

Faith communities' contribution to scaling up HIV and AIDS responses:

What's happening in SADC

An ARHAP view

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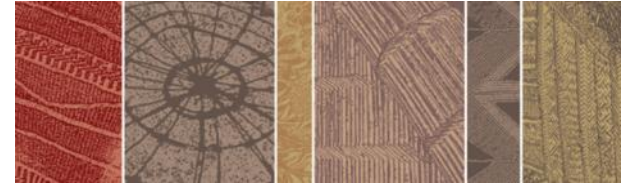


Structure

- **Research initiatives**
- **Overview/general findings**
- **HIV Services**
 - Prevention
 - Treatment
 - Care / impact mitigation
 - Advocacy
- **Funding**
- **Networking**
- **Best practices**



Research initiatives



- **ARHAP**
- **WCC** – EHAIA mapping studies
- **CHART** at UKZN
- **JLICA** Joint Learning Initiative on Children & HIV/AIDS; **JLIFA** (FBOs & AIDS) to launch soon

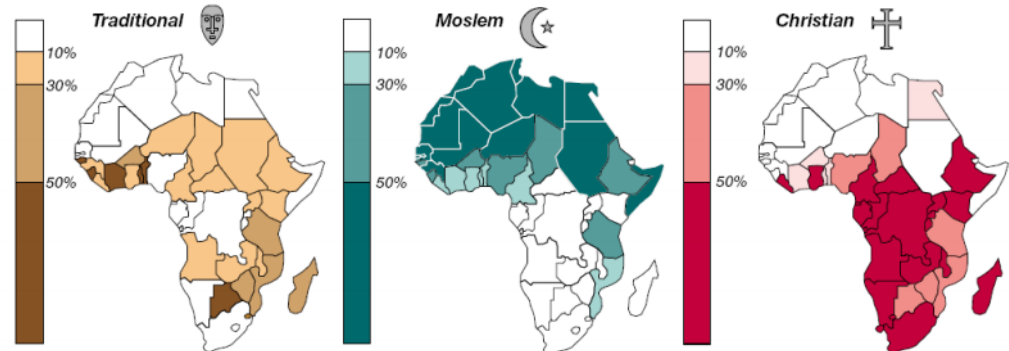
The trend is to work interfaith - get the whole picture.

Include African Initiated Religions and Traditional Healers

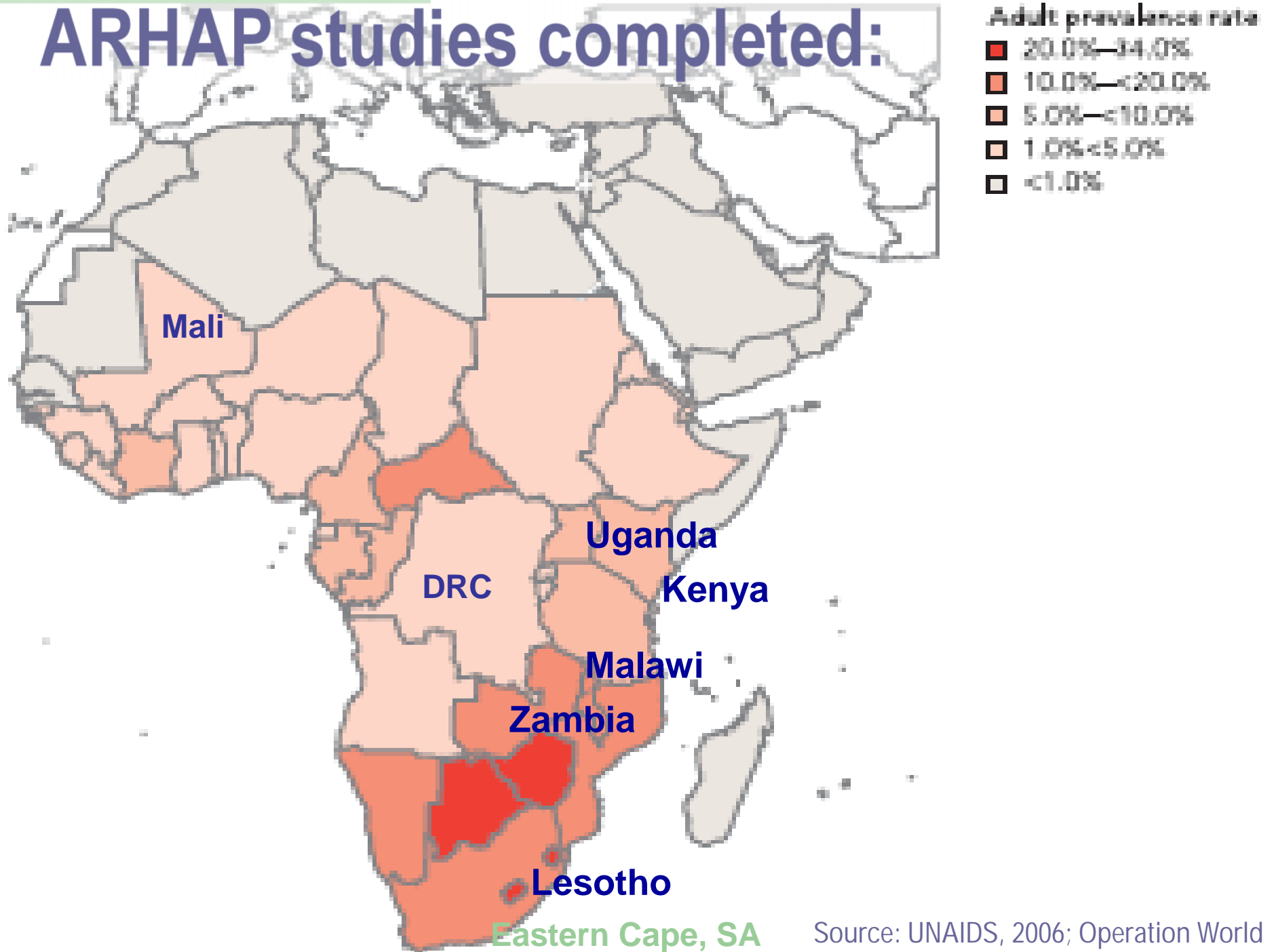
Inclusive term: Religious entity (RE)

What's happening in the faith-based sector in SADC? (I)

- Contribution to health (and HIV) **varies considerably**
- In part due to differences in predominant **religions**
- Also colonial **history** and current **policy**
- Between countries from 2 – 50% of health service
- Within countries: urban-rural
- Many faith-based initiatives are local



ARHAP studies completed:



What's happening in the faith-based sector in SADC? (II)

- It is common for congregations in the “AIDS belt” to offer some HIV/AIDS activities; eg Namibia 87%
- They draw on tangible and intangible assets
- **Facility based** services play important role: provision of ART & treat HIV opportunistic infections
- Concern about impact of **vertical AIDS services** & funding on the health system
- **Non facility based** service provision by REs is HUGE: small local groups provide HBC, OVC
- Mixing of bio-medical, traditional & faith healing is very common, mostly hidden

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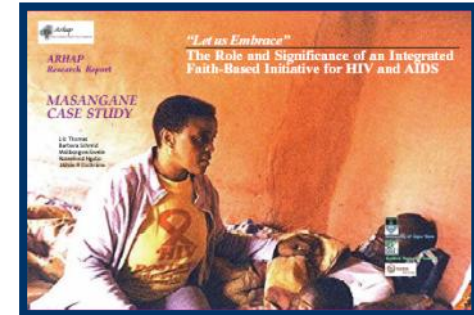


HIV Services: Prevention

- **Wide range of activities**
- **Target groups** mainly youth, women – what about children, men?
- **Focus** on AB(c) – some shift to SAVE
- What is appropriate for Africa & who decides
- Difficulty of addressing Sexuality
- Persistence of stigma
- Role of religious leaders - SADC??
- Role of traditional healers as partners vs AIDS



Treatment



- FB facilities offer treatment – OI (and ART); also VCT
- **Innovative treatment models:**
 - Eg SACBC & Masangane Moravian AIDS programme
- Openly positive role models – **Lazarus effect**
- Value added of religion? **God's sanction** for ART
- ART too expensive for most; but REs can offer Treatment literacy & Adherence support
- Role of **religious leaders** is contested
- **Treatment mixing** - plural health worlds

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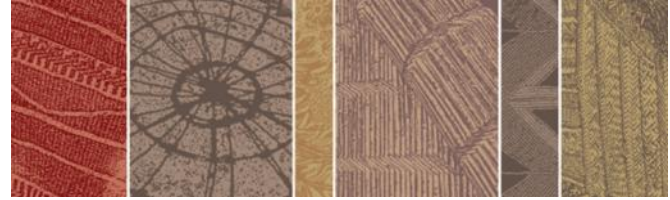


Care / impact mitigation



- **Big big** role of the faith community,
- Traditional role for REs – still the mainstay of their responses
- Can mobilize **volunteer** spirit
- Differs according to religion and denomination
- **Lack of local coordination** even competition between actors – “All want to count Lucy”
- **Lack of skills**
- Crucial role of intermediaries, but too few of them

Advocacy



- Some religious leaders are models, but too few
 - ANARELA, Desmond Tutu, Kevin Dowling
- Operates mainly at the national leaders' level
- Strong statements difficult to turn into action eg EHAIA Plan of Action
- Addressing HIV & AIDS is complex: poverty, gender, justice,
- Is often politically complex, church too close to state
- Local relig leaders are overwhelmed by this – but can play role in advocacy to their followers

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Funding



- FBOs are used extensively for care and support – no figures for their contribution
- **79% of FBOs received no external HIV/AIDS funding (Namibia)**
- Availability of funding for HIV or AIDS entices initiation of projects - but often unsustainable
- “Abuse” by PEPFAR and other funders
- Lack of skills for sustainability – Intermediaries!
- Few offer treatment – too expensive
- Mission hospitals – not getting what they need too maintain facilities, staff and service

Networking & collaboration

- Traditionally REs work in (confessional) isolation;
 - the enormity of AIDS is bringing them together.
 - **Yet** 60-90% of FBOs in Namibia are not part of an HIV network.
- Collaboration with MoH common esp for facility-based; **Yet** they often compete for staff & donor funds
- Need tri-partite partnership between: REs, Governments, International agencies

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Best practices for Scaling up

- *Prevention:*
 - need for faith leaders to be role models
 - Open talk on sex - Masangane
- *Treatment:*
 - Any purchase on the Masangane quick entry model
 - Can FBO sector step in re short term drug shortages
 - Need to move to HIV to build the health system – rather than vertical programmes - how??
- *Care and support:*
 - intermediaries needed for sustainability,
 - need for local co-ordination & support
- *Advocacy:*
 - when vulnerable groups are prejudiced
 - also for strong health system



Examples of Best practices

- Don't undermine other players, eg Zambia
- Prevention & care, eg Catholic AIDS Action (Namibia)
- Prevention & Advocacy, eg Positive Muslims (SA)
- Intermediary, eg CHEP (Zambia) supporting 80 local CBOs for 1st 2 yrs

- Add more to the map