THE POTENTIALS AND PERILS OF PARTNERSHIP

Christian religious entities and collaborative stakeholders responding to HIV in Kenya, Malawi and the DRC

SUMMARY REPORT
The potential and perils of partnership
Christian religious entities and collaborative stakeholders responding to HIV in Kenya, Malawi and the DRC

Summary report

Authors: B Haddad, J Olivier and S De Gruchy, 2008

Study commissioned by Tearfund and UNAIDS – interim report
Published by ARHAP

Summary report editor: Nick Corby

Cover photographs: Marcus Perkins/Tearfund, Tearfund partner

© Tearfund 2009

Tearfund is a Christian relief and development agency building a global network of local churches to help eradicate poverty.

Tearfund has more than 30 years’ experience of working with churches and church-based partner organisations to improve community hygiene and safe sanitation.
The potential and perils of partnership

Christian religious entities and collaborative stakeholders responding to HIV in Kenya, Malawi and the DRC

Summary report

Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive summary</td>
<td>3</td>
</tr>
<tr>
<td>1 Objectives of the research</td>
<td>5</td>
</tr>
<tr>
<td>2 Research approach and methodology</td>
<td>6</td>
</tr>
<tr>
<td>3 General findings, reflections and recommendations</td>
<td>8</td>
</tr>
<tr>
<td>4 Research findings by country</td>
<td>11</td>
</tr>
<tr>
<td>4.1 Kenya</td>
<td>11</td>
</tr>
<tr>
<td>4.2 Malawi</td>
<td>17</td>
</tr>
<tr>
<td>4.3 Democratic Republic of Congo</td>
<td>23</td>
</tr>
<tr>
<td>5 Proposal for the second phase to ensure further engagement</td>
<td>29</td>
</tr>
<tr>
<td>with Christian religious entities and collaborative stakeholders</td>
<td></td>
</tr>
<tr>
<td>Abbreviations</td>
<td>30</td>
</tr>
<tr>
<td>References</td>
<td>31</td>
</tr>
<tr>
<td>Appendices</td>
<td>32</td>
</tr>
</tbody>
</table>
Executive summary

This report concerns the possibilities and challenges of collaborative relationships in the response to HIV in Africa, specifically between Christian religious entities (CREs) on the one hand, and national governments, donors and other religious entities (collaborative stakeholders) on the other. These collaborative partnerships are considered within the framework of the ‘Three Ones’ policy promoted by UNAIDS, which calls for one agreed action framework, one national co-ordinating authority, and one monitoring and evaluation system. These partnerships are also considered in light of the international commitment first made by G8 leaders in 2005 to achieve Universal Access to HIV and AIDS prevention, treatment, care and support by 2010.

The findings in this report emerge from a participatory research process, the first of two planned research phases, with a range of stakeholders in three African countries. They point to both the challenges facing collaboration in the ‘Three Ones’ approach, but also to the potential these partnerships have for responding effectively to HIV epidemics in Kenya, Malawi and the Democratic Republic of Congo (DRC).

Background

This research, developed by Tearfund in partnership with UNAIDS and conducted by the African Religious Health Assets Programme (ARHAP), aims to build mutual trust and create effective and long-term sustainable partnerships in the response to HIV.

By common agreement between UNAIDS, Tearfund and the ARHAP research team, this research focuses primarily on Christian organisations as these represented the most prevalent form of religious organisations in the three countries. As the research involved partnership with government and donors, it was further decided to focus first on those organisations with a national presence.

The term ‘religious entities’ was used rather than the more common ‘faith-based organisation’ to better capture the reality of religious formations in Africa. ARHAP’s work over the past five years has found that the traditional generic term, faith-based organisation, fails to reflect that many of the most significant religious responses do not have a fixed organisational status. ARHAP has also found that the term is not broad and comprehensive enough to capture the full range of religious responses. As a result, the term ‘religious entities’ is used by ARHAP to encompass the more formalised religious entities such as faith-based organisations as well as those less institutionalised entities such as worshipping congregations or individual traditional healers.

Research overview

The research to date has involved a qualitative research design using three methods; desk review, participatory inquiry, and self-administered questionnaires. The desk review made use of previous ARHAP research reports, and a variety of further materials including academic databases, web-based information, and information gathered directly from religious entities and participant questionnaires. In all cases, materials were individually assessed in terms of relevance, interest, the scarcity of other documentation of its type, and quality. The report of the literature review1 is itself a significant contribution to the goals of the research.

The study population for the participatory workshops was divided into two groups, Christian religious entities and collaborative stakeholders (government, donors and groups of other faiths), each with their

---

1 Haddad et al 2008, Chapter 3
own workshop. Those who participated in the research represent a significant cross section of the key organisations involved in responding to the HIV epidemic in the three countries. As a result, the findings are representative of the situation as it exists.

The self-administered questionnaires were used to confirm the findings of the participatory workshops, and to provide more specific detail where necessary.

Findings

During the course of this first phase, seven common findings across the three countries have emerged that are important in terms of strengthening the collaborative involvement of Christian religious entities in the ‘Three Ones’ approach:

1. Different contexts in Africa are at different stages of multi-sectoral collaboration as expressed in their commitment to the ‘Three Ones’ principles. The implementation of the ‘Three Ones’ principles is a development strategy, and not simply a response to a medical problem.

2. The achievement of one national action framework, one co-ordinating body, and one monitoring and evaluation system, in and of itself, does not promote better collaboration between government, donors, and Christian religious entities. Trust is an important element in making the ‘Three Ones’ work.

3. The ‘Three Ones’ principles can be effective only if there is recognised and effective representation on the co-ordinating structures through which government operates, and a common commitment to monitoring and evaluation.

4. For multi-sectoral collaboration to provide an effective response to HIV epidemics, each group of collaborative stakeholders needs to be in existing collaborative relationships within their sectoral grouping.

5. The nature of donor involvement is crucial to national governments and Christian religious entities ‘owning’ the agendas of strategic plans to mitigate the epidemic.

6. National governments should recognise the vital assets of religious entities, which are crucial in the response to the HIV epidemic. These include their reach, legitimacy, resources and structures. Ongoing collaboration and better mutual understanding is necessary to ensure these strengths are used effectively.

7. Christian religious entities need to acknowledge where conservative belief systems are hindering an effective collaborative response and be willing to build a contextual theological response that recognises poverty as a key driver of the HIV epidemic.

In addition, a number of country-specific findings and recommendations emerged. These findings focus upon the context in which Christian religious entities are working, the work of Christian religious entities in the promotion of Universal Access and the strengths of Christian religious entities. They also highlight the strengths and weaknesses of collaborative partnerships between Christian religious entities and other role players as well as the challenges and potential of collaborative partnerships.

The overall findings as outlined above, along with the in-country findings and related recommendations, do present preliminary suggestions to stimulate a second phase of the research.

It is hoped that this report, its findings and the next phase of the research will contribute to a wider vision of the eradication of HIV in our generation. To fulfil this vision, a solid and creative partnership must be forged between all the key stakeholders identified in this report. Such a task will need ongoing dialogue, mutual understanding and respect.
1 Objectives of the research

“The AIDS pandemic demands a more effective response. The church in Africa offers much but needs help. International development agencies and the church need to work together. However, they must address their differences and suspicions if they are to achieve more in the response to AIDS.”

A drive towards multi-sectoral collaboration in the international response to HIV has been evident for several years now. Whilst there are vocal calls to increase this collaboration further still there remain lingering questions surrounding collaboration and partnerships between religious entities, donors and governments.

These questions stem from a desire to improve the response to HIV by utilising, aligning and integrating all possible assets in a broader national effort or health system. This desire emerges from organisations such as the World Health Organisation (WHO), UNAIDS, the President’s Emergency Plan for AIDS Relief (PEPFAR) and The Gates Foundation and is balanced by a realisation that they know little about religious entities; who they are, what they can do, what assets they hold that can be leveraged for good health and how they function.

Assets refer to a range of capabilities, skills, resources, links, associations, organisations and institutions, already present in a context, by which people endogenously engage in activities that respond to their experienced situation. A ‘religious health asset’ (RHA) is an asset located in or held by a religious entity that can be leveraged for greater health. The notion of RHAs captures the basic idea that assets carry an intrinsic value that has potential for action.

This Tearfund study, developed in partnership with UNAIDS and conducted by the African Religious Health Assets Programme (ARHAP) aims to address some of these lingering questions. In doing so, this study intends to strengthen future collaboration between religious entities, donors and governments, increase mutual respect and understanding and ensure significant long term contributions are made to national AIDS plans.

In particular, this study has three main objectives:

1. To identify the kinds of HIV work being undertaken by religious entities (in the initial stage specifically Christian religious entities with a national presence) in Malawi, Kenya and the Democratic Republic of Congo (DRC).
2. To examine the interaction of this work with national AIDS strategies in those countries, with a view to examining the nature of the relationship between the government, donors and these religious entities.
3. To propose strategies for strengthening the collaboration for health between the religious entities, government and donors.

2 Taylor N, 2006
3 See ARHAP 2006
2 Research approach and methodology

To meet these objectives, the research has been divided into two phases. The first phase aims to survey the religious sector in Malawi, Kenya and the DRC and identify what and how key national CREs are responding to the HIV epidemic in their national contexts. It also aims to identify the strengths and weaknesses of the relationships between CREs and collaborative stakeholders, namely governments and/or donors. This section outlines the approach and methodology adopted to achieve this.

The three countries (Malawi, Kenya and the DRC) that are part of this research were selected by the research team in consultation with Tearfund and UNAIDS in-country representatives. These countries were chosen according to a combination of factors, including the interest of the UNAIDS in-country representatives in the research, ARHAP’s familiarity and networks in those countries and country-specific factors that would assist in future learning. The focus of this research is on Christian entities, rather than on the religious sector as a whole. However, throughout this study, researchers also sought the viewpoints of other faith groups where possible.

The first phase of this study involved three complementary research methods; a desk review of current literature; participatory workshops and self administered questionnaires.

The desk review incorporated academic databases, grey and academic literature and information directly from religious entities and participants. It was limited to literature in English and French, literature produced from 1998 onwards as well as literature focusing on religious entities engaged in HIV work in Kenya, Malawi and the DRC. In all cases, the materials were individually assessed in terms of relevance, interest, the scarcity of other documentation of its type and quality (e.g. author, publication etc).

The participatory workshops were adapted from the ARHAP-designed Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA) workshops for health providers to gather the views of two specific study populations:
- Representatives from key CREs
- Representatives from key collaborative stakeholders.

In total, six workshops were held (two in each country). Fifty-six CREs were identified as meeting the research criteria in the three countries, and of these, 38 participated in the workshops (67 per cent). Fifty-eight collaborative stakeholders were identified as meeting the research criteria in the three countries, and of these, 32 participated in the workshops (55 per cent). (See Appendix 1 for the full list of participants.)

In the workshop for representatives of key CREs, participants completed several exercises that were designed to gain a sense of history and context, to understand the HIV work being undertaken by CREs and to probe the collaborative context. Further exercises were designed to ensure participants reflected upon the strengths, weaknesses and way forward in regard to interaction with government policy and practice and with international donors. Similarly, the workshops for representatives of key collaborative stakeholders involved several exercises designed to gain a sense of the collaborative context and then to identify the strengths and weaknesses of working with CREs and hopes for the future.

Finally, the self-administered questionnaires were designed to augment the data collected through the desk review and the participatory workshops. They covered organisational profile, mission statement, geographical profile funding and collaboration. A separate questionnaire was designed for each study.

---

4 The French literature review was limited to a smaller study completed for Schmid et al 2008
group – representatives of key Christian religious entities and representatives of key collaborative stakeholders – and sent to all organisations that expressed interest in the research.

This research design and methodology was passed through the Ethics Committee, Faculty of Development, Human and Social Sciences, University of KwaZulu-Natal. Participants in all workshops were fully informed of the purpose and character of the research in the invitation to, and at the start of, the workshops. Furthermore, a full consent form which all participants were required to sign was read, translated and discussed in detail where necessary. This form asked for the participants’ consent for their collective insights and images to be used in research reports.

The general and country-specific findings from this research are summarised in the following two sections. It is important, however, to note a limitation to the research design. Malawi, Kenya and the DRC can not be considered as representative of sub-Saharan Africa or the rest of the continent. Furthermore, all three countries are predominantly Christian. As a result, the findings are not necessarily directly applicable to the rest of the region or elsewhere. However, they give useful insight into many of the issues which are commonly faced in this region and in wider HIV response.
3 General findings, reflections and recommendations

This section focuses on the general findings, reflections and recommendations that have emerged from all three countries during the first phase of this research. Additional, country-specific findings also emerged during this phase; these will be discussed in Section 4.

Overall there were several broad findings that emerged.

■ Different contexts in Africa are at different stages of multi-sectoral collaboration as expressed in their commitment to the ‘Three Ones’ principles. The implementation of the ‘Three Ones’ principles is a development strategy, and not simply a response to a medical problem.

Kenya has a clear national HIV/AIDS strategic plan, a national AIDS committee and a single monitoring and evaluation system in place. CREs feel valued by government stakeholders for their work and there is a ‘context of openness’ to collaboration. Civil society has been included in the national AIDS response and until recently the socio-political context has been stable and all stakeholders have proactively responded to the epidemic.

In comparison, stakeholders’ responses to the epidemic in Malawi are fragmented, despite the Government’s commitment to the ‘Three Ones’. For example, it was felt that the national AIDS policy is not owned by all stakeholders. In the DRC, stakeholders were even more fragmented and least able to engage in multi-sectoral collaboration as a result of over a decade of conflict.

Given the different stages of multi-sectoral collaboration in these countries, different strategies are needed in response to HIV. Furthermore, the ‘Three Ones’ need to be understood as a development strategy, not simply a response to a health issue.

■ The achievement of one national action framework, one co-ordinating body, and one monitoring and evaluation system, in and of itself, does not promote better collaboration between government, donors, and Christian religious entities. Trust is an important element in making the ‘Three Ones’ work.

Commitment to and implementation of the ‘Three Ones’ does not necessarily mean that collaboration is working. Trust between stakeholders is also crucial.

The relationship between the Government and CREs appeared far most trusting in Kenya than it did in Malawi or the DRC. Whilst there may be underlying reasons why CREs do not trust government leaders and government policy, it appeared that this trust is important to effective collaboration.

■ The ‘Three Ones’ principles can only be effective if there is recognised and effective representation on the co-ordinating structures through which government operates, and a common commitment to monitoring and evaluation.

Existing co-ordinating structures should be challenged regularly in terms of how well they represent all stakeholders. This is particularly the case with the religious sector, which contains a broad and complex range of organisations and individuals. For example, the Kenyan and Malawian Governments were found to most closely adhere to the ‘Three Ones’. Both governments use the co-ordinating structures of the religious sector to channel resources and information. However, this research highlights that these structures do not represent all stakeholders in this sector.
Furthermore, the work of CREs is often driven by religious principles and intentions that are difficult to evaluate. To work together more effectively, it would help if CREs embrace a focus on observable health outcomes in line with a common monitoring and evaluation system. This move will involve the development of a standardised and uniform reporting system around key outcomes and indicators as well as monitoring and evaluation capacity building within the religious sector.

- **For multi-sectoral collaboration to provide an effective response to HIV epidemics, each group of collaborative stakeholders needs to be in existing collaborative relationships within their sectoral grouping.**

  This first phase of the research revealed that for multi-sectoral collaboration to be effective, stakeholders need to have good relationships within their own groupings.

  This research found a fragmentation of relationships within the CREs group and within the donor group in Malawi, Kenya and the DRC. This fragmentation leads to competition within and between each group which hinders effective collaboration and in turn limits any commitment to the 'Three Ones'.

  Where there are a large number of donors, forums need to be established where donors can liaise, strategise and develop monitoring and evaluation systems that are consistent with those put in place by the national government. Similarly, CREs need a forum where they can discuss and share information or co-ordinate action plans. This needs to happen at district and local levels. Where local CREs lack capacity or skills to do this, support from recognised intermediary bodies may be necessary.

- **The nature of donor involvement is crucial to national governments and Christian religious entities ‘owning’ the agendas of strategic plans to mitigate the epidemic**

  The first phase of this research revealed that the reality of power dynamics and the need for funding has led to donor agencies playing a powerful role in driving AIDS strategies in all three countries. This has led to tension and resentment as well as a sense that agendas are being imposed on the local context. This sense of a discrepancy in power was found to be exacerbated by the financial reporting requirements for each donor and the bureaucracy surrounding access to and accountability for funding. A shift of decision-making from donors to national structures and civil society must therefore be addressed to improve multicultural collaboration.

- **National governments should recognise the vital assets of religious entities, which are crucial in the response to the HIV epidemic. These include their reach, legitimacy, resources and structures. Ongoing collaboration and better mutual understanding is necessary to ensure these strengths are used effectively.**

  This first phase of the research revealed that in each context CREs have vital assets which are being used to mitigate the epidemic. The leverage of these assets for public health provides the basis upon which collaboration becomes possible.

  In Malawi, Kenya and the DRC, collaborative stakeholders recognise the legitimacy and credibility CREs have in HIV work. However, this is not enough. Many CREs expressed concern that an overwhelming responsibility for orphans and vulnerable children has stretched some organisations to breaking point. To mitigate such experiences, CREs need access to greater financial resources to enable them to play a stronger role in the HIV response.
Christian religious entities need to acknowledge where conservative belief systems are hindering an effective collaborative response and be willing to build a contextual theological response that recognises poverty as a key driver of the HIV epidemic.

Many CREs continue to be perceived by collaborative stakeholders as conservative, and intransigent on issues such as the promotion of condoms. Certain harmful beliefs of many CREs risk the effectiveness of collaborative efforts. A greater appreciation of the social determinants of health would open CREs to crucial social aspects of the response to HIV and lead to a more contextual approach to both their theology and to their ethics.
4 Research findings by country

In addition to the previous broad findings and recommendations that emerged from the interim report\(^5\), the data collected in the literature review and through participant workshops also provided detailed country-specific case studies of the role played by CREs and recommendations for how to strengthen this further. In particular, the participatory research process was designed to identify:

- The context in which CREs are working
- The work of the CREs in the promotion of Universal Access
- The strengths and weaknesses of collaborative partnerships between CREs and other stakeholders
- The challenges and potential of collaborative partnerships between CREs and other stakeholders.

This section provides an overview of these country-specific findings and recommendations, looking first at Kenya, followed by Malawi and finally the DRC.

4.1 KENYA

State of the epidemic

Kenya has a severe and generalised HIV epidemic. National adult HIV prevalence is estimated to have halved in a decade to 5.1 per cent in 2006\(^6\) – ‘a dramatic and sustained decline that has rarely been seen in Africa’.\(^7\) This decline has been attributed in part to critical HIV services being scaled up, resulting in increased awareness and behavioural change as well as a lower incidence of new infections and higher death rates. Mortality rates are now double the rate of 1998.\(^8\)

Little is known about high-risk groups, who have been neglected in programming, treatment and care. However, current estimates place infection levels twice as high among urban residents as those among rural residents (8.3 per cent to 4 per cent)\(^9\). Furthermore, women face considerably higher risk of HIV infection than men and also experience a shorter life expectancy due to HIV. There are also an estimated 2.4 million orphans in Kenya, half of which are caused by the AIDS pandemic.\(^10\)

The national response to this epidemic is set out in Kenya’s National HIV/AIDS Strategic Plan (KNASP) 2005. The KNASP commits Kenya’s response to the principle of the ‘Three Ones’. The KNASP document itself constitutes one agreed HIV and AIDS action framework. The National AIDS Control Council (NACC) provides the national co-ordinating authority and one monitoring and evaluation system is set in place. KNASP also states Kenya’s commitment to a multi-sectoral and participatory approach.

NOTE The data used above is what was available at the time of research. However, the current data, based on the Kenya AIDS Indicator Survey released in June 2008, states the prevalence rate (for 15–49 years) as 7.4 per cent. Urban prevalence is 8.4 per cent and rural prevalence is 6.7 per cent.

---

5 http://www.arhap.uct.ac.za/publications.php
6 UNAIDS 2007
7 NACC 2008
8 See UNAIDS 2006a and NACC 2008
9 NACC 2008
10 NACC 2008
Six findings emerged from this first phase of the research in Kenya:

1. CREs in Kenya perceive themselves to have a long history of participation in national and social life, including responding to the HIV epidemic. Furthermore, they recognise the contextual factors in this national and social life that drive the epidemic.

2. CREs in Kenya are committed to, and involved in, promoting Universal Access to prevention, treatment, care, and support in a number of significant ways, including education and awareness, provision of ART, care for orphans and vulnerable children and vocational support. This work is aimed at a wide range of beneficiaries, although there is a particular focus on the rural areas, and on women.

3. In their contribution to Universal Access, CREs in Kenya are acknowledged by collaborative stakeholders as having three key strengths; reach, legitimacy and resources. These strengths represent vital assets that are essential to strengthening multi-sectoral collaboration.

4. CREs in Kenya are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. The main strengths are perceived to be the clarity of the national HIV/AIDS strategic plan, the collaborative structures that have been established, and the increased funding for CREs. The main weaknesses are perceived to be the lack of collaborative processes despite strong collaborative structures, the lack of representation in some forums, the lack of financial commitment from government, and the burgeoning bureaucracy especially around financial reporting.

5. CREs and their collaborative stakeholders see both challenges and potential in such partnerships. Specific challenges such as competition amongst stakeholders, certain conservative beliefs of CREs, and their lack of capacity in the face of overwhelming need are balanced by a mutual appreciation of the strengths of each partner, and a shared desire to improve collaboration.

6. There is an obvious commitment from both sides to strengthening the partnership between CREs and collaborative stakeholders. From the CREs there is a desire for greater participation of a range of stakeholders in formulating national policy and donor strategies. From the collaborative stakeholders there is a desire for a stronger commitment to the national monitoring and evaluation process.

To better understand these findings they will now be discussed in more detail.

The context CREs are working in

Many of the CREs responding to the HIV epidemic have a long-established presence in Kenya, some dating back to the nineteenth century. Many others pre-date Kenyan independence. The predominant religions have historically set up health centres and hospitals as missionaries arrived in Kenya. For example, Catholic health care in Kenya dates back to pre-independent Kenya in the early 1900s, continuing to the present day. There are also records of Islamic hospitals and health centres established in Kenya during the colonial period. More than 900 faith-based facilities now provide 40 per cent of national health services in Kenya. Less is known about the historical role of traditional religions and healers, other minority religions or about community-based projects run by religious entities.

CREs perceive themselves to have responded quite early to the HIV epidemic, with participants agreeing that there was a response to the epidemic in the late 1980s and early 1990s. For example, in 1986 the Presbyterian Church of East Africa had a symposium on the emerging crisis and invited the Government to partner with them.
Furthermore, CREs believe they partly pioneered the response to HIV in Kenya and found a stronger sense of direction when the Government declared HIV a national disaster in 1999.

The promotion of Universal Access

Each entity in Kenya covered by this research is not equally involved in all aspects of enabling Universal Access. However, it is clear that taken as a whole CREs in Kenya perceive themselves to be involved in all parts of the HIV response – prevention, treatment, care and support.

Prevention messages developed by CREs tend to focus on abstinence and behaviour change, particularly among the youth. However, some CREs also provide peer education on reproductive health. Some organisations are also involved in prevention of mother-to-child-transmission (PMTCT) and voluntary counselling and testing (VCT). Furthermore, some organisations provide ART as well as treatment for sexually transmitted infections, care for orphans, home based care networks, psycho-social support, credit support and economic empowerment, amongst other services.

CREs are also involved in other responses such as radio programmes, targeting issues of stigma and discrimination and advocacy work.

CREs deliver these services to a wide range of beneficiaries. For example, there is a strong commitment to rural areas, or those who have migrated to urban slums. CREs also recognise the importance of working with men. In practice though, most of the work is with women. Similarly, CREs are committed to working with all people, regardless of their faith, but in practice there is limited engagement with non-Christians, particularly in terms of treatment.

CREs key strengths

When representatives of collaborative stakeholders – the Government, donors and other religions – were asked to reflect on the work of CREs they identified three major areas of strength; reach, legitimacy and resources.

CREs were considered one of the few organs of civil society accessible to rural communities and therefore in a position to influence them. They were also seen to have considerable legitimacy within those communities because of their history, accessibility, and moral authority. Finally, they were recognised as having considerable human and material resources in rural areas in comparison to other stakeholders, including the Government.
The strengths and weaknesses of current collaboration

This research found that CREs are currently involved in a range of collaborative partnerships. Representatives from CREs indicated the following key issues:

■ Most CREs have a number of relationships with each other, government and donors, although some were not connected to co-ordinating bodies.

■ In Kenya, there was some relationship between CREs and government. Some CREs were connected to several Government structures (e.g. NACC, Ministry of Education (MoE), Ministry of Health (MoH) and the Children’s department).

■ Donors in Kenya appeared to mainly work with the Government (through NACC) and did not seem to dominate this relationship.

■ There was some interaction between CREs present at the workshop and interfaith bodies.

CREs recognised that the KNASP reflected the ‘Three Ones’. They also agreed that the KNASP set out clear goals and sought to involve a number of key stakeholders. For example, many research participants agreed they had been involved in developing the KNASP and that there was a participatory approach to the Government’s work which had generated a sense of ownership of this policy. Participants also acknowledged that having donors as collaborative stakeholders was invaluable. Long-term financing had enabled CREs to develop a long-term vision for their work. Furthermore, most felt that collaborative relationships were strengthened by partnerships that included mutual sharing of resources, experiences and ideas, not just funding.

However, a number of weaknesses were identified. For example, it emerged that not all religious organisations were represented within the co-ordinating body involved in developing the KNASP. As a result, many participants felt that problems arose around communication and support being channelled through that one co-ordinating body. There was also concern that the KNASP focuses on resource allocation without being adequately linked to the national budget, which leaves the Government reliant on external funding. Participants felt this led to gaps in service delivery.

Also, many participants felt the bureaucratic nature of the NACC made it difficult to pursue the ‘Three Ones’ policy. This hampered resource allocation and open communication with rural communities. It also led to poor implementation of monitoring and evaluation. They also felt that Government practice did not adequately address women aged between 25 and 39 years.

CREs felt that donors did not trust them, particularly in terms of financial management. They felt this was demonstrated by the placement of their own personnel in project management. There was also concern that external agendas were forced onto local organisations and that agendas and resource allocation could change focus without warning. Finally, CREs were concerned that the short time period within which some funding needed to be spent inhibited long-term financial planning and that this was exacerbated by the expectation of elaborate and frequent reports.

The challenges and potential of collaborative partnerships

This first phase of the research identified a mutual appreciation of the strengths of each partner and a shared desire to improve collaboration. However, CREs and their collaborative stakeholders also recognised a number of challenges.

Competition for funding and the perceived dogmatism or conservatism of CREs particularly emerged as challenges to these partnerships. For example, collaborative stakeholder participants felt that a conservative ethos makes some CREs unwilling to deal with some high-risk groups, such as commercial sex workers. Similarly, an unwillingness amongst most to promote condoms continues to create tension.
A perceived lack of capacity also emerged from this research as a key challenge to collaborative partnerships. This included human and financial capacity as well as insufficient skills. These problems were thought to be exacerbated by some CREs recruiting staff on the basis of faith rather than skill. However, research participants from CREs saw this as a lack of trust in their ability. There was also recognition that despite a lack of capacity, the work ethic of CREs was strong and encouraged volunteerism.

Strengthening collaborative partnerships

Despite the above challenges to collaborative partnerships, a clear commitment by all stakeholders to greater partnership emerged from this research.

To improve collaboration on Government policy, research participants from CREs identified that:
■ Criteria for funding should be more specifically noted in the KNASP document.
■ A clear, more detailed and holistic policy and strategy on orphans and vulnerable children should be developed (e.g. including free education, free healthcare, social protection and access to basic services).
■ People living with HIV should have greater involvement and be included more visibly in the strategy.

To improve collaboration in terms of government practice, research participants from CREs identified that:
■ National co-ordinating structures should be strengthened.
■ Public-private partnership policy should be developed and applied more consistently.
■ There should be open forums to discuss policy review.
■ Government should involve CREs as partners when they put their policies into practice.
■ There should be greater interpretation and dissemination of KNASP to grassroots agencies.
■ More co-ordinated events should take place in order to ensure equitable resource allocation and an effective monitoring and evaluation framework.

To improve collaboration in terms of donors, research participants from CREs identified that:
■ There should be a forum to share strategic issues and agree on funding structures and accountability.
■ Such a forum should also ensure that resource allocation is equitable and measured according to extent of service delivery.
■ Genuine and mutual partnerships should be encouraged with mutually agreed agendas. Financial support should be channelled directly through CREs, rather than through global bodies.

The Government and donors expressed considerable willingness to strengthen collaboration with CREs. Furthermore, they recognised the need for further dialogue and greater networking between all stakeholders. Similarly, representatives of key organisations (e.g. NACC) that are seen as drivers of collaboration openly admitted to organisational weaknesses and sought discussion on how to redress them.

These collaborative stakeholders agreed to facilitate channels of communication in relation to information sharing. However, they expressed strong concern that an effective forum would only be possible if CREs were willing to engage in national monitoring and evaluation processes.
Recommendations arising from the research findings in Kenya

A number of recommendations specific to Kenya have emerged from this first phase of the research, for the attention of each or all stakeholders. They include:

For the attention of the CREs

- Assess effectiveness of the various faith-based collaborative structures (e.g. the Kenya Inter-Religious AIDS Consortium and the Inter-religious Council of Kenya) and restructure, ensuring appropriate representation.
- Strengthen relationships with one another through establishing regular forums for dialogue and information sharing.
- Differing beliefs and values systems can be a hindrance to relationships with government stakeholders particularly in relation to the condom issue. CREs need to be willing to address harmful beliefs and to develop a contextual approach to their theology and ethics.
- Strengthen the commitment to the ‘one’ monitoring and evaluation process, so that the work of CREs can have greater impact upon the national HIV and AIDS strategies.

For the attention of government

- Communicate the principles of the ‘Three Ones’ more deliberately and engage with the work of CREs more effectively.
- Ensure better representation on co-ordinating structures used by government to relate to CREs.
- Involve the faith-based organisations in ensuring that HIV information is reaching grassroots communities.

For the attention of donors

- Establish a forum of representatives of all funding partners as a matter of urgency.
- Develop one set of monitoring and evaluation procedures which is harmonised and aligned with the nationally accepted monitoring and evaluation ones and not develop their own.
- Recognise the importance of long-term relationships with other collaborative stakeholders.

For the attention of all

- Utilise the principles of the ‘Three Ones’ as an entry-point for greater collaborative efforts.
- Ensure adequate representation in all co-ordinating structures.
- Establish regular regional forums for all collaborative stakeholders that enable ongoing dialogue, information sharing, and evaluation of strategic interventions.
4.2 MALAWI

State of the epidemic

Malawi’s HIV epidemic has stabilised. However, in 2005, approximately 14.1 per cent of the adult population aged 15 to 49 in Malawi was living with HIV – almost twice the overall rate for sub-Saharan Africa. With one of the highest adult prevalence in the world, the epidemic has exacerbated existing social problems, but there is some evidence of behavioural changes that could be reducing people’s risk of acquiring HIV infection.

HIV prevalence in Malawi is significantly higher in urban areas, although on current trends this may change. Evidence suggests that infection rates are slowing in urban areas but continue to increase in rural areas. Furthermore, women are disproportionately affected by the epidemic. In 2005, approximately 500,000 women 15 years and older were living with HIV. There are also an estimated 1 million orphans and other vulnerable children in Malawi, half of which are due to HIV.

In response, the Government has developed several policies and guidelines on various aspects of the national HIV response. The 2003 National HIV and AIDS policy and the National HIV and AIDS Action Framework 2005–2009 are particularly important. They set a number of objectives and priority areas for action, including monitoring and evaluation, treatment care and support, prevention and impact mitigation. They also reflect the Government’s commitment to a multi-sectoral and participatory approach. The latter document also emphasises the Government’s commitment to the ‘Three Ones’.

Six findings emerged from this first phase of the research in Malawi:

1. CREs in Malawi are proud of the role played by religious leadership in the social life of the country, but recognise that they have only recently begun to respond to the HIV epidemic.

2. CREs in Malawi are committed to and involved in promoting Universal Access to prevention, treatment, care and support including education around abstinence and behaviour change, the provision of ART, home-based care groups and work with orphans and vulnerable children, and psycho-social support services. While the work is aimed at a wide range of beneficiaries, young people, women and rural citizens form the key target groups.

3. CREs in Malawi are acknowledged by collaborative stakeholders as having key strengths; their reach to the grassroots, the resources they have at their disposal, and the capacity to offer psycho-social support. These strengths represent vital assets that are essential to strengthening multi-sectoral collaboration.

4. CREs in Malawi are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths and weaknesses. The main strengths are perceived to be the wide range of funders supporting work in Malawi, the willingness expressed in the national policy to engage with the religious sector and good working relationships at local and district level. The main weaknesses are perceived to be the lack of engagement by CREs at a national level with the National AIDS Commission (NAC) and the Malawi Interfaith AIDS Association (MIAA), competition and conditions around funding and the lack of a common agreement on the efficacy of ‘spiritual healing’.

5. Both the CREs and their collaborative stakeholders see challenges and potential in such partnerships. Specific challenges include differing belief and value systems, difficulties with adhering to
monitoring and evaluation standards, the dissemination of information, adequate representation, conditions set on funding and inter-faith collaboration. These challenges are balanced by an awareness of the potential for these partnerships amongst both CREs and collaborative stakeholders, given the commitment to the ‘Three Ones’ policy.

6 There is a desire for stronger multi-sectoral collaboration in Malawi, without a further proliferation of initiatives. CREs desire a greater focus on local and district level initiatives. Collaborative stakeholders desire a greater commitment to collaborative planning, monitoring and evaluation. All parties hope for a greater focus on cultural and gender aspects of the epidemic.

To better understand these findings they will now be discussed in more detail.

The context CREs are working in

Health-related CREs were established in Malawi in the 1960s but it was the movement from a one-party state to multi-party democracy in 1992 that brought greater visibility to NGOs, religious entities and the involvement of civil society in social issues. Since then, churches in Malawi have played a vocal role in matters ranging from politics and policy to health and development. Now, ‘collectively, they have an infrastructure bigger than that of the Government, covering every district, town and village in the country, and functioning as a source of education, health, agricultural and financial information and service delivery.’

The 2004 UNFPA report recognises that, ‘Faith-based organisations have come a long way since 1985 in helping to care for the spiritual, material and physical needs of those living with or affected by HIV. Moreover, this support is growing. In the last five years alone, at least 40 religious institutions have begun responding to the HIV epidemic on a national and local level. The potential to expand this support through carefully formed partnerships is enormous.’ CREs consequently perceive themselves to have a well-established role in national and social life.

Moreover, some religious entities have been involved in responding to the epidemic since its early stages, with religious leaders taking a vocal position (although in some instances contributing to stigma and discrimination). Now, more CREs acknowledge they must respond to the HIV epidemic.

The promotion of Universal Access

Like Kenya, each and every religious entity in Malawi covered by this research is not equally involved in all aspects of ensuring Universal Access. However, it is clear that taken as a whole, CREs perceive themselves to be involved in all parts of the HIV response – prevention, treatment, care and support.

The main prevention activity is education and awareness work, particularly amongst youth. Messages seem to focus on abstinence and behaviour change although World Vision and Scripture Union also offer life-skills training. Furthermore, an agreement was reached in 2005 through the state-faith dialogue that the Government would not force the faith community to distribute condoms and that the faith community was expected not to condemn condom use. Some CREs are also involved in the provision of ART, home-based care, care for orphans and vulnerable children as well as income generating activities, psycho-social support and micro-credit support, amongst others.

CREs are also involved in other work, including advocacy work, capacity building and radio programmes.

---

16 UNFPA 2004
17 UNFPA 2004
Whilst this work is aimed at a wide range of beneficiaries, it seems clear that young people, women and rural citizens form the key target groups. All research participants, however, rejected the 2004 UNFPA reports claims that the majority of faith-based organisations are based in the South and Central regions, subsequently neglecting the North and that these religious organisations are concentrated in urban areas where funds are more readily available.

**CREs’ key strengths**

Representatives of collaborative stakeholders identified three major areas of strength for CREs. The first was the reach of CREs, particularly in rural areas. Collaborative stakeholders felt that CREs were one of the few organs of civil society that were accessible to and trusted by rural communities. Furthermore, CREs were seen to be in contact with large numbers of people. The other recognised strengths were their human and material resources and their capacity to offer psycho-social support.

**The strengths and weaknesses of current collaboration**

CREs are involved in a range of collaborative partnerships. A critical dialogue of these partnerships by CRE participants uncovered a number of key issues during this first phase of the research;

- There is an enormous number of diverse funders (at least 22 were noted) within such a geographically small country.
- There are a few funding relationships between the local CREs present at the workshop.
- The Christian Health Association of Malawi (CHAM) was the only organisation present at the workshop that raises funds on behalf of others.
- CHAM was the only organisation present that was in a relationship with many of the other organisations.
- All CREs relate to NAC, but few have formal relationships with one another.
- All funding from NAC is channelled through MIAA to the participant organisations. MIAA does not receive funds for dispersal at the moment, as this role has been suspended. MIAA recommends to NAC funding for organisations.
- CREs did not report a strong relationship with MIAA.

The representatives of CREs were supportive of the section on religious and cultural practices and services in the 2003 National HIV and AIDS policy and were positive about the political will of the Government to deal with the epidemic. They also felt they had a strong relationship with the Government that included the sharing of resources and information. This especially seemed to be the case at district level in rural areas where in many instances the leaders of CREs are members of district committees.

CREs were also appreciative of their partnership with donors because of their willingness to assist and fund programmes and because their flexibility enabled a more timely response to urgent needs. Participants also valued the capacity-building opportunities offered by these partnerships as well as the technical expertise they gain.

Despite these strengths, participants identified a number of weaknesses. Different values and belief systems were seen as a stumbling block. In particular, the issue of condoms continues to colour how CREs collaborate with the Government. CREs also felt that resources were not reaching rural
communities speedily because of the Government’s stringent funding conditions and bureaucratic structures.

CREs also identified the large number of donors as a problem (as well as a strength) both for their relationships with one another and for the long-term sustainability of their projects. There was also a general feeling that funding was not reaching projects in rural communities because NAC was not accessible to CREs and because of a weak relationship with MIAA.

Finally, participants acknowledged that they felt frustrated by the powerful role donors had in the national HIV response and that local realities were not appreciated. They also felt that the conditions and expectations of donors can be a burden. Many participants highlighted the need for greater coordination between donors to ease these expectations.

The challenges and potential of collaborative partnerships

Participants pointed to the potential for future collaboration of all stakeholders and expressed a desire for stronger collaboration. However, they identified a number of challenges to collaborative partnerships during this first phase of the research.

One such challenge was the differing belief and value systems of CREs and collaborative stakeholders. There are ongoing overt tensions between CREs and the Government in areas such as condom promotion and monitoring and evaluation procedures. Collaborative stakeholders perceive that CREs’ conservatism extends beyond reluctance to engage in condom promotion, to a resistance to change and an unwillingness to adopt new approaches.

There were also recognised difficulties in adhering to monitoring and evaluation standards and disseminating information, as well as inadequate inter-faith collaboration or representation. Collaborative stakeholders expressed concern that there is limited female representation from CREs at forums. In fact, CREs acknowledged that most of their programmes were created by men for a largely female audience. More generally, Government stakeholders and CREs both acknowledge that representation at forums is often not balanced or representative of all stakeholders. For example, the MIAA was set up with Government funds as a co-ordinating and representative body without adequate consultation. As a result, many CREs have at best an informal relationship with the MIAA and at worst no relationship at all. Several CREs subsequently feel resentment or are at least disinterested in the fact that this body is seen as their representative.

Another challenge was funding. Government stakeholders highlighted that funding levels and timings from international donors could be unpredictable. They also found it difficult that CREs receive funding directly but do not report this or its outcome to the national co-ordinating mechanism. On the other hand, many CREs find donor reporting mechanisms a burden that hinders their ability to do the necessary work.
Strengthening collaborative partnerships

There was a clear desire among participants for stronger multi-sectoral collaboration in Malawi, without a further proliferation of initiatives (the researchers felt there was a certain level of saturation in the number of collaborative initiatives that had already been put in place). CREs seem to desire a greater focus on local and district level initiatives whilst collaborative stakeholders desire a greater commitment to collaborative planning, monitoring and evaluation. All parties hope for a greater focus on cultural and gender aspects of the epidemic.

To improve collaboration on Government practice, research participants from CREs identified that:

■ Decentralisation should be encouraged, with less weight placed on national structures.
■ There is a need to focus on strengthening district level structures so that they are able to cope with the demands of decentralisation.
■ There is a need to strengthen district level capacity and collaborating mechanisms enabling them to access funds more readily.
■ There is a need to build capacity within the grassroots so that they are more accountable to the district structures in terms of monitoring and evaluation frameworks.

To improve collaboration on Government practice, research participants from CREs identified that:

■ Donors should form their own collaborative forums, particularly at district level and that there should be better monitoring of donors’ commitment to signed MOUs by government.

There was also agreement among CREs that existing legislation that ensures gender equity in all committees needed to be implemented more rigorously in the future. They felt that the Government needed to ensure that gender and cultural issues were discussed within primary education and that existing NGOs that address gender and cultural issues should be strengthened.

Collaborative stakeholders made the following suggestions to improve multi-sectoral collaboration:

■ Stakeholder meetings should be conducted at all levels of government.
■ Ensure better communication and information sharing, particularly at a district level.
■ Strengthen joint planning and monitoring and evaluation structures.
■ Ensure more user-friendly monitoring and evaluation frameworks.
■ Strengthen umbrella organisations such as MIAA.
■ Undertake to conduct more research at a grassroots level in order to better understand their needs.
■ Conduct a bi-annual conference on collaboration between the religious entities and government.

Recommendations arising from the research findings in Malawi

A number of recommendations specific to Malawi emerged from this first phase of the research, for the attention of each or all stakeholders. They include:

For the attention of the CREs

■ Assess effectiveness of the MIAA and restructure ensuring appropriate representation.
■ Strengthen relationships with one another through establishing regular forums for dialogue and information sharing.
■ Differing beliefs and values systems can be a hindrance to relationships with government stakeholders, particularly in relation to the condom issue. CREs need to be willing to address harmful beliefs and to develop a contextual approach to their theology and ethics.
For the attention of government

■ Communicate the principles of the ‘Three Ones’ more deliberately and effectively, particularly at a district level.
■ Ensure better representation within their co-ordinating structures.
■ Involve CREs in ensuring that HIV information is reaching the grassroots communities.

For the attention of donors

■ Establish a forum of representatives of all funding partners as a matter of urgency.
■ Develop one set of reporting and monitoring and evaluation procedures.
■ Recognise the importance of long-term relationships with their collaborative stakeholders.

For the attention of all

■ Prioritise the principles of the ‘Three Ones’ as a way forward for collaborative efforts.
■ Ensure adequate representation in all co-ordinating bodies.
■ Establish regular regional forums for all collaborative stakeholders that enable ongoing dialogue, information sharing, and evaluation of strategic interventions.
4.3 DEMOCRATIC REPUBLIC OF CONGO (DRC)

**State of the epidemic**

The DRC has a ‘widespread’ epidemic. Prevalence varies from 1.7 per cent to 7.6 per cent depending on the region and may be as high as 20 per cent among women who have suffered sexual violence in areas of armed conflict.\(^{19}\) The epidemic is strongest and may be increasing among young people, particularly women, between the ages of 15 and 24. Evidence gathered from antenatal clinics attendees indicates that whilst HIV prevalence has remained relatively stable in Kinshasa, it has risen in other cities, including the second largest city, from 4.7 per cent in 1997 to 6.6 per cent in 2005.\(^{20}\)

The epidemic in the DRC is further complicated by extreme poverty and weak or nonexistent public health infrastructure.\(^{21}\) The country has suffered numerous conflicts which have displaced an estimated 1.4 million people. Although areas of unrest remain, the country is now seen to be in a process of national reconstruction.

A critical challenge now remains to increase the level of political commitment and leadership around HIV. The Government’s response to the HIV epidemic has been tied to the country context. As a result, AIDS control is currently part of the Poverty Reduction Strategy Paper.\(^{22}\) The current national strategic HIV and AIDS plan, created in 1998–1999 is outmoded but the new one should emerge at the end of 2008. Furthermore, the lack of clarity in the division of labour between the National AIDS Control Programme (NACP) and the National Multisectoral Programme to Fight AIDS (PNMLS) ‘is responsible for a weak national leadership which is detrimental to co-ordination of programmes’.\(^{23}\)

Six findings emerged from this first phase of the research in the DRC:

1. CREs in the DRC perceive themselves to have had a long engagement with the epidemic from a medical perspective. However, it is only since 2000 that there has been a significant pastoral engagement. CREs also perceive the HIV epidemic to be strongly related to other social and political crises in the country, and acknowledge that initiatives have been hampered, until recently, by the civil war.

2. CREs in the DRC are committed to and involved in promoting Universal Access to prevention and treatment, and to a lesser extent care and support. Prevention involves education and the distribution of condoms and there is an extensive involvement in the provision of ART. CREs recognise that the majority of their beneficiaries are Christians, particularly women. Work is undertaken in both urban and rural settings.

3. In their contribution to Universal Access, CREs in the DRC are acknowledged by collaborative stakeholders as having three key strengths; reach, credibility and well-developed structures. These strengths represent vital assets that are essential to strengthening multi-sectoral collaboration.

4. CREs in the DRC are currently involved in a range of collaborative partnerships with a number of stakeholders in promoting Universal Access. These partnerships are perceived to have a number of strengths but a large number of weaknesses. The main strengths are perceived to be the relationships that CREs have with their funding partners and particularly the Global Fund as well as their relationships with government departments. The main weaknesses are perceived to be the lack of relationship between and co-ordination of work amongst CREs, and the different levels of

---

\(^{19}\) UNAIDS 2006a  
\(^{20}\) UNAIDS 2007  
\(^{21}\) WHO 2005  
\(^{22}\) UNAIDS 2006a, WHO 2005  
\(^{23}\) UNAIDS 2006b
knowledge and value systems between the partners. A further weakness is the difficulty of producing and administering a national policy in the midst of wider political crises and a lack of government funding, together with the vulnerability caused by reliance on external donors.

5 CREs and their collaborative stakeholders see both challenges and potential in partnerships. The challenges are associated with the fragile state of the country and of co-ordinating structures, the ‘dependency-syndrome’ regarding funders, the lack of knowledge about HIV amongst CREs and the conservative doctrinal emphases of certain churches. Yet it was also acknowledged that the potential for partnerships lies in the relationships that both government and CREs have with international donors, the recognition of mutual strengths, and a desire to work together.

6 There is an obvious commitment from both sides to strengthening the collaboration between CREs and collaborative stakeholders. From the CREs there is a desire for greater participation in decision-making around the control of funds. From the collaborative stakeholders there is a desire that CREs be drawn into the national plan, its policy formulation and implementation.

To better understand these findings they will now be discussed in more detail.

The context CREs are working in

In the DRC, the history of medical missions and health professionals working with religious entities goes back more than a hundred years. However, until the 1970s there was little awareness of the role of the church in community life. In 1974, the Government policy of Zairianism meant that the Congolese were expected to manage their own affairs ‘whether they were ready or not’.24 As part of this policy, all social services were handed over to the churches in 1977. Then, significantly, in 1999 the Ministry of Health turned over responsibility for health care in 60 health zones to a coalition of mostly faith-based non-governmental health organisations.25

In the face of political and economic crises and instability, religious entities have continued to play a long-term and obvious role in health care at a national level. According to secondary literature, faith-based organisations and networks now provide up to 70 per cent of health services in the DRC.26 The large Christian majority in the country means that most of the religious entities are from a Christian background, with Protestant and Catholic efforts being most prominent, according to secondary literature. It is important to note that although predominantly Christian, DRC has a significant Muslim population. As part of the CIC, (Council of religious organisation on HIV and AID in the DRC) Muslim organisations were consulted and participated actively in the workshop.

CREs perceive themselves to have had a long engagement with the epidemic. This has, however, been seen predominantly as a medical problem to be dealt with by medical services. Much of the current pastoral work around HIV only began in 2000, at the end of the civil war. Since 2006, free ART has been more readily available, although there is some uncertainty as to the extent of the roll-out of this programme country-wide.

There is also a general feeling that the response to the epidemic is not well co-ordinated. In part this is because of an out-of-date national strategy and disparate funding. According to UNAIDS reports, ‘the lack of a national strategic plan which has been updated and budgeted for and of long-term vision is a hindrance to the involvement of civil society and of the different sectors, as well as to the harmonisation and integration of interventions by all stakeholders.’27 Participants were confident that national co-ordination will improve with the new strategy at the end of 2008.

24 Comment made by research participant.
25 IDT 1998, Baer 2001
26 ECC 2007
27 UNAIDS 2006b
The potential and perils of partnership

The promotion of Universal Access

Again, whilst all CREs are not equally involved in all aspects of Universal Access, it is clear that as a whole CREs perceive themselves to be involved in prevention, treatment and to a lesser extent care and support. CREs are predominantly involved in education, including peer education programmes and awareness work. Unlike Kenya and Malawi, the distribution of condoms also seems to be quite widespread amongst CREs. This pragmatic approach could be because it is mainly faith-based medical practitioners who are engaged in responding to the epidemic. CREs also play a major role in the distribution of ART. Some provide micro-credit support or psycho-social care such as HIV-positive support groups.

CREs also identified that they provide other services which for example address the underlying poverty that makes young girls vulnerable to sex trafficking and drives women into sex work.

The research participants were reluctant to specify one particular age group that especially benefited from their services. Most felt they work with all age groups. In contrast, most participants recognised their work was mainly with women and that they worked mostly in urban areas. However, they also indicated that there were many CREs working in rural areas and that the majority of work done in such areas was undertaken with little involvement of the Government.

CREs’ key strengths

Representatives of collaborative stakeholders identified three major areas of strength of CREs. They recognised that CREs were one of the few organs of civil society accessible to rural communities and therefore able to mobilise and influence large groups. Also, they recognised that CREs had credibility within communities and were trusted, which enables them to effectively disseminate information about HIV integrated into their teachings. Finally, CREs were perceived to have well-developed structures which enable them to work in an organised way in rural areas.

The strengths and weaknesses of current collaboration

During this phase of the research, representatives from CREs identified several key issues related to their current collaborative partnerships. Namely, that:

- CREs have extensive relationships with a large number of external donors.
- Many CREs are funded by a number of different external donors.
- The relationships between CREs are not as strong as the relationships they each have with external donors.
- There is no strong relationship with a co-ordination body.
- There are minimal inter-faith relationships. There is an interfaith platform constituted of mainline churches, Muslim revival and independent churches. However, the effectiveness of the interfaith platform is challenged by church politics and access to resources.
- Most CREs seem to have some kind of relationship with relevant government departments.
- Relationships with government departments are less significant than with external donors.
- There is no one government body channelling funds to CREs.

Despite not having a strong co-ordinating body, participants felt that some collaboration did exist as a result of government policy.

Furthermore, whilst the Interfaith Council to Fight AIDS (CIC) was formed by the mainline churches, it was felt it didn’t bring everyone together.
CREs’ collaboration with the Government is undermined by the outdated national AIDS policy. As recognised above, the existing strategy was drawn up in the late 1990s. It largely focuses on a medical response and is not widely known or understood. A new national AIDS plan with a co-ordinated financial strategy is expected. There was general consensus that this new national plan needed to be drawn up in a participatory manner. However, participants were sceptical whether sufficient time and energy will be invested in making sure the national action plan is implemented.

CREs reiterated their appreciation for the support of international agencies. However, it was noted that because programmes are heavily reliant on external funding, agendas were often driven by donors. Some CREs also indicated that this reliance rendered their programmes unsustainable in the long term as funding is usually given to a project for only a limited period of time. Other participants felt monitoring and evaluation procedures were time consuming, and that funding applications were complex. Participants also felt that competition between donors hampers an effective response and that funding from international agencies was not reaching rural communities.

The challenges and potential of collaborative partnerships

There is no doubt that collaborative stakeholders see CREs as crucial in mitigating the HIV epidemic. These stakeholders want to see CREs play a more significant role in responding to the epidemic. Equally, CREs want to be in a mutual partnership with other stakeholders. However, a number of challenges were identified in this phase of the research.

Collaborative efforts remain unco-ordinated. As a result, a number of existing structures and forums fail to maximise their enormous potential. For example, collaborative stakeholders assume inter-faith work is happening through the CIC, yet participants from CREs acknowledged that this body is not functioning effectively and does not represent all interested parties.

There was also a general feeling that the financial dependency of many CREs prevents real partnership. Some collaborative stakeholders also believe CREs lack essential knowledge of HIV.

A further challenge relates to doctrinal differences amongst CREs. For example, some churches do not see HIV as part of their mission. They see it as a medical not a spiritual problem. Also, the promotion of condoms remains a source of contention among CREs. Moreover, the conservatism of CREs is thought to contribute to stigma and discrimination.

An additional challenge relates to the perceptions of the role of the Government in mitigating the epidemic. As noted earlier, national co-ordinating structures are not functioning well and the old national AIDS plan is no longer relevant. On the other hand, some Government representatives thought CREs were unwilling to align themselves with Government policy – highlighting the current breakdown in communication between the stakeholder groups.

Strengthening collaborative partnerships

This research revealed a clear desire from all stakeholders to improve collaboration. To do so, participants identified a number of key issues.

Representatives from CREs felt it was important to develop effective co-ordinating structures and a national AIDS plan. Even more important to CREs were the funding relationships. They felt for collaborative efforts to improve in the future, donor engagement with CREs needed to be reassessed, including the complexity of funding applications and monitoring and evaluation procedures. Funding also needed to be context-specific and include the recognition of Congolese expertise, if it is to reach the targeted communities.
Collaborative stakeholders also felt that funding issues were important, but for different reasons. They felt that CREs needed to be far more accountable and transparent in their use of funds so that in the long term, their work would be more effective. However, this view needs to be tempered by the considerable influence and control international donor agencies have of national agendas.

Collaborative stakeholders identified additional issues that needed to be addressed to improve future collaboration. As one participant at the collaborative stakeholders’ workshop summarised; ‘there is a need for a national plan with clear outputs, a platform to include all faith-based organisations and educate the leaders. Faith-based organisations should be included in planning, a national co-ordinating body [needs to be put in place], and improved collaboration and co-ordination leading to mutual respect.’

Recommendations arising from the research findings in DRC

A number of recommendations specific to the DRC emerged from this first phase of the research, for the attention of each or all stakeholders. They include:

For the attention of the CREs
- Assess effectiveness of the CIC and restructure to ensure appropriate representation.
- Strengthen relationships with one another through establishing regular forums for dialogue and information sharing.
- Strengthen relationships with government stakeholders by inviting them to these faith-based forums.

For the attention of government
- Involve all collaborative stakeholders in the process of updating the National Action Plan.
- Plan strategic interventions that operate from the premise that HIV is a development issue and not simply a medical issue.
- Involve religious entities in ensuring that HIV information is reaching the grassroots communities.

For the attention of donors
- Establish a forum of representatives of all funding partners as a matter of urgency.
- Develop one unified set of reporting and monitoring and evaluating procedures.
- Work with government and CREs in establishing priorities for strategic interventions.

For the attention of all
- Prioritise the principles of the ‘Three Ones’ as a way forward for collaborative efforts.
- Build on the existing agreement signed by all parties in December 2007.
- Establish regular regional forums for all collaborative stakeholders that enable ongoing dialogue, information sharing, and evaluation of strategic interventions.
CONCLUSION

The above country-specific findings and recommendations from Kenya, Malawi and the DRC present a detailed picture of the HIV work undertaken by CREs. They also reflect the relationship between this work and the national AIDS strategies in those countries and the collaboration between CREs, governments, donors and other religious entities. Finally, they identify how this work can be strengthened.

These findings go a significant way to meeting the three objectives of this research. However, the research approach and methodology envisaged this as just the first phase of this research. The following section will propose the second phase of this research. The next phase aims to ensure further engagement with the CREs and collaborative stakeholders. In conjunction with the findings from the initial phase, the next phase seeks to foster a solid and creative partnership between all the key stakeholders that will serve to strengthen responses to HIV across CREs, government and donors.

Update

We have already presented the findings of the research with Christian religious entities, collaborative stakeholders and partners in Kenya and Malawi. We are in the process of presenting the findings in DRC.

We will be working with a representative gathering of key leaders from both the Christian religious entities and collaborative stakeholders to establish ways of strengthening their partnerships and their alignment around the National AIDS Strategy.

It is our hope that this report will contribute to the wider vision of the defeat of HIV and AIDS epidemic in our generation. It is clear that to achieve this goal, then a solid and creative partnership must be forged between all the key stakeholders identified in this report.
5 Proposal for the second phase to ensure further engagement with the Christian religious entities and collaborative stakeholders

The first phase was undertaken by ARHAP on behalf of Tearfund and UNAIDS (from January to July 2008), and involved literature review, participatory workshops and questionnaires in each of the three countries – and dissemination to both participants and an international audience at the Mexico AIDS Conference 2008. The first phase is described in full in the interim report.

From the initial stages of the first phase, it was understood that it would be necessary and appropriate to continue into a second phase. The participatory and intentionally ‘non-extractive’ nature of the research, as well as the focus on collaboration, lends itself to a practical, stakeholder-owned implementation of the research findings. It is important to support the continuation of the collaborative process begun in Phase 1, both in the form of providing feedback to the participants, and in further facilitating stakeholder dialogue, building on the relationships and interest generated in Phase 1. This understanding was confirmed in consultation with the participants during and after the research.

The basic goal and purpose of the second phase will remain unchanged from the original project documentation:

The GOAL: Ensure significant long-term contributions will be made to National AIDS Plans through effective collaboration between government (including donors) and religious entities.

The PURPOSE: Strengthened collaboration, increased mutual respect and understanding between CREs, government and donors in three countries.

However, the key activities in the second phase will be different. The focus will no longer be on gathering knowledge through the research process, but on the facilitation of dialogue and collaboration that builds on the earlier participatory research activities.

Central to understanding this phase of the project is the idea of ‘ownership’. It was considered critical that each process be ‘owned’ by the in-country participants – since collaboration cannot be driven from external sources. It was confirmed in the research that the collaborative situation and process in each country was unique, and therefore required its own method for further development.

At the time of publication of this summary report, Tearfund had carried out part of the next stage which was gathering participants together, and building on this collaborative process as part of our continuing work in those countries.
Abbreviations

AIDS  acquired immune deficiency syndrome
ARHAP  African Religious Health Assets Programme
ART  antiretroviral treatment
CHAM  Christian Health Association of Malawi
CIC  Interfaith Council to Fight AIDS
CRE  Christian religious entity
DRC  Democratic Republic of Congo
HIV  Human Immuno-deficiency Virus
KNASP  Kenya’s National HIV/AIDS Strategic Plan
MIAA  Malawi Interfaith AIDS Association
MOU  memorandum of understanding
NAC  National AIDS Commission
NACC  National AIDS Control Council
NACP  National AIDS Control Programme
NGO  non-governmental organisation
PEPFAR  President’s Emergency Plan for AIDS Relief
PIRHANA  Participatory Inquiry into Religious Health Assets, Networks and Agency
PMTCT  prevention of mother-to-child transmission
PNMLS  National Multisectoral Programme to Fight AIDS
TB  tuberculosis
UNAIDS  Joint United Nations Programmes on HIV/AIDS
UNFPA  United Nations Population Fund
VCT  voluntary counselling and testing
WHO  World Health Organisation
References


Kretzmann J and McKnight J (1993) Building Communities from the Inside Out: A path toward finding and mobilizing a community’s assets, Chicago: ACTA Publications


© TEARFUND 2009
### APPENDIX 1:

**Workshop participants**

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>KENYA CHRISTIAN RELIGIOUS ENTITIES</strong></td>
<td></td>
</tr>
<tr>
<td>Adventist Development and Relief Agency (ADRA)</td>
<td>Mr Barrack Bosire: BCS</td>
</tr>
<tr>
<td>Anglican Church of Kenya, Directorate of Social Services (DOSS)</td>
<td>Mr. Joseph Nyaga Wangai: Health and HIV/AIDS Co-ordinator</td>
</tr>
<tr>
<td>Catholic Relief Services (CRS)</td>
<td>Mr Timon Mainga: HIV/AIDS unit manager</td>
</tr>
<tr>
<td>Christian community services of Mt Kenya East (CCSMKE)</td>
<td>Rev Ben Kanina</td>
</tr>
<tr>
<td>Christian Health Association of Kenya (CHAK)</td>
<td>Mr Peter Ngure: HIV/AIDS Co-ordinator</td>
</tr>
<tr>
<td>Kenya Episcopal Conference (KEC)</td>
<td>Dr Margaret Ogola:</td>
</tr>
<tr>
<td>Kenya Inter-Religious AIDS Consortium (KIRAC)</td>
<td>Bishop Stephen Muketha: Chairman</td>
</tr>
<tr>
<td>Lifeskill promoters (LISP)</td>
<td>Ms Emma Wachira: Director</td>
</tr>
<tr>
<td>Presbyterian Church of East Africa (PCEA)</td>
<td>Rev Simon Githiora Njuguna: Youth Director</td>
</tr>
<tr>
<td>St Johns Community Center (SJCC)</td>
<td>Mr Peter Njuguna: Project Manager</td>
</tr>
<tr>
<td>Young Women’s Christian Association (YWCA)</td>
<td>Ms Grace HA Okello: Programmes and Training Director</td>
</tr>
<tr>
<td><strong>KENYA COLLABORATIVE STAKEHOLDERS</strong></td>
<td></td>
</tr>
<tr>
<td>All Africa Conference of Churches (AACC)</td>
<td>Mr Peter Gichira Solomon: Research and Development Officer</td>
</tr>
<tr>
<td>Council of Anglican Provinces in Africa (CAPA)</td>
<td>Mr Emmanuel Olatunji: Programme Co-ordinator</td>
</tr>
<tr>
<td>Church World Service, East Africa (CWS)</td>
<td>Ms Mary Obiero: Programme Co-ordinator</td>
</tr>
<tr>
<td>Ecumenical Pharmaceutical Network (EPN)</td>
<td>Mr Jonathan Mwiindi: HIV and AIDS Manager</td>
</tr>
<tr>
<td>Inter-religious Council of Kenya (IRCK)</td>
<td>Dr Francis Kuria: Programmes Director</td>
</tr>
<tr>
<td>Kenya AIDS NGO's Consortium (KANCO)</td>
<td>Ms Jane Mwangi: Programme Director</td>
</tr>
<tr>
<td>National AIDS Control Council (Office of the President) (NACC)</td>
<td>Ms Harriet Kongin: Head of Stakeholder Co-ordination</td>
</tr>
<tr>
<td>Norwegian Church Aid East Africa (NCA)</td>
<td>Ms Wasye’ Musyoni</td>
</tr>
<tr>
<td>Organisation of Africa Instituted Churches (OAIC)</td>
<td>Rev Nicta Lubaale: General Secretary</td>
</tr>
<tr>
<td>Sikh Supreme Council</td>
<td>Mr Joginder Marjara: Chairman</td>
</tr>
<tr>
<td>TICH, Great Lakes University of Kisumu (TICH)</td>
<td>Sr Masheti Wangoyi</td>
</tr>
<tr>
<td>UNAIDS Kenya (UNAIDS)</td>
<td>Ms Sari Seppanen-Verrall</td>
</tr>
<tr>
<td>World Conference of Religions for Peace (WCRP)</td>
<td>Ms Zebib Kavuma: Programme Co-ordinator for HIV and AIDS in Africa</td>
</tr>
</tbody>
</table>
### MALAWI CHRISTIAN RELIGIOUS ENTITIES

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church of Central Africa Presbyterian – LISAP</td>
<td>Landson Thindwa: IEC Officer</td>
</tr>
<tr>
<td>CCBC (Baptist) – KOSI</td>
<td>Lessie Mankhanamba: Finance and Admin</td>
</tr>
<tr>
<td>Christian Health Association of Malawi</td>
<td>Francis Gondwe: Executive Director</td>
</tr>
<tr>
<td>Evangelical Association of Malawi</td>
<td>Howard Kasiye: Project Manager</td>
</tr>
<tr>
<td>EAM</td>
<td>Bryer Mlowoka: Head of Programmes</td>
</tr>
<tr>
<td>Episcopal Conference of Malawi</td>
<td>Dr Max Meis: Health Advocate</td>
</tr>
<tr>
<td>Evangelical Lutheran Church in Malawi</td>
<td>Dean A Msuku: Dean and HIV/AIDS Co-ordinator</td>
</tr>
<tr>
<td>MANERELA+ (and BICC)</td>
<td>Ephraim Disi Mbewe: General Director</td>
</tr>
<tr>
<td>Malawi Adventist Church HIV/AIDS programme – SDA</td>
<td>Dennis Matekenya: National Director</td>
</tr>
<tr>
<td>Partners in Hope</td>
<td>Lestor Chikoya: Pastoral Care Director</td>
</tr>
<tr>
<td>Private Schools Association of Malawi</td>
<td>Wilson Asibu: Programmes Manager</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>Captain Dyson Chifudzeni: Development and Project Services</td>
</tr>
<tr>
<td>Scripture Union of Malawi</td>
<td>Rodrick Banda: General Secretary</td>
</tr>
<tr>
<td>World Relief, Malawi</td>
<td>Gibson Nkanaunena: Director of Programmes</td>
</tr>
<tr>
<td>World Vision, Malawi</td>
<td>Paul Nkhata: International Church Partnerships Co-ordinator</td>
</tr>
</tbody>
</table>

### MALAWI COLLABORATIVE STAKEHOLDERS

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Religious Affairs, University of Malawi, Chancellor College, Dept of TRS</td>
<td>Prof JC Chakanza: Professor</td>
</tr>
<tr>
<td>Malawi Interfaith AIDS Association</td>
<td>Robert G Ngaiyaye: Executive Director</td>
</tr>
<tr>
<td>Muslim Association of Malawi</td>
<td>Saiti Burhan D Jambo: Executive Director</td>
</tr>
<tr>
<td>MAM</td>
<td>Dr Imuran Shareef Mahomed: Secretary General</td>
</tr>
<tr>
<td>National AIDS Commission of Malawi</td>
<td>Maria Mukwala: CMO</td>
</tr>
<tr>
<td>Norwegian Church Aid</td>
<td>Esther M Masika: Senior Programme Manager</td>
</tr>
<tr>
<td>Quadria Muslim Association of Malawi</td>
<td>Manuel Mbendela: HIV/AIDS Programme Co-ordinator</td>
</tr>
<tr>
<td>QMAM</td>
<td>Sheik Abdulwahab Ali Thelele Mwale: National Dawah Co-ordinator</td>
</tr>
<tr>
<td>UNAIDS Malawi Office</td>
<td>Emebet Admassu: Partnership Adviser</td>
</tr>
</tbody>
</table>
### DRC Christian Religious Entities

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Presbyterian Contre SIDA</td>
<td>APCS Pasteur Albert Kabwe: Coordinateur APCS</td>
</tr>
<tr>
<td>African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS</td>
<td>Anerela+ Rév Philippe Ndembe: Coordinateur Régional en Afrique Francophone</td>
</tr>
<tr>
<td>APCS</td>
<td>APCS Kashada Lengulula: Coordinateur Provincial</td>
</tr>
<tr>
<td>BDOM Kinshasa (ECC: Eglise du Christ au Congo)</td>
<td>BDOM Dr Benedicte Claus: Médecin-Directeur</td>
</tr>
<tr>
<td>Congolese Network of Religious Leaders Living with or Personally Affected by HIV and AIDS</td>
<td>CONERELA+ Abbé François Nseka: Coordinateur National</td>
</tr>
<tr>
<td>EHAIA/WCC: Conseil Œcuménique des Eglises</td>
<td>EHAIA Hendrew Lusey*</td>
</tr>
<tr>
<td>Kimbanguiste (Kibanguiste Medical Department)</td>
<td>KMD Dr Divenge Nzanbi: Coordinateur National</td>
</tr>
<tr>
<td>Projet SIDA CEK</td>
<td>SA Pasteur Thomas Matonga Mvwamba: Coordinateur Communautaire</td>
</tr>
<tr>
<td>Salvation Army</td>
<td>SA Dr Nku Imbie David: Médecin Directeur</td>
</tr>
<tr>
<td>SANRU-IMA</td>
<td>SANRU-IMA Dr John Okende: HIV Officer</td>
</tr>
<tr>
<td>Vorsi-Congo</td>
<td>VORSI Dr Kamathe Sekera: Directeur National Vorsi-Congo</td>
</tr>
</tbody>
</table>

* Mr Hendrew Lusey acted as facilitator and translator, but also provided his insights

### DRC Collaborative Stakeholders

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic Relief Service</td>
<td>CRS Dr Bajah Raphael: Directeur Programme SIDA AMITTE</td>
</tr>
<tr>
<td>Christian Aid, RDC (DRC)</td>
<td>CA Jean Ilunga Mukulu: HIV Programme Officer</td>
</tr>
<tr>
<td>COMICO: Muslim Community</td>
<td>COMICO Muamba Kadiayi: Chargé des Programmes SIDA RIPD</td>
</tr>
<tr>
<td>Catholic Organisation for Relief and Development Aid</td>
<td>CORDAID Arjanne Rietsema: Chef de Mission</td>
</tr>
<tr>
<td>Family Health International</td>
<td>FHI Dr Jocelyne Kibungu: Chargée de SLE</td>
</tr>
<tr>
<td>Memisa-Belgique</td>
<td>MEMISA Dr Anicet Mazaya: Coordinateur Médical</td>
</tr>
<tr>
<td>ONUSIDA – UNAIDS</td>
<td>UNAIDS Chirume Mendo</td>
</tr>
<tr>
<td>National AIDS Control Programme</td>
<td>PNLS Dr Ekofo Felly</td>
</tr>
<tr>
<td>Programme National Multisectoriel de lutte contre le SIDA</td>
<td>PNMLS</td>
</tr>
<tr>
<td>World Conference of Religious for Peace</td>
<td>WCRP Rev Armand Kinyamba Linge</td>
</tr>
</tbody>
</table>
APPENDIX 2

The African Religious Health Assets Programme (ARHAP)

History of ARHAP

The African Religious Health Assets Programme (ARHAP), an international research collaboration, was formed in December 2002 in order to address the general paucity of studies on faith based organisations working in health, in the face of growing public health crises in many parts of the world. Africa became the focus because it offers the potential for contributing a great deal of learning globally, given major public health challenges, a complex mix of religious traditions in varying contexts, and a wide variety of actors in the field of health.

Since its launch, ARHAP has worked at refining its focus and conceptual frameworks, and extending its dialogue with religious and public health agencies, practitioners and academics, particularly in Africa. In the process, ARHAP has become visible to players in the field of public health internationally, and a series of case studies have been undertaken in southern Africa.

The major ARHAP partners are: the University of Cape Town (UCT), University of KwaZulu-Natal (UKZN), the University of the Witwatersrand (WITS), Le Bonheur Methodist Health Care, Memphis and Emory University – but there are firm connections to other key individuals and organisations.

ARHAP vision and objectives

ARHAP’s overall objectives are as follows:

- To assess existing baseline information sources and conduct an inventory (‘mapping’) of religious health institutions and networks in Africa.
- To articulate conceptual frameworks, analytical tools, and measures that will adequately define and capture religious health assets from African perspectives, across geographic regions and different religions, in order to align and enhance the work of religious health leaders and public policy decision-makers in their collaborative efforts.
- To develop a network that will include nodes of scholars and religious as well as public health leaders in sub-Saharan Africa; plus scholars from outside Africa, religious leaders and representatives of key funding, development and policy-making organisations.
- To train future leaders of both public health and religious institutions in religious health asset assessment skills (capacity building).
- To provide evidence to influence health policy and health resource allocation decisions made by governments, religious leadership, inter-governmental agencies and development agencies.
- To disseminate and communicate results and learnings widely and regularly.

A guiding research question for ARHAP is: In the context of major health crises (linked to environmental and social conditions), given the widespread engagement of religious entities (REs) in health activities, what criteria, categories and related assessment tools will engender a richer, more dynamic and more productive view on religious health assets (RHAs), their contribution to health, and their alignment (or lack of it) with public health systems?
ARHAP is interested in focusing on what these religious health assets are, how they work, and what potential exists for strengthening them without undermining the very things they offer or destroying them through inappropriate interventions or engagements.

We begin with a positive view of faith-based initiatives in health in the first instance, hence our description of them in terms of religious health assets, which we understand much more broadly than the more traditional focus on facilities such as hospitals and clinics. At the same time, a naïve view of the role of religion would undermine our grasp of the necessary social realities; hence we recognise the need to balance the positive with a clear grasp of the limits and possible negative impact of religious traditions or faith-based practices in particular contexts.

See www.arhap.uct.ac.za for further information.