 13

2. Discovering Fire: Changes in International Thinking on Health Care—The Challenge for Religion 16

*Gillian Paterson*

3. ‘An FB-oh?’: Mapping the Etymology of the Religious Entity Engaged in Health 24

*Jill Olivier*

Mapping the ‘Faith-Based Organisation’ Landscape 24
Exploring the Terminological Battlefield: Why Does it Matter? 30
A Clash of Paradigms and Forms of Evidence 32
The Power in Naming 36
Conclusion: Power and Resistance 38


_Steve de Gruchy, James R Cochrane, Jill Olivier, Sinatra Matimelo_

An Historical Overview 44
Four Key Ideas Behind PIRHANA 45
The Theoretical Foundations of PIRHANA 47
An Overview of the PIRHANA Tool 50
Technical Research Matters 54
What Does Participatory Inquiry Achieve and What Not? 56
Conclusion 59

5. Boundary Leaders: Seeing and Leading in the Midst of the Whole 62

_Mimi Kiser_

Institute for Public Health and Faith Collaborations 63
Recognising the Systems Nature of Health Challenges 63
Leadership that Sees the Self in the Whole 66
Liberative Pedagogy 68
Analysis 70

6. Liquid Boundaries: Implications for Leaders
Mobilising Religious Health Assets for Transformation 75

_Gary Gunderson_

Section 2

HIV and AIDS

7. A Purpose-Driven Response: Building United Action against HIV & AIDS for the Church in Mozambique 86

_Geoff Foster, Carina Winberg, Earnest Maswera, Cynthia Mwase-Kasanda_
8. Challenges and Possibilities of Religious Health Assets: Charting an Islamic Response to the HIV and AIDS Pandemic 105

*Muhammad Khalid Sayed*

- Introduction 105
- Potential Problems of an Orthodox Islamic Response to HIV and AIDS 107
- Islamic Marriage and the Risk to Women of Contracting HIV 108
- The ‘Islam-centred’ Response by Positive Muslims to HIV and AIDS 110
- Islamic Jurisprudence for an Orthodox-Centred Response Effective Against HIV and AIDS 111
- Conclusion 116

9. Tough Negotiations: Religion and Sex in Culture and in Human Lives 118

*John Blevins*

- PIRASH Workshops: The Research Findings of a New Methodological Tool 119
- Findings from the Workshops 120
- Conclusion from the Workshops and Further Questions 122
- Christian Theology and Sexuality 123
- Religion, Sexuality and Identity 124
- Critiquing Modern Power, Grounded in Social Justice 127
- Towards Religious Communities with many Sexual Subjects 129

10. On the Pedagogy of HIV and AIDS: Conversations with Indigenes 135

*Sepetla Molapo*

- Introduction 135
- On the Pedagogy of HIV and AIDS: A Brief Overview 136
On Defeated and Contaminated Blood: Understanding the Causes of HIV and AIDS among Indigenes 139
What about Safe Sex? Indigenes on Sex that Involves the Use of Condoms 142
Concluding Remarks 145

Section 3
Practice

11. Trustworthy Intermediaries: Role of Religious Agents on the Boundaries of Public Health 150
James R Cochrane
Introduction 150
The Context 151
The Challenge 152
Building Trustworthy Intermediaries 155
Assessing GSOs, and Beyond 158
Conclusion 160

12. The Relevance of Healthworlds to Health System Thinking About Access 164
Lucy Gilson
Introduction 164
Understanding Access and Addressing Access Barriers 165
Unpacking Acceptability 167
Bridging the Worlds of Patients and Providers: What Role for Trust? 170
What are the Implications of These Insights for Improving Health Care Access? 173
To conclude 176

Frank Dimmock with Tali Cassidy
Introduction 178
Method of CHAs Study 179
Historical Background of CHAs 179
14. The Memphis Model: ARHAP Theory Comes to Ground in the Congregational Health Network

*Teresa Cutts*

Introduction 193
The Memphis Landscape 194
Theories and the Logic Model 195
Covenant Committee Design 199
Programme Expansion and Structure 200
Evaluation of CHN 203
Early Mapping Efforts and Data Snapshots 204
Summary and Lessons Learned 206

Section 4

**LOOKING BEYOND AND AHEAD**

15. Frontiers of Public Health and Social Transformation: Faith at the Table

*Katherine Marshall*

Setting the Scene 212
Caveats and Definitions 214
Navigating Disconnects and Tensions around Religion and Development 215
Trends in International Development, Faith, and Health 220
Faith and Health: Moving towards More Concrete Action 224
Malaria and Faith – A Case Study 228
Ideas on Paths Forward 231

Index 235
Chapter Seven

A Purpose-Driven Response: Building United Action against HIV & AIDS for the Church in Mozambique

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Introduction

Local churches and their coordinating bodies throughout the world are increasingly establishing responses to HIV and AIDS. The Catholic Church, for example, is thought to sponsor one quarter of all HIV and AIDS-related services worldwide (Barragan 2006:4). Throughout Africa, religious structures are extensive, ever-present, influential and linked to surrounding communities. In some countries, over half the churches have established an HIV and AIDS response whilst two-thirds of community-level HIV and AIDS responses in Zambia were faith-related (ARHAP 2006:56; Yates 2003:16; UCAN 2003:14).

Governments and their partners now recognise the important role played by faith communities with regard to HIV and AIDS initiatives and look to them and their leaders for help in formulating responses. There has been a resurgence of interest in the developmental role of faiths by international agencies and donor scepticism is being replaced by active interest to work with them in responding to the pandemic. Foundations and private sector partners are exploring new forms of partnership with the faith sector and some bilateral organisations now focus explicitly and centrally on the role of faith institutions (Edwards & Sen 2002:46; James 2009:6; World Bank 2007).

Yet church HIV and AIDS initiatives are rarely developed through strategic planning processes. Most are small, isolated responses driven by need; they are largely self-resourced, unconnected to government structures and not aligned with national plans of action. Most church responses have weak monitoring systems, are poorly connected to
networks of best practice, lack documentation and do not engage in advocacy. Many fail to expand, in part because church leaders lack the information and skills necessary to acquire resources. In the past, few church initiatives sought to engage with policy makers to influence the development of HIV and AIDS strategies, with the notable exception of their opposition to indiscriminate condom promotion, a pointer to their potential to engage in advocacy (Foster 2009b). Coordination networks of church HIV and AIDS initiatives exist but many are small and ineffective, contributing to the lack of alignment of church HIV and AIDS responses with national strategic plans and to lack of dialogue by the faith sector with governments concerning HIV and AIDS policies and strategies. As a result, both national and international policy engagement by faith-based organisations (FBOs) is fragmented and there is little profile of faith-based HIV responses (Foster 2008; PACANet 2008).

In recent years, better understanding of church and faith-based HIV and AIDS responses has developed as a result of mapping studies by scholars and researchers (ARHAP 2006; Nussbaum 2005); national situation analyses (ARHAP 2008; Munene 2003; Parry 2002; Parry 2005; UCAN 2003; Yates 2003); policy studies ( Tearfund 2006; Woldehana et al. 2003); assessments of funding (DIFAEM 2005); multi-country analyses of AIDS, orphans and vulnerable children responses (Foster 2004; Lux & Greenaway 2006); reviews (Liebowitz 2002); and bibliographies (CHART 2009; Family Health International 2002; Olivier et al. 2006). Nevertheless, there remains a considerable lack of information about the nature, scale and scope of religious activities on HIV and AIDS, especially at local level.

The goal of this study was to enable better understanding of the characteristics of church HIV and AIDS initiatives in Mozambique, utilising the perspectives and experience of the churches, NGOs and other partners. The study aimed to strengthen the impact of church-based responses through developing a joint church HIV and AIDS strategy, and by improving church collaboration, co-ordination and access to technical capacity and resources. It sought to raise the profile of church HIV and AIDS responses by means of harnessing evidence and bridging the divide between the sacred and secular bodies dealing with the pandemic.

BACKGROUND

Mozambique was a colony of Portugal for 470 years, during which time the official religion was Catholicism. In the colonial period, the majority of Mozambicans adhered to traditional African religions; Protestant ministries existed in restricted numbers and with small impact. In 1975, Mozambique gained its independence from Portuguese rule and the ruling Frelimo government adopted Marxism-Leninism as its guiding philosophy. Missionaries were expelled and Christians suffered intimidation and imprisonment. Since 1988 there has been formal
religious freedom in Mozambique, which has since experienced the fastest church growth of any sub-Saharan African country (see Figure 1) (Johnstone 2003).

By 2000, 58% of the population of Mozambique had become Christian, belonging to some 10,000 congregations and 500 denominations. Over half the congregations are not affiliated to existing denominations. These independent churches are the fastest growing sector of Christianity. Both the Catholic Church and independent churches have over 4 million adherents each or nearly half the population in total, whilst Protestant denominations have some 1.6 million adherents (Johnstone 2003).

Mozambique has one of the worst HIV and AIDS epidemics in the world. Its Ministry of Health estimated in 2007 that 1.8 million people were living with HIV, the adult prevalence rate was 16% and that the epidemic was getting worse (Reference Group for Prevention 2008:1).

METHODOLOGY

A convenience sample for the study consisted of 40 local church leaders (38 male, 2 female) from the cities of Maputo, Beira and Chimoio. Intermediary FBOs involved in the provision of technical or financial support to CBOs identified local churches in the study. Data was also collected from FBOs (14 respondents), denominations and network organisations (six respondents) and resource and policy organisations (six respondents). Data collection tools were developed during a prior study of church HIV and AIDS responses in Zimbabwe conducted by one of the authors, Geoff Foster, with the support of a grant from the Kellogg Foundation.

Questionnaires were completed during focus group discussion (FGD) meetings attended by an average of 12 participants per meeting. Four

Figure 1: Changes in religious affiliation in Mozambique, 1900 – 2010 (Johnstone 2003)
meetings consisted predominantly of church leaders, whilst two FGDs consisted mainly of NGO staff. After data analysis, findings were fed back to stakeholders during three workshops leading to the development of strategic recommendations.

**Results**

Local churches had an average of 186 members (range 30 – 580) and two-thirds were affiliated to a denomination; 55% of the pastors were trained for an average of 2.9 years, the remaining ones were untrained.

*Church HIV and AIDS-related Activities*

Most churches relied on volunteers to conduct HIV and AIDS activities, with an average of 24 volunteers per church (range 0 – 106) involved. Respondents were asked to identify which of 13 possible activities they were engaged in, categorised according to Tearfund’s (2006) five strategic areas of engagement. Churches engaged on average in 10 HIV and AIDS-related activities (range 4 – 13), the most common being home visits to orphans and the chronically ill, teaching and marriage counselling (see Figure 2). Most activities were informal responses, part of existing church activities, rather than organised programmes. Activities were supervised through existing church structures and supported through established mechanisms rather than being conducted as separate projects with specific co-ordination and reporting. The study did not attempt to assess the amount, quality or impact of activities.

**Figure 2: HIV and AIDS activities implemented by churches in Mozambique (n=38)**

<table>
<thead>
<tr>
<th>Strategic area</th>
<th>% of congregations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Children affected by HIV and AIDS</td>
<td></td>
</tr>
<tr>
<td>2. Treatment support for people living with HIV &amp; AIDS</td>
<td></td>
</tr>
<tr>
<td>3. Prevention of mother-to-child transmission</td>
<td></td>
</tr>
<tr>
<td>4. Stigma reduction against those affected</td>
<td></td>
</tr>
<tr>
<td>5. Youth and behaviour change</td>
<td></td>
</tr>
<tr>
<td>home visits</td>
<td></td>
</tr>
<tr>
<td>material support</td>
<td></td>
</tr>
<tr>
<td>accommodation</td>
<td></td>
</tr>
<tr>
<td>home visits</td>
<td></td>
</tr>
<tr>
<td>counseling</td>
<td></td>
</tr>
<tr>
<td>material support</td>
<td></td>
</tr>
<tr>
<td>marriage advice</td>
<td></td>
</tr>
<tr>
<td>women's group</td>
<td></td>
</tr>
<tr>
<td>VCT promotion</td>
<td></td>
</tr>
<tr>
<td>teaching</td>
<td></td>
</tr>
<tr>
<td>support groups</td>
<td></td>
</tr>
<tr>
<td>youth</td>
<td></td>
</tr>
<tr>
<td>income generation</td>
<td></td>
</tr>
</tbody>
</table>

**Strategic area**

1. Children affected by HIV and AIDS
2. Treatment support for people living with HIV & AIDS
3. Prevention of mother-to-child transmission
4. Stigma reduction against those affected
5. Youth and behaviour change
Changes in Engagement with HIV and AIDS

Most HIV and AIDS responses were established recently, 18 out of 34 (53%) in the preceding four years (see Figure 3). Two factors, discussed below, have contributed to recent engagement of churches in HIV and AIDS activities.

First, members of congregations—in some cases, leaders—had died of AIDS. This led to a change in the attitudes and practices of church leaders concerning HIV and AIDS. Pastors became aware that HIV and AIDS was a problem within their church. They realised that their previous responses, such as condemning the behaviour of people who had contracted HIV, was inappropriate. Pastors became less judgmental towards people living with HIV and AIDS and some established compassionate responses.

Second, respondents observed increasing numbers of children being orphaned as parents died from AIDS. The dire situation facing many orphans had increased awareness of the epidemic among pastors, resulting in churches engaging in more compassionate HIV and AIDS responses.

Religious leaders are important in facilitating church HIV and AIDS responses, acting as ‘gatekeepers’ who facilitate or impede the responses of church members to HIV and AIDS. Religious leaders at denominational level had on occasion in the past discouraged church pastors from developing HIV and AIDS responses.

Prevention and Condom Promotion

In the early responses to the pandemic, most churches were involved in HIV prevention activities through regular Christian meetings, such as weekly congregational teaching and preaching, youth and women’s groups meetings. Churches frequently discussed risk avoidance behaviours, such as abstinence and faithfulness. Preventive counselling took place during pastoral and marriage counselling conducted by
Church leaders. Preventive activities also involved discussion of the benefits and use of condoms and the desirability of knowing one’s HIV status through accessing voluntary counselling and testing.

Church leaders frequently raised issues relating to HIV prevention during FGDs. Some pastors now embraced AIDS as an important issue, which they saw as their ‘own.’ They often spoke about the disease, including 5-minute mini-sermons about HIV during weekly meetings. Other church leaders, even though trained in technical aspects related to HIV, had difficulty talking publicly about HIV and AIDS; their difficulty related to the sensitive nature of issues relating to sexual intimacy, leading them to avoid any specific mention of HIV and AIDS in public.

Church leaders had focused in the past on promoting abstinence and marital faithfulness because of their Christian belief that sexual intercourse should be conducted only within marriage relationships. In recent years, risk reduction approaches involving the use of condoms have been advocated for HIV prevention. Pastors frequently mentioned condom promotion during FGDs, sometimes acknowledging condom use as an acceptable risk reduction strategy. However, most church leaders felt unable to mention condom use during public Christian meetings. Churches are still not involved in condom distribution though some advise condom use during private counselling sessions. During the FDGs, pastors expressed their discomfort discussing sexuality and several requested training in issues related to HIV prevention.

Leaders believe that national HIV prevention strategies administered by government and international organisations have not stressed ‘A’ (abstinence) and ‘B’ (being faithful) ‘risk avoidance’ messages and behaviours, focussing instead excessively on the ‘C’ (condoms) ‘risk reduction’ component of prevention. They expressed concern that this encourages risky behaviours, such as pre-marital and extra-marital sex. Leaders believed that inappropriate promotion of condoms through public channels such as billboards, literature, radio and television have contributed to increasing commercial sexual activity and youth engagement in premarital sex, an observation consistent with previous studies on prevention strategies (Pfeiffer 2004:90).

Motivation and Resources

Church leaders felt that more resources should be channelled to beneficiaries, especially to orphans and vulnerable children. They were critical of NGOs and FBOs that received donated resources but spent these within their own organisations without directly benefiting affected communities and households. Organisations engaged in condom promotion were singled out for criticism because they were believed to be profiteering at the expense of local responses. Leaders believed they played an important role in monitoring the use of external HIV and AIDS resources at community level.
Respondents were concerned that externally funded projects failed to provide holistic services and undermined the sustainability of community-level HIV and AIDS responses. They contrasted the financial motivation of NGOs with the humanitarian motivation of church responses. According to them, well-resourced external agencies were able to choose local organisations as partners and remunerate volunteers, but in so doing were likely to undermine the sustainability of locally run initiatives that carried out similar activities using the services of volunteers who received no material reward. Some charged that pastors were being ‘stolen’ from churches and employed by FBOs to deliver HIV and AIDS programmes in the community. Leaders believed that church HIV and AIDS-related activities were hampered by lack of resources and recommended that churches join in consortia and submit joint applications to obtain resources. As noted in previous studies, respondents recommended that international and donor FBOs focus on strengthening local church capacity to implement and run church programmes (Pfeiffer 2004).

Needs

In considering their need to strengthen HIV and AIDS-related activities, respondents prioritised training in administration and in HIV and AIDS (see Figure 4). Few respondents had received any training and where provision had occurred, it was often considered inadequate, as it was...
done without resource materials or follow-up support and failed to cover priority areas such as stigma and discrimination. Respondents expressed acceptance at receiving training from secular organisations provided these were sensitive to church values and beliefs. However, religious leaders preferred training on HIV and AIDS ‘on-the-job’ or through institutions incorporating their own theological perspectives. No church received training on HIV and AIDS from its own denomination. Money and networking were identified as other priority needs to strengthen church HIV and AIDS responses.

Networking, Technical and Financial Support

Most churches involved in HIV and AIDS-related activities did not receive external support and were not part of supportive networks. Only eight churches (20%) belonged to a network that provided them with support for their HIV and AIDS activities.

Respondents in the study identified 15 organisations that supported and networked church and FBO HIV and AIDS responses. There are several categories of organisation involved in faith-based networking. Some NGOs have been established specifically to network HIV and AIDS responses, including national and Christian HIV and AIDS network organisations. FBOs, both international and local, provide technical support and network church partners as part of the HIV programmes which they administer. Some religious bodies co-ordinating religious activities of churches and denominations have also established HIV and AIDS networks. These include denominations co-ordinating member churches and national religious councils co-ordinating denominations. Christian donors have established HIV and AIDS networks involving their faith-based partners. The study did not assess the effectiveness of church HIV and AIDS networks.

Only 12 churches (30%) received any external technical or financial support in the form of training (58% of these), money (42%), visits (42%), advice (33%), information (8%) and material support (8%). Churches provided details concerning their sources of support—money or in-kind contributions—for their HIV and AIDS-related activities. Overall, 87% of churches conveyed that member contributions were an important source of support or had some importance in this regard (see Table 1). Local contributions from businesses or through fundraising provided small amounts of support to one-third of churches. External support from donors, denominations or government sources provided support for one quarter of churches, but this was an important source for only five churches. Even though most churches belonged to a denomination, only one mentioned this as a source of support.
**Table 1: Proportion of churches that identified different sources of support**

<table>
<thead>
<tr>
<th>Source of support (e.g. money, food) for HIV and AIDS activities</th>
<th>Degree of importance of support from this source</th>
<th>No support from this source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member contributions (e.g. church offerings)</td>
<td>Important: 59%</td>
<td>Slightly important: 28%</td>
</tr>
<tr>
<td>External support (from outside community)</td>
<td>Important: 15%</td>
<td>Slightly important: 10%</td>
</tr>
<tr>
<td>Local businesses and fundraising</td>
<td>Important: 0%</td>
<td>Slightly important: 34%</td>
</tr>
</tbody>
</table>

Policy and Advocacy

Religious leaders in the study noted three main areas of policy concern:

- **Prevention:** Respondents were concerned about the strong focus on condom promotion in programmes delivered by government and international organisations and a corresponding lack of emphasis on risk avoidance behavioural approaches.

- **Orphans:** Respondents believed that a greater proportion of HIV and AIDS resources should be utilised directly to support people affected by HIV and AIDS, especially orphans and vulnerable children. They expressed concern that children affected by HIV and AIDS were dropping out of school because their households were not being provided with adequate external support.

- **Resources:** Respondents were concerned about the inappropriate use of external HIV and AIDS resources. An example given was the use by some organisations of expensive vehicles to conduct brief and occasional field visits and training that was seen as inappropriate in addressing the needs of communities.

Informants noted that HIV and AIDS policies in Mozambique were largely driven by government and donors with little involvement of civil society. The study suggested another reason why engagement of churches in HIV and AIDS policy dialogue was ineffective—the low priority given by churches and FBOs to influencing government and donor HIV and AIDS policies combined with their lack of effective consultative processes. One seat on the Country Co-ordinating Mechanism (CCM) for the...
Global Fund for AIDS, TB and Malaria is reserved for an FBO. The organisation that was selected initially to represent the faith community was replaced by another FBO, however, because of its failure to attend CCM meetings. The lack of policy engagement with government and donors by the faith sector reduced the profile of church HIV and AIDS responses in Mozambique and weakened advocacy efforts by civil society as a whole.

**Discussion**

This study and its conclusions are presented recognising the limitations of this rapid assessment. Most church respondents were from urban Evangelical, Pentecostal, Charismatic and Independent churches connected to intermediary organisations implementing HIV and AIDS-related activities. These churches were probably more likely to implement such activities than rural churches not connected to organisations with HIV and AIDS programmes. Although the sample does not represent a cross section of church responses to HIV and AIDS in Mozambique, the study nevertheless provides some important insights into church responses in this regard.

Driven by compassion and a devotion to their faith, churches have established health and HIV and AIDS responses that are both culturally sensitive and influential in the lives of the local people. These solutions vary widely in scope and scale. Whilst some of the projects addressing the pandemic were professionally run, most were homegrown, community-based initiatives implemented by congregations serving small numbers of beneficiaries.

In this survey, every church involved had established an HIV and AIDS response, 20% belonged to an HIV and AIDS support network, with 12% receiving funding from an external organisation. Most church responses took the form of informal activities conducted as part of mainstream church activities.

The findings were similar to studies of church HIV and AIDS responses in other African countries. In three other such national studies, 34 – 87% of churches had established HIV and AIDS responses, most of which were ‘basic,’ characterised by lack of committees, work plans or external funding, a small number had fully functioning HIV and AIDS programmes with dedicated staff, developed work plans and sources of external funding (see Table 2 data from UCAN 2003; Weekes 2007; Yates 2003).
Mobilising Religious Health Assets for Transformation

<table>
<thead>
<tr>
<th>Country</th>
<th>Number churches</th>
<th>Church HIV &amp; AIDS response (%)</th>
<th>Level of HIV &amp; AIDS response (%)</th>
<th>Receive funding (%)</th>
<th>No network (%)</th>
<th>Support from network (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uganda</td>
<td>223</td>
<td>68</td>
<td>68 28 5</td>
<td>28</td>
<td>42</td>
<td>29 18 10</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>353</td>
<td>34</td>
<td>53 37 10</td>
<td>23</td>
<td>54</td>
<td>24 18 3</td>
</tr>
<tr>
<td>Namibia</td>
<td>95</td>
<td>87</td>
<td>32 38 30</td>
<td>21</td>
<td>61</td>
<td>19 20</td>
</tr>
<tr>
<td>Total or Av. %</td>
<td>671</td>
<td>53%</td>
<td>55% 34% 11%</td>
<td>25%</td>
<td>51%</td>
<td>25% 24%</td>
</tr>
</tbody>
</table>

*Table 2: National surveys of church HIV responses* [In the final column, the results for ‘Namibia’ and ‘Total’ combines ‘some’ and ‘strong’ support]

The study illustrates some of the strengths and weaknesses of churches in responding to the epidemic that have been documented elsewhere (Foster 2009b) as illuminated by the following discussion.

**Sustainable Community-Based Responses**

Churches are rooted in communities and interact with people over everyday issues—births, children, marriages, deaths, health, poverty, family relationships and psychosocial support in times of crisis. Churches frequently respond to HIV and AIDS because of contact with affected people in the course of such interactions. Many church initiatives are reactive rather than being strategically planned and are isolated rather than working alongside other organisations involved in HIV and AIDS activities. Initial responses of churches to HIV and AIDS often involve teaching marital faithfulness through ongoing worship of the congregants, youth and women’s meetings and mitigation of impact through regular activities of home visiting, charitable support and counselling. As church HIV and AIDS responses increase, they may develop into specific church projects with committees, budgets and trained volunteers (Yates 2003:16-18).

Whilst the involvement of external organisations in HIV and AIDS is often driven by the availability of financial resources, church responses are usually motivated by local needs, relying on locally raised resources to meet them (Kelly & Birdsall 2007:188). This augurs well for the sustainability of church HIV and AIDS-related activities, even in the face of increasing need.
Impact Mitigation

A previous study in Mozambique found that churches were minimally involved in the provision of assistance to people affected by HIV and AIDS and that most assistance was directed toward non-church members; this assistance consisted of psychological support, personal care and household help rather than material or financial help (Agadjanian & Sen 2007:362). The current study found that most churches were involved in home visits and material support for the chronically ill, including people living with HIV and AIDS and children affected by it.

Many people living with HIV and AIDS (PLWHA) face discrimination from family members and health workers. Churches have also contributed to stigma by segregating PLWHA within their congregations. The theological beliefs of church leaders concerning the disease influence how they relate to people living with it and whether the church will support them. Some religious leaders believe that HIV and AIDS is a divine punishment against those who behave promiscuously and who do not comply with religious precepts. As a result, some Mozambican pastors engaged in ‘aggressive preaching,’ teaching their members not to associate with people living with the disease because they represent ‘bad examples’ (CNCS 2004).

Increasing engagement by church leaders in HIV and AIDS activities is linked to their changing perceptions. Pastors are recognising that their judgmental attitudes and condemnatory preaching in the past had contributed to marginalisation of people living with the disease, but as church leaders came to realise that faithful wives, innocent children and ‘model’ church members and even relatives could also be infected with HIV, many have begun to modify their judgmental theological viewpoints, leading their churches toward compassionate and caring responses.

Promotion of Behaviour Change

Surveys show that risky sexual behaviour in Mozambique is higher than in other southern African countries and has increased in the past decade, confirming the observations of church leaders (UNAIDS 2008; Annex 2, Table 16). ‘A’ (abstinence) and ‘B’ (being faithful) risk avoidance behaviours have been associated with reductions in HIV incidence and prevalence in Uganda, Kenya and Zimbabwe (Green et al. 2006; Gregson et al. 2006; Stoneburger & Low-Beer 2004). Policymakers in Mozambique recognise that behavioural interventions are not being adequately delivered to young people and those in concurrent sexual partnerships (DFID Mozambique 2008:2-3).

Recent policy statements, however, fail to mention clear ‘A’ or ‘B’ risk avoidance strategies. Three Mozambican HIV strategy and prevention statements focus on condom promotion and risk reduction in high risk group settings but fail to mention strategies to discourage pre-marital
sexual activity or remain faithful to one’s sexual partner (CNCS 2004; DFID Mozambique 2008; Reference Group for Prevention 2008). One statement addresses behaviour in a tangential way by including an arcane recommendation on avoiding multiple concurrent partners to ‘reduce the density of sexual networks’ (DFID Mozambique 2008). The behavioural strategy of the national strategic plan focuses narrowly on ‘enhancing the negotiation capacity of adolescents and youths with a view to postponing the onset of sexual activity as well as the capacity of sex workers to use condoms’ (CNCS 2004). ‘Sexual partner’ language is used throughout the statements; terms such as ‘marriage,’ ‘husband,’ ‘wife,’ ‘spouse’ or their equivalents do not appear in any statement, even though the Mozambican government has ratified the Universal Declaration of Human Rights, which obliges it to protect marriage rights and ‘uphold the family as the natural and fundamental group unit of society’ (United Nations 1948). The perception of church leaders that policymakers undermine the Christian view of marriage through statements that reinforce multiple pre- and extra-marital sexual partnerships hence seems justified.

National HIV prevention efforts have failed to engage with churches that are well placed to provide regular, effective HIV prevention activities to two key target populations, youth and people in regular sexual partnerships. Religious belief is an important determinant of sexual behaviour (Garner 2000; Wawer et al. 1996). Churches can promote sexual behaviour change especially abstinence, delay in onset of sexual debut, promotion of mutual fidelity and reduction of the number of sexual partners through risk avoidance strategies that discourage pre-marital and extra-marital sexual activity (Green 2003:16). Church involvement in national HIV prevention efforts can promote ‘A’ and ‘B’ risk avoidance behaviours and address barriers to overcoming the implementation of ‘C’ (condoms) strategies.

Capacity Limitations

Though churches can make unique contributions to HIV and AIDS responses, their initiatives are characterised by underlying weaknesses that limit their effectiveness. Church leaders identified the following as the three most important needs to develop HIV and AIDS responses: training in administration, training in HIV and AIDS and external funding. These are similar to priorities identified by churches in a Namibian study (Yates 2003:32). Mozambican church responses were typified by two contrasting characteristics. An almost unanimous request for training was matched by an almost complete absence of external support. Only 17% of churches had received HIV and AIDS-related training, the content of which was not always relevant.

What is required is a massive scale-up in provision of training for churches at congregational and denominational level. Denominations, noticeably absent in the provision of training to churches, are those
potentially capable of providing member churches with appropriate long-term support. Whilst networks and local NGOs are well placed to provide support to some churches, international NGOs may be better placed to build the capacity of denominations that can support their networks of member churches.

Most churches rely on contributions from members to support their HIV and AIDS responses. Consequently, they have limited capacity to meet the needs of those affected by HIV and AIDS. The current study found that few churches received government or donor grants. Donors made a small number of large grants to NGOs whilst smaller community-led initiatives largely failed to access external support. A survey of 66 civil society organisations involved in HIV and AIDS responses found that 10% of them accounted for 87% of the funds allocated in Mozambique (Kelly & Birdsall 2007:64). Though funds have been made available to support civil society HIV and AIDS responses, the experience of many churches is that funding is difficult to access even after considerable commitment has been demonstrated on their part (Taylor 2005:15).

Ironically, according to government sources, where FBOs manage to obtain funds, their reporting of expenditures is often better than that of comparable secular organisations (World Bank 2007:16).

The amount of money required by churches is often too little to source through conventional mechanisms. There is need for the development of innovative funding mechanisms and for external organisations to help build the capacity of local church HIV and AIDS responses through provision of appropriate technical and financial support.

Lack of Networking

Few churches in the study received support from one of the many faith-related HIV and AIDS networks operated by denominations and NGOs. Networking of churches engaging in HIV in Mozambique is characterised by inadequate coverage and poor support. Most networks are small and ineffective in strengthening the institutional and organisational capacity of church response programmes. Most networks did not co-ordinate their activities with other networks. There is need for more co-ordinated faith-based responses that can assist capacity building, resource allocation and advocacy. Building HIV and AIDS networks of best practice for churches through existing structures is an appropriate strategy since most churches in the country are aligned with denominations. For independent churches with emerging responses to the pandemic, the establishment or strengthening of networks administered by NGOs may be a more appropriate response.

The lack of representative structures to bring together different church HIV and AIDS networks represents a significant lack in Mozambique and has contributed to the low profile of faith-based responses. Collaboration of networking organisations could strengthen church responses through co-ordinated provision of training and
financial support. Possible strategies for strengthening networking include further study of organisations engaged in networking churches and FBOs; assisting the coordination of existing networks; building collaborations between networks through advocacy and policy initiatives and strengthening provincial networking through supporting the activities of existing organisations engaged in networking.

Lack of Policy Engagement

In Mozambique, churches have had little influence on national HIV and AIDS strategies and policies. Church leaders expressed strong views on this issue, especially in relation to a prevention strategy, orphan support and resource provision; they believed they could make important contributions to policy processes and local practices. However, there are currently few mechanisms for public participation through which churches can develop policy formulations and through which these can be represented at national level. Churches also lack capacity and ‘know how’ to engage in advocacy initiatives.

A small number of countries have made headway in engaging churches in national HIV and AIDS policy responses. In Lesotho, 14 church leaders developed a consensus statement of commitment on AIDS following a workshop organised by World Vision, Catholic Relief Services and UNAIDS (Foster & Winberg 2009:70). Guyanan churches organised a national conference, established a national faith and HIV and AIDS coalition, developed a declaration of commitment and policy guidelines and established a mechanism through which churches can influence national policies and strategies (Foster & Winberg 2009:35).

However, throughout most of Africa, there is a lack of national inter-church mechanisms to enable ecumenical co-ordination on HIV and AIDS, to develop faith-based national strategic plans and to influence national policies and strategies.

The strengthening of church co-ordination structures effectively to address the pandemic is a prerequisite for church involvement in national advocacy and policy development. Given the fact that a majority of HIV and AIDS responses are faith-based in some countries, such initiatives in sub-Saharan African are overdue.

CONCLUSION

The current study led to the development of recommendations, outlined above, to strengthen faith-based responses to HIV and AIDS. Feedback of these recommendations to stakeholders led to the establishment of a working group with representatives from denominations, local churches, networks and donors to take these forward. The working group participated in the process of developing a new national HIV and AIDS strategic plan for Mozambique by providing submissions from the faith sector. The momentum created through the study caught the attention
of some key agencies responding to HIV and AIDS in Mozambique, leading to an invitation to submit a proposal to develop a strengthened, co-ordinated and resourced church HIV and AIDS coalition. This has resulted in a submission to develop a pilot for replication by churches; through this, they would access antiretroviral treatment initiatives as well as a prevention initiative among church leadership. The latter aims to raise awareness of HIV transmission and vulnerabilities, to increase awareness about safer sex practices and to implement effective behaviour change programmes.

The faith community represents an important, but as yet under-utilised, constituency for HIV and AIDS mitigation and prevention efforts. Government and international partners increasingly recognise that faith leaders and institutions are key actors. Churches are increasingly engaging in appropriate responses to HIV and AIDS and represent potentially powerful allies in Mozambique’s HIV and AIDS strategy. What distinguishes the work of churches and makes them invaluable for the national HIV and AIDS strategy, is their connection with local communities, their ability to reach the poorest who fail to access formal health infrastructure and their sustainability. However, the capacity of church HIV and AIDS responses is severely limited since few churches receive external support or participate in local networks.

This study has provided information about the nature and extent of faith-based HIV and AIDS responses in Mozambique. In addition, the process of involvement by churches, FBOs and secular organisations in the study facilitated the establishment of ongoing collaborations and helped strengthen church HIV and AIDS networks. In order to achieve universal access to treatment for the disease and its prevention, it will be important to further engage with the faith sector and strengthen its HIV/AIDS networking activities and policy engagement with regard to HIV and AIDS.

REFERENCES


