

EMPOWERED BY FAITH

COLLABORATING WITH FAITH-BASED
ORGANIZATIONS TO CONFRONT HIV/AIDS



WILLIAM L. SACHS

WITH A MESSAGE FROM ARCHBISHOP DESMOND TUTU

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Cover: A volunteer home care team from Namibia, mobilized by Catholic AIDS Action and supported by FHI (William L. Sachs); **Back cover:** A Buddhist prays as Khut Ong, founder of the Kien Kes Health Education Network in Cambodia, looks on (Karl Grobl Photography); **Interior title page:** Muslim imams in Dhaka, Bangladesh, gather to learn about HIV/AIDS through a program supported by FHI and the Masjid Council for Community Advancement.

Appearance in photos does not indicate health status.

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In July 2011, FHI became FHI 360.



FHI 360 is a nonprofit human development organization dedicated to improving lives in lasting ways by advancing integrated, locally driven solutions. Our staff includes experts in health, education, nutrition, environment, economic development, civil society, gender, youth, research and technology – creating a unique mix of capabilities to address today's interrelated development challenges. FHI 360 serves more than 60 countries, all 50 U.S. states and all U.S. territories.

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ACKNOWLEDGMENTS

AS THIS PROJECT DEEPENED, MY GRATITUDE FOR THE OPPORTUNITY became profound. Initial appreciation for the vision of Family Health International's staff multiplied many times over as I visited FHI offices in seven countries and found consistent examples of high professionalism, dedication, and warm hospitality. As a newcomer to FHI, I was moved by the quality of its programs and staff. Their knowledge and engagement with local faith-based organizations facilitated this project and made it richly fascinating. I hope this work adequately reflects the depth of compassion I discovered in FHI staff and in the people of faith with whom they work.

I would especially like to thank those who facilitated my work in the field: the Moulana Abul Kalam Azad, Robert Kelly, Sultana Aziz, Diane Lindsey, Tony Michael Gomes, and A. F. M. Iqbal in Bangladesh; the Venerable Khut Ong, Ngak Song, Caroline Francis, Amara Bou, Cindy Milford, and Nheub Bunthoeurn in Cambodia; Kwame Asiedu and Tomaisha Hendricks in Guyana; Father Rick Bauer, Rev. Dr. Henry Platt, Lucy Steinitz, and Rose De Buysscher in Namibia; Peter Mwarogo and Simon Ochieng in Kenya; Misti McDowell, Jessica Price, and Anne Marie Ayinkamiye in Rwanda; and Father Joseph Maier, Somchai Sriplienchan, and Jintana Sriwongsa in Thailand.

Mary Dallao of FHI has been instrumental to this project. At every step she has proven to be skilled, responsive, and encouraging. She has been the ideal contact person for a consultant. With draft in hand, she also has been a thoughtful and effective editor. The work

has gone smoothly because she embraced the idea and facilitated its realization. It has been a pleasure to work with her.

I would also like to express deepest appreciation to Gordon Raley and John Engels of FHI for their helpful comments and careful reading of the manuscript. Their insights also have been extremely valuable. Jimmy Bishara's design skill has helped translate my words into a professional and attractive finished product, and I am also grateful to him.

In gratitude this work is dedicated to Thomas Turner Bruneau and Austin Boyd Bruneau. May they grow into the depth of compassion that people of faith exemplify, as these pages reveal.

William L. Sachs
Richmond, Virginia
December 2007

A MESSAGE FROM ARCHBISHOP DESMOND TUTU

THIS IS A REPORT ABOUT PEOPLE OF FAITH IN GOD IN THE PROCESS of offering compassion. In part it describes how people of faith have mobilized and through cooperation with a major nongovernmental organization have collaborated to address the devastation of HIV/AIDS in various countries. These stories can serve as a guide to what is possible through such collaboration even in the face of daunting challenges. Faith in God encourages broad cooperation in response to illness.

In the midst of what you read, there are insights into the sort of compassion that faith alone can encourage. The people whose caregiving is described on these pages represent different religions, nations, and cultures. Yet all of them dedicate their lives to making God's love known in tangible ways, ways that affirm people as loved by God. The differences among people fade because they have a shared faith commitment: they respond to illness with respect for human dignity and dedication to promote healing.

It becomes clear that faith can bind people together across lines that otherwise divide. On these pages you will see how readily such ties are formed, among caregivers and between those who offer care and those who receive it. Out of such bonds, faith builds a broad and powerful sense of common good, and offers means to strive for it. In the midst of responding to one disease, broad aspects of human circumstances come into focus and receive loving attention.

As well as guide, these stories should inspire. They show how profound a resource people of faith can become. They describe the power and goodness that emerge when people of faith mobilize. I pray that through these accounts you will discover a more faithful basis for your own efforts to offer compassion.

+Desmond Tutu
Archbishop of Cape Town, Emeritus
Anglican Church of Southern Africa

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PREFACE

I AM PLEASED TO PRESENT *EMPOWERED BY FAITH*. THIS REPORT documents some of Family Health International's most successful programs working with local religious groups to provide HIV/AIDS care and treatment services as well as prevention messages. In many places where we work, we find that faith-based organizations are best positioned to help us reach vulnerable and most-at-risk populations. They are often an important part of the community and possess great credibility among those we hope to reach. In addition, adherents of faith traditions who live in places where we work—whether Christian, Hindu, Muslim, or any other—have often proven ready partners in our work. They have been eager for information on how to prevent the spread of HIV and provide support to those affected by the epidemic. They have served as reliable and indispensable partners in reducing the spread and impact of the epidemic in resource-constrained communities all over the world. We are grateful for all they have contributed to our efforts.

We hope you find this publication about our collaborations with faith-based organizations interesting and informative, and encourage you to provide feedback or request additional copies. Contact aidspubs@fhi.org with the words “Empowered by Faith” in the subject line.

Peter Lamptey
President, Public Health Programs
Family Health International

**EMPOWERED
BY FAITH**

INTRODUCTION

FORMED IN 1971, FAMILY HEALTH INTERNATIONAL (FHI) IS AMONG the most established nonprofit organizations active in international public health, with a mission to improve lives worldwide through its synergistic strengths of research and programs in public health. FHI manages research and field activities in more than seventy countries to meet the public health needs of some of the world's most vulnerable people. We work with a variety of partners, including governmental and nongovernmental organizations, research institutions, community groups, and the private sector. Through global reach and local action, we help countries and communities to prevent the spread of HIV/AIDS and sexually transmitted infections and care for those affected by them; improve people's access to quality reproductive health services, especially safe, effective, and affordable family planning methods; and improve the health of women and children, especially those who live in resource-constrained settings.

This publication presents some of FHI's positive experiences working with faith-based organizations. Since religious groups are often integral parts of society in places where we operate, they frequently serve as implementing partners for our HIV/AIDS programs. Collaborating with local faith-based organizations has enhanced our efforts in many ways. We are proud of all we have accomplished together and wish to document some of our joint achievements. Although limited resources have prevented us from writing about all of our projects involving faith-based groups, this report presents a snapshot of some of our best. It also shares some of the reasons we feel faith-based organizations have been strong partners, and provides insights on what collaborative approaches have

worked. Understanding what faith-based organizations do uniquely well is essential for any nongovernmental organization seeking to collaborate with such groups.

Since it is difficult to offer precise formulas for effective collaboration with faith-based groups in the way one might offer practical steps for clinical service delivery, we relate general principles and approaches our staff applied to such partnerships. We hope this report will help others who are considering working with faith-based organizations as key implementing partners.

Primarily, this publication conveys ideas through storytelling. The stories of faith leaders, FHI staff, and program beneficiaries present concrete glimpses of the everyday work of faith groups and FHI in helping people affected by the epidemic. This report gives voice not only to FHI staff and faith leaders in host countries, but also to the people whose lives of loss, due to HIV/AIDS, have been made better by our work.

Information was gathered through interviews conducted in seven countries where staff reported strong links to religious groups and favorable impressions of the role of faith communities in FHI's work. Taken as an aggregate, these countries—Guyana, Bangladesh, Thailand, Cambodia, Kenya, Rwanda, and Namibia—represent a varied set of social, cultural, and religious circumstances.

Travel took place between February and June 2007. Interviews were conducted during visits to FHI offices, religious institutions, facilities of interfaith groups, homes of patients and community volunteers, and community centers. They were conducted with FHI program staff, patients and clients, faith leaders, health workers, and community leaders. FHI staff members also made reports derived from their work available. Other information was drawn from pertinent publications and websites.

This report does not offer detailed summations of activities by country. Rather it presents recurring themes that emerged from conversations

with people involved with FHI faith-based programs. Our hope is that, in this way, the report can illustrate the practical compatibilities between faith-based and nongovernmental organizations.

1

REVEALING STORIES

SHE WAITS PATIENTLY FOR A CHANCE TO SPEAK, HER DEMEANOR offering no hint of the power of her story. Wearing her best dress and clutching her purse, she sits quietly in a hospital conference room. She has prepared carefully for this meeting but does not draw attention to herself. It would have been easy to overlook her if someone had not whispered that she was waiting. She greets the interviewer deferentially, and even when encouraged to speak she hesitates at first. But after shifting nervously in her chair and clearing her throat, she begins her story and all hesitation vanishes. She has something important to say, something revealing that she has not described so honestly before. After a few moments in her presence, it is clear that when she speaks her story proves unforgettable.

With little affect, in a soft voice, this woman, whom we will call Natalie, recounts how her life in rural, central Rwanda has changed. The journey that brought her to this interview began the day she learned her husband was HIV-positive. The shock of that knowledge was followed by resignation. She felt profound grief and cared for him as best she could. It never occurred to her until after his death that she would become more implicated. After a simple test she learned to her horror that she was infected as well. The numbing sense of her husband's death became acute distress as she grasped the seriousness of her situation. Questions she never imagined asking assaulted her: How long would she live? Who would care for

her? What could she do? Where would she turn? Where might she find understanding in the midst of loss?

Naturally she turned to her church. Religion permeates life in Africa, and her area of Rwanda was no exception. Religion creates the framework of community, crossing lines that ordinarily divide and linking individuals and families in powerful social bonds. Often particular beliefs are obscured by the social purposes religious life embodies. It is more than a set of beliefs or rituals. Staggered by her loss, Natalie instinctively looked to her Protestant congregation, with its powerful ties, for hope and understanding. But such support was not immediately forthcoming.

Natalie already felt stigmatized by her husband's illness. It was even more difficult to face his death. But then there were also hints of moral judgment linked to his sexual behavior. Her immediate experience in the church reinforced the image prevalent in some parts of the world that religion centers on moral condemnation and that religious groups prove exclusive rather than inclusive. Natalie's own infection intensified her sense of stigma. She felt further isolated, without apparent possibilities, with only her eventual death, which she would surely face alone.

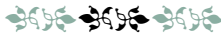
Then something unanticipated happened, something that defies the impressions often held about religion. Her local congregation began to rally around her. She was one of their own, and the fact of her illness mattered more than the nature of it. Moral condemnation evaporated. Stigma shrank. Her fellow church members shifted from suspicion to compassion. Natalie was fortunate to receive antiretroviral therapy, and the medication began to improve her health. As the disease's progress slowed, she resumed some ordinary activities. The care provided by church members was making a difference at a pivotal stage of her treatment.

The change in outlook among church members did not stop with care for Natalie. Her illness made them feel a responsibility to care for others. Soon Natalie and several of her church family exercised groundbreaking

leadership in creating local associations for the treatment and prevention of HIV/AIDS. At first there were only six people in the group. But in only a few years it grew to more than three hundred members, most from Natalie's congregation. They found training as caregivers for people affected by the virus, and their example inspired others through the links offered by the church.

And the growth of such associations did not stop with Natalie's locality. Soon, others affected by the disease sought training in giving care and education about the disease and its prevention. Local associations sprang up across Rwanda. Consistently they took root because of the encouragement and ties local churches offered. Far from being impediments, faith communities offered ready bases for combating the disease.

Natalie tells her story in a disarmingly quiet voice. But as she describes her life today, one senses the emotional power surging in her. She has come a long way and is justifiably proud. Not only is she the treasurer of her local association, she also works in the nearby hospital where she first received treatment. Her hospital and congregation have given her a life beyond illness she never could have imagined. Natalie has not just survived; she has adapted and thrived. At the heart of her story lies the capacity of faith-based action to unite and heal.



NATALIE'S STORY READILY FINDS COUNTERPARTS IN VIRTUALLY every country where HIV/AIDS looms as a significant threat. It is a story that is not confined to any one culture, religion, or socioeconomic group. In western Cambodia, for example, sixteen people affected by HIV/AIDS gather for a monthly meeting. Some are infected by the virus; others have loved ones who are infected; others joined to help in the face of suffering. None of these people could have imagined facing a deadly disease a

Cindy Milford, Coordinator, Community-based Care and Support, FHI/Cambodia

My family arrived in Australia in late 1980 as Cambodian refugees after the downfall of the Khmer Rouge regime. I was eight years old at the time and only remembered a war torn homeland. Coming back to Cambodia for the first time in late 2003 I had to relearn the Khmer language (in Australia my parents forbade us to speak Khmer in their attempt to forget the past) and relearn a culture that is familiar yet a stranger to me.

I started working with FHI/Cambodia in September 2004 coordinating the Women At Risk Program. Working with sex workers and men who have sex with men was a huge challenge for me personally and professionally—a challenge I loved. Coming from a traditional Christian upbringing, many of my own prior stereotypes about sex workers and gay men were diminished as I got to know them and advocate for their acceptance in mainstream society. Professionally it was such a contrast to my previous work in Melbourne, where I had worked with general practitioners in the inner city on immunization issues. Surprisingly, I was just as comfortable chatting with sex workers in a wooden shack brothel in Cambodia as I was chatting with doctors in up-market private clinics in Melbourne.

Working with FHI in Cambodia has fulfilled a lifelong dream—to work among the poor in my own homeland. I feel very blessed to be able to work with a committed team of staff to reach out to a diverse group of people who are often marginalized or neglected in society.

FHI's work with Buddhist monks and Muslim imams on HIV programs is effective because religious leaders are highly esteemed and central to the Khmer culture. Through their love, compassion, support, and acceptance of people infected and



affected by HIV/AIDS, these religious leaders model and mobilize their communities to do the same.

Now coordinating a program for orphans and other vulnerable children, I am very passionate about my work. At the end of the day, I get a buzz from knowing that I can make a difference to the children and families I come in contact with, even though my contribution may be small. In a resource-constrained country like Cambodia, every bit can make a difference in vulnerable people's lives. These children may be infected or affected by AIDS today, but they can still be future leaders of Cambodia tomorrow if we all do our part.

few years ago, much less imagined they would be on the frontline of care. But they understand that they provide care that might not be found otherwise. They recognize that training from their religious community has enabled them to do this work.

The religious backdrop encourages people to tell their stories openly. At a recent meeting, one man tells his story. Unhesitatingly, he reveals that he became infected in 2001. The disease progressed until he could not work or care for himself. Family members did not know how to provide care and it was unclear where to turn. His future was bleak. Then a program led by Buddhist monks linked him to a hospital where he received antiretroviral therapy and learned of this support group. His health improved and his life got better. He describes his return to work, adding that he has been able to afford a new motorbike.

His story is not the only one. There is a revealing discussion about dealing with the side effects of antiretroviral therapy. Men and women who had been strangers to one another describe their physical states and the conditions of loved ones in detail. Group members listen respectfully, and when they speak it is to offer support. Revealing experiences gradually give way to humor and more mundane topics. A warm, easy rapport has emerged. Conversation is lively, open, and caring.

While care is an obvious theme of the group's meeting, the content of their discussions is not immediately religious. There are no debates about belief or recourse to religious practices or texts. But when asked, they are clear about their basis and intention. Faith motivates their compassion. They learned the substance of their activity through a program at a nearby Buddhist monastery. Religious people have taught them to give care.

In Thailand, the initiative of one religious leader resulted in the development of a community center offering services to people infected and their families, including home care and in-patient hospice care for adults and children.

In Guyana, religious leaders developed a peer educator network to train people in disease treatment and prevention.

In Kenya, a local church sponsors a young adult drama group that performs skits and gives talks in public places to educate people about the disease.

In Bangladesh, hundreds of Muslim leaders received training in prevention and treatment, and have conveyed their new knowledge in lessons during prayers at local mosques.

In Namibia, the friendship of a Roman Catholic nun and a Jewish social worker led to the creation of an agency that spans the country and engages hundreds of staff and volunteers in care and prevention.

In each instance, the lives of thousands of people have been enhanced, and even saved, because of initiatives that reflect religious commitment. As a nongovernmental organization, FHI has worked alongside these groups, providing technical advice on HIV/AIDS prevention and care, convening interfaith groups that address HIV/AIDS issues, and sharing financial resources supplied by our donors, especially the US Agency for International Development (USAID) and the US President's Emergency Plan for AIDS Relief.

It should not be surprising that religious groups offer one of the most obvious resources for combating HIV/AIDS. Nor should it be surprising that many of the programs they have embarked on with FHI's help have taken root and thrived in local communities. Worldwide there are more religious congregations and organizations than any other sort of social gathering. Historically, faith groups have been the greatest source of founding and sustaining medical and educational institutions. They have been the most consistent basis for providing social and economic development and influencing local leaders.

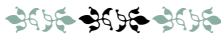
With the involvement of religious groups, it is possible to prevent and attend to the disease's underlying circumstances. Because religion is

rooted in local life, connecting with faith groups facilitates understanding of the broader circumstances in which the disease proliferates. At the grassroots, in one cultural context after another, ordinary people give extraordinary care because of their religious foundations. In addition, many faith groups network with one another and see possibilities for expanding and enhancing the care they give. When asked what motivates them to respond, they offer no elaborate explanations. They simply speak of caring for those in need because of their faith.

2

THE VISION OF COLLABORATION

A STAFF MEMBER IN CHARGE OF ONE OF FHI'S THIRTY-SEVEN COUNTRY offices (called a "country director") faced a situation most country directors encounter at some point: How to implement a newly funded program? As he considered whom he might rely on, one of the country's Muslim leaders came to pay him a visit. To the country director, this visit brought an unexpected opportunity: the Muslim leader explained that a few months earlier, religious leaders had discussed interfaith cooperation and begun looking for ways to collaborate. He said he had heard that a new FHI program was beginning, and wondered if faith leaders could help. The result has been major work to educate people in HIV/AIDS prevention. The work relies on the efforts of hundreds of imams who are being trained through a Muslim community action organization. They use booklets of suggested talks developed through the faith-based organization with FHI collaboration. The blend of FHI expertise with faith-group capacity to reach ordinary people credibly and persuasively is proving effective.



THE EXPERIENCE OF FHI REVEALS THAT WE SHARE MUCH COMMON ground with faith-based organizations that makes collaboration mutually rewarding. First and most fundamentally, individuals associated with

faith-based organizations and FHI staff often have similar motivations for working in HIV/AIDS. Many people of faith speak of their desire to provide care and be of service to others—a worldview grounded in their religious beliefs. FHI employees also frequently cite similar reasons. While these beliefs may also be grounded in faith, others may simply feel a sense of altruism. Whatever the primary driver of personal philosophies, associates of faith-based organizations and FHI employees are often governed by similar moral imperatives.

The concrete goals of most faith-based organizations working in HIV/AIDS—regardless of the religion they practice—are also not unlike those of FHI. Both aim to prevent new HIV infections and care for and improve the quality of life of those infected and their families.

FHI and local faith-based partners each possess different practical strengths that make them suited to address the disease. Those who are formally linked to faith-based organizations are often readily available to begin work and eager to collaborate. FHI has technical expertise in combating the disease, skill in organizing volunteers (a skill faith-based organizations also possess), and experience presenting public health information in ways that can inspire people to change behavior.

The capacity to build bridges between people, and between people and wider organizations and resources, is a pivotal strength FHI and faith-based organizations share. FHI's work often requires building bridges between those who offer resources and those who need them. Religious organizations often offer the most readily accessible doorway into the lives of people who need the services we provide.

Collaboration with religious organizations legitimates and promotes information and services that might otherwise escape public notice and acceptance. The authority of faith leaders and their organizations is never automatic: public response to leaders always depends on their capacity to persuade and act credibly. But we will glimpse the extent to which local

and national faith leaders possess such credibility and exercise it responsibly and innovatively. In fact, collaborations with FHI and faith-based organizations that enhance the knowledge of faith leaders also enhance their credibility. Thus there has been a natural convergence between FHI's desire to disseminate knowledge and the innate intention of religious groups to serve people.

Also, faith-based organizations typically emphasize processes of formation by which people are educated and leaders equipped in specialized ways. FHI often undertakes educational programs for community leaders and those in healthcare. Though the basis is again somewhat different, and the intended outcomes vary, the religious emphasis on education offers a platform for FHI's work.

The combination of overlapping goals and complementary strengths has enabled FHI and faith-based groups to have an even stronger impact together.



ASKED HOW HIS COLLABORATION WITH MUSLIM RELIGIOUS LEADERS has gone, the country director beams. "It is their reliability," he says. "Religious people are committed people; they want to help because of their faith. If you find that their capacity or their resources need enhancing, you can readily do it. And there is sustainability. There is so much more to draw on than with secular groups. They are there for the long haul and they never run out of sympathy. I have worked in other countries and consistently this is what I have seen."

One religious leader in the country has a television program that attracts hundreds of thousands of viewers. The FHI country director was on the program and a series of broadcasts that addressed the realities of HIV/AIDS. FHI would not have been able to reach this large audience

if the religious leader had not offered his influence and communications outlets to the work of combating AIDS. Clearly this work had become a close collaboration between FHI and faith-based groups.

This instance is not isolated. To the delight of many FHI staff, religious groups are responsive to possibilities for collaboration. Consistently, religious leaders and their groups are amenable to working with other religious groups and nongovernmental organizations because they recognize the threat presented by HIV/AIDS stops at no religious or secular boundary. It is not unprecedented for religious leaders to approach FHI, just as FHI staff readily approach religious leaders, about joint work. Each recognizes mutual intention and respect in the other. Another FHI country director on a different continent sees such collaboration as typical. “Working with religious groups is nothing new. They access a lot of resources and they are nice partners. And we can expedite the work with them. They are ready to go to work and they have immediate contact with people on the ground.”

She cites collaboration between FHI and a Roman Catholic youth organization. “We worked with them technically and they really mastered it. These kids felt they could change the world, and the Church and FHI backed them.” The lesson of this one group had wider implications. “We learned from what the kids did and took it elsewhere. It has informed the way we approach community mobilization and working with youth. It became a case of transferring innovation. That has extended our collaboration with the Church because they are also interested in taking what is learned in one place to other places.” Combating HIV/AIDS became the basis of innovative strategy and networking.

Such collaboration often begins informally, typically with friendship or acquaintance between a few key people. FHI staff members have to get to know religious leaders, but that usually is not difficult. Religious leaders are often visible and accessible. In Guyana, FHI staff knew and

enlisted religious leaders in creating an interfaith manual, *Faith Matters*, for encouraging AIDS prevention. The FHI staff person designated to work with faith-based organizations found they were waiting to be mobilized. “If you give people tools and support, they will use them. You have to speak the language of the faith group. FHI brought different faith groups together to work on this manual and on a program of prevention, and they responded. They see that they are all affected and they are ready to help people. With training they will communicate what they have learned to their congregations.”

“Just talking about sex was difficult for some religious leaders,” she adds. “But they did it and the response generally has been good.” The focus of this work has been on education and it has required that faith groups not only talk about difficult subjects, but that they talk to one another in ways they never had done before. FHI successfully convened them and the interfaith manual is one result. Another is a program to train peer educators, including faith leaders themselves. The training is ongoing and the impact on prevention efforts is yet to be felt. Yet it is clear that faith-based organizations and those who lead them have responded and are taking their learning to the people they serve.

In all cases the vision of collaboration prompts introductions between key people in religious and civic life, often people who have not worked together or even known one another. FHI has facilitated such introductions. In Guyana, FHI staff brought together religious leaders who had not convened before. The breadth of religious life that assembled was striking: Muslims, Hindus, and various denominations of Christians. They compared beliefs and practices and found a substantive basis for collaboration to prevent the spread of HIV/AIDS. *Faith Matters* includes quotations from all of their sacred texts. It was written and edited by a Rastafarian, reflecting a religion present in the Caribbean. In turn, these religious leaders are using the manual to train peer educators to apply

lessons from it to local circumstances and diverse groups across the country. Religious groups acted innovatively and cooperatively because FHI staff convened them.

Regardless of the country or the cultural circumstances, basic lessons can be drawn from FHI's experience with faith-based organizations. First, nongovernmental organization staff must become acquainted with the religious circumstances of a country, and especially with local and national leaders. It is often difficult to draw hard and fast distinctions between religious and civic leadership in a society. Religious organizations and their leaders are so integrated into their societies that religion inevitably is the doorway to engaging the major leaders of a nation and its localities. But, second, it is just as important to know religious leaders in various regions of a country, and to gauge how a particular faith group is organized and to what extent it touches the life of different localities. In multi-faith settings, a given religion may be spread unevenly across a country. Of course, even in nations where one religion predominates, the success of a given project may rest on the ability to engage religious leaders and people.

But for all its institutional presence and organizational infrastructure, religious life is not only organizational; it is communal and it is lived in diverse forms of assembly, many small and local. Mobilizing faith-based organizations entails engaging local people who participate in the activities of their faith-based group. They often have a capacity to act compassionately by providing care.

The director of one facility in Southeast Asia noted that nongovernmental organizations typically base their work on a response to a problem. But, he said, faith-based organizations base their work on care for the people of a place, and a vision of uplifting those people. In western Cambodia, a program to combat AIDS was launched by a regional Buddhist leader from his base at Kien Kes, a major monastery. Khut Ong saw the extent of the need and realized what needed to be

done. The infection rate was not high nationally, but there were infected people and there was danger of the disease spreading further. Using his recognition as a religious leader, Khut Ong began teaching about the disease and calling for a response. He found land for facilities and he went in search of technical expertise—a search that soon led to FHI. Today he notes that FHI provided the technical resources for his Kien Kes Health Education Network, but local people, acting on the basis of faith, provided the capacity to respond.

“There is a broad need and there is broad capacity among the people,” he says. Gradually FHI support included strategic planning, management training, leadership training, and advice on understanding project cycles. Home care groups were formed in an ingenious manner: local villagers reached consensus about who among them was best suited to be trained to offer care to persons and families affected by the disease. Now home care groups fan out across the area. FHI could not instill the motivation to care, but it tapped that motivation with impressive results. Through Khut Ong’s initiative, new support networks involving the whole community grew from the efforts of one committed, dynamic religious leader.

Another program of home care in Southeast Asia was launched by the families of patients. “We used to send the patients straight home,” comments the director of one treatment facility created by a religious leader. “But the families were scared. They were afraid they could not care adequately. They asked the staff to help and that led to home visits.” But staff had to be trained in home visits, including assessment of the patient’s medical condition and the family’s social circumstances. That led to special training and then creation of a group to provide home healthcare. Now the home healthcare staff consists of twelve people. All are HIV-positive, receiving antiretroviral therapy, and doing well.

Often the religious foundation of such care is not immediately apparent. “The basis of this place is religious,” notes the care center director.

“But we don’t flaunt it. There are a few religious symbols here, Christian and Buddhist. But our faith is expressed by what we do, by our care.”

The care provided by these faith-based organizations represents faith that is lived. It is faith expressed through care that begins with visits to people and localities. This form of care ensures that people are linked, and through these links their circumstances are understood and addressed.

In the context of responding to HIV/AIDS, such visits are conducted after training and with ongoing accountability and supervision. But no amount of training can instill the basic impulse to visit as an extension of a faith community. In the midst of assessment and service delivery, the people who make these visits are linking people in need to a web of support. The value of this linkage is huge. Persons who are diminished physically and fear isolation because of it find they are not forgotten. In the midst of a grave threat, they are drawn back into a social circle of meaning. The experience of home care programs in Thailand, Cambodia, and Namibia reinforces this perception.

Of course people suffering from HIV/AIDS also face medical and social issues, such as TB and poverty. They also may face the bewildering complexity of hospitals, clinics, and government offices, as well as the daunting challenge of accessing such service providers. The care offered by these faith groups often focuses on connectivity: linking people to people, people to community, and people to services. Thus people working under the auspices of faith groups are alert to the importance of getting people to services and services to people. Aware of this need, they have often found creative solutions to making such connections.

3

PROVIDING CARE

NOW, AS IN THE PAST, RELIGIOUS LIFE ENTAILS THE DEVELOPMENT of elaborate caregiving networks, making faith-based organizations natural partners for nongovernmental organizations. Often faith-based organizations represent a significant, even dominant, portion of a nation's infrastructure. In some African countries, they are the dominant social service providers. In part this is a legacy of Western missionary work, which has focused on the creation of hospitals, schools, and social service facilities. Often such facilities are the principal caregivers in a nation. For example, interviews for this study were conducted at Catholic and Protestant facilities in Rwanda. One was founded in the late twentieth century; the other was a product of the nineteenth-century missionary presence. They illustrate both the religious past and emerging forms of religious life. Such examples could be cited from all of the sites mentioned in this book.

Catholic AIDS Action in Namibia (CAA) is one strong FHI partner that exemplifies the capacity of faith-based organizations to launch extensive forms of care targeting persons living with HIV/AIDS. Although only ten percent of the Namibian population is Catholic, CAA reaches far more than ten percent of those affected. In the north of the country, for instance, four local offices provide forty-four home care groups, including over five hundred and thirty active volunteers. These volunteers made over twenty thousand client contacts in 2006.

In addition, nearly thirty-two hundred clients were seen by these four offices for voluntary counseling and testing, information, referrals, or requests for services. While two hundred and sixty clients left the service in 2006, over eleven hundred new ones arrived. There were nearly eleven thousand one-on-one contacts between clients and CAA staff in four northern offices.

Another strong organization that works with FHI in Namibia is the Church Alliance for Orphans (CAFO). It was founded in 2002 and quickly had an impact despite beginning with only one staff member and a small board. By the summer of 2007 more than four hundred congregations were affiliated and sponsoring training and support for AIDS orphans in their communities. In some cases local ecumenical committees bubbled up and took initiative to respond to particular needs. According to the Rev. Dr. Henry Platt, director, the content of religious teaching was not invoked; rather there was broad emphasis on religious intention to offer compassion and support children in need. As CAFO grew, it expanded beyond Christian churches to include Bahá'ís and Muslims in some parts of the country. The success of CAFO, Platt adds, is its marriage of professional care with the compassion that seems instinctive for many religious people. Further, the impulse to care is matched by a capacity to be trained and formed into teams, and to welcome ongoing monitoring and evaluation (M&E). CAFO has relied upon FHI for M&E assistance.



BECAUSE THEY ARE INTENT ON SERVING THE PARTICULAR NEEDS of their localities, and because of their entrepreneurial potential, faith-based organizations inevitably offer a wide range of caregiving programs. Some serve the most desperately disadvantaged people.

Near Ondangwa in the north of Namibia, a home care worker representing Catholic AIDS Action visits a woman living in a tiny hut in an informal settlement. She sits in front of the hut in the bright sun, surrounded by a few items of clothing, a few car parts and some trash, the ashes of a recent cooking fire, and a few small baskets in various stages of being woven. Relentlessly flies circle, undeterred by the breeze. The home care worker sits on an oil drum and talks to the woman. She has been treated for TB and recently went to the hospital for a foot problem. She makes baskets to raise money to go by taxi to the hospital. There is no other income, and yet she supports a ten-year-old girl who lives with her, apparently an orphan. The care worker suspects she is HIV-positive and encourages her to receive testing, but she hesitates. She is concerned about enrolling the girl in school, and the worker promises to inquire. The worker gives her sugar, flour, and oil, and she expresses gratitude for the gifts and the attention. Her husband died of AIDS and she would have no assistance were it not for CAA.

In Naivasha, in Rift Valley Province, Kenya, FHI cooperates on a range of programs with the YMCA, which was founded as a Protestant, interfaith organization dedicated to health and personal wellbeing. Life Bloom, one of these programs, seeks to reeducate women who have been commercial sex workers. In four years the program has featured discussions and one-on-one sessions in its offices and in homes, and even in public places where sex workers meet clients. Most of these women want to leave the sex trade but feel trapped by economic need. They also fear “reentry” into society, anticipating their pasts stigmatize them, especially in churches. Most are not HIV-positive, but fear infection.

Some of these women are “secret mothers,” having gotten pregnant from their sex work. Some have moved from church to church in search of acceptance, bringing their children along. Increasingly they report

acceptance in the churches, some rising to leadership roles in their congregations, many having their children baptized. Signs of acceptance are accompanied by the job training and support they receive at Life Bloom. Many are trained in tailoring or in making cloth bags that replace the plastic grocery bags that litter many streets. A few become counselors for their peers or for adolescents. Consistently they report that acceptance in the church, coupled with vocational training, has turned their lives around.

Far away in Bangkok, Mercy Centre, founded by a Catholic priest and a nun, has served poor people in the city's most challenging communities. Education and healthcare have been among its emphases, and the threat of HIV/AIDS readily became a focus for its work. It reaches thousands of people a year in tangible ways, including hospice care for children and adults. At any given time Mercy's wards, classes, meeting facilities, dining facilities, and treatment rooms are full. Its impact over the more than thirty years of its history has been immense.

In rural Cambodia, two members of a home care group visit a woman and two of her children, all of whom are HIV-positive. Another child is not infected. The woman tells her story in matter-of-fact terms. The Kien Kes program, launched and run by Buddhist monks, has given her emotional support as well as education that opened a new opportunity to work. When she was first sick, she recalls, program staff took her to a nearby hospital for antiretroviral therapy and she began to feel better. Then they helped her start a vegetable stand, which has gone well because she lives on a busy road. Her treatment is succeeding and so is the business. She now earns three times the average daily wage in Cambodia and wants to expand the business since she is the family's sole wage earner. Nine people live in the house because her income permits her to support an extended family. The tangible improvement she has experienced, she emphasizes, has come from the intangible care Kien Kes has provided. It is another case of care motivated by faith that

focuses on the needs of the person and the family without highlighting the religion itself.



IF THE IMPACT OF FAITH GROUP-SPONSORED CARE FOR PERSONS affected by AIDS is profound, the impact on caregivers also is significant. One afternoon, eight members of a home care group in rural Cambodia assemble to describe their work. Their responsibilities include care for orphans and other vulnerable children and people living with HIV/AIDS. They not only make home visits, they conduct educational and play groups that integrate orphans and other vulnerable children with other children in their localities. The home care workers, known as “community assistants,” are proud of the training they received for this work. They have been schooled in a wide range of knowledge and skills, including the basic facts of HIV, health assessment, hygiene, and family and social dynamics. They have learned about available medical and social services and are equipped to make referrals. Above all, they have learned to build trust with their clients and help them make informed choices.

Asked to describe how they became involved in the program, these community assistants immediately cite compassion and concern for their communities. But there was no way for them to mobilize their care until Kien Kes program facilitators spread word of their initiative in villages; then each was nominated by their neighbors. Although they represented different villages and had never met, the training bonded them as fast friends and colleagues. Several have been in the program for only two or three years, but most have participated for the eight years of the program’s duration. They have experienced much together, and the work of serving people in need has added unanticipated meaning to their lives.

**Tomaisha Hendricks, Faith-Based Organization
Officer, FHI/Guyana**

I have a background in social work. For the past two-and-a-half years, I have been the faith-based organization officer employed by FHI under the USAID/Guyana HIV/AIDS Reduction and Prevention (GHARP) Project.

Working with the faith-based community in Guyana has been a demanding but rewarding task. At the beginning of the project, there was little work being done with this population. Faith leaders were not clear on their roles and responsibilities in the response to HIV. Also, since sexual activity is the main mode of transmission in Guyana, it was hard to involve faith leaders in discussions of HIV/AIDS. They are conservative, and this mindset did not allow for open discussions on sex and sexuality. The stigma attached to HIV, coupled with other stigmas, also prevented faith leaders from being open in their discussions about HIV within their communities. Another challenge in working with this population is that there were different levels of understanding of the disease and different perceptions of issues related to the disease.

Based on all this, FHI created several mechanisms to engage faith leaders from the three major religions in the country (Christianity, Hinduism, and Islam) in a productive manner.

First, we built an amicable relationship with the leaders of the major faith-based organizations as individuals. They were then brought together for meetings that sought to sensitize them. At these forums they were challenged to go back to their communities and



begin work. They all committed to doing this.

To facilitate the work, we developed the Faith Matters manual to specifically cater to the unique needs of faith-based organizations. The manual was guided and informed by behavior change communication, spiritual insights, and teachings. Its content and process was fully covered in step-by-step guidance and notes that incorporated the doctrines of Christianity, Hinduism, and Islam, and to a lesser extent other religions practiced in Guyana.

Most faith-based organizations continue to work within their communities and also show interest in partnering with GHARP to respond to HIV in Guyana.

They emphasize their care for the whole person and for their villages. Asked about the source of HIV/AIDS and other diseases they encounter, the community assistants cite poverty as the underlying cause of and continuing impediment to eradicating illness. “Many children cannot afford to go to school,” one group member notes somberly, a hint that education as well as medical care is interrupted by poverty.

They also note the problem of dealing with an increasingly mobile population. Some people from their villages go to the border area with Thailand in search of work. Other people in transit to the border pass through their villages. Sometimes they find work and are able to send back money. But often they are unsuccessful and leave behind anxious family members who must rely on local services and networks of friends. Occasionally people return home infected and out of work.

In the face of complex problems, these community assistants persevere and believe they are making a difference. “We feel proud that we are doing this job. We feel happy because we can help people solve problems,” one reveals. “In the past people were not aware that resources were available,” another elaborates. “People were afraid to disclose that they had a problem. Now people can speak. With education they know where to go for resources. The community assistants have become popular and people look up to us.”

Response to the horror of HIV/AIDS includes this surprising by-product: ordinary people at the grassroots are being equipped not only as caregivers but as community leaders. They have received training that spills over into all facets of local life. Through regular group sessions and ongoing training and reflection, they have built a rapport that serves as a model for local caregiving and organization. At one group meeting, participants note they had never encountered small groups or the kinds of intimate sharing and responsibility for strangers they now handle regularly. But they understand that their work is invaluable and they feel honored

to have been chosen to do it. Without hesitation all confirm that their Buddhist outlook has given them the basis for learning this work. They also note that they are volunteers.

The same pride surfaces half a world away, in a small home in a village in eastern Guyana. A peer education class has gathered under the tutelage of a Hindu pandit. The group of eight is following the course prescribed by *Faith Matters*, the manual developed by FHI with an ecumenical group of leaders it assembled. The lesson is “Handling Pain.” The instructor explains that there are various levels of listening. When you listen to someone you may only hear the facts that are conveyed. When you listen with your heart, however, you move to a deeper level, the level of emotions.

Then, without changing his tone, the instructor asks when members of the class have felt pain, both physical and emotional. Having built rapport with each other, the class members readily begin to speak. One woman describes how Hindu religious practices have helped her; she practices meditation and yoga. Another person speaks of music, and one mentions support from friends. The instructor weaves these anecdotes into a key point: if we learn from our own experiences of pain, we are equipped to support those who suffer physical and emotional pain caused by HIV/AIDS. He enforces his point with citations from Hindu scriptures. People nod appreciatively.

But he is not quite finished with the lesson. “How do we change behavior?” he asks. Several people urge that only sexual abstinence can guarantee they will be free from infection. The instructor nods without comment. “But can my faith protect me from HIV?” he asks persistently. The group is silent for a moment, and then he suggests his own answer to the question: “Faith protects you first by informing you, by providing accurate information, and through you, informing others. Faith breaks down resistance to change; it is incentive to change, to do what is needed to be safe.”

Heads nod. One woman comments that in her community people did not always discuss difficult subjects. Even when they faced difficult times, such as the breakdown of marriages and relationships, they were reluctant to speak to anyone. It became even more difficult to trust someone else in the face of such hurt. “But we can learn to love ourselves and then we can learn to love others,” she adds. “And then we can learn to trust.”

“I feel educated,” an older man says as the class ends. “I feel good. I feel more secure and more courage. We get to share experiences and understand. If everyday people teach us, and we teach others, then I am glad. This is how to live life.”

The stories told by people who are infected, by their loved ones, and by those who care for them inevitably reveal obstacles that have challenged them, as well as opportunities to care for them. For faith-based organizations, perhaps the greatest obstacles are stigma and discrimination. In the eyes of some, religious convictions and the moral standards to which they give rise can fall prey to these realities. There are instances where religious people and their leaders are reluctant to participate. Occasionally some insist that because of their faith they are exempt from the threat of HIV/AIDS. A disease that can be transmitted sexually, it is claimed, will only threaten those who succumb to temptation.

But the larger story of faith-based organizations and the response to HIV/AIDS concerns the ways in which compassion has arisen. Amid sporadic instances of religious people resisting efforts to address the issue, there are scores of instances of faith-based responses. Some people who have been interviewed readily point out that they and other faithful people have awakened to the realities of the disease. In some countries, for example, the disease is not just transmitted sexually. In all cases, there are infected and orphaned children who suffer. But even in the case of sexual transmission, the challenge of caring for anyone who suffers proves decisive for faith-based organizations. Confronted with the human realities

of the disease, FHI has found that the overwhelming majority of people in faith-based organizations readily seek ways to show compassion.

One FHI staff member in Guyana puts the matter squarely. “Religious people are more likely to want to be educated about life’s realities and to want to do whatever they can to help people in need. They are responsive to accurate, well-presented information and they want to learn practical things they can do to address this challenge.” Another staff member in Guyana emphasizes that “everyone we need to work with—government leaders or doctors or teachers or leaders of every kind—are all members of faith groups. We have to take faith into account. And it is the faith groups and their people who have an unparalleled capacity to bring this issue before the public and convene discussion. Faith groups are the doorway into society.”

Of course questions remain. Faith-based organizations often need materials and guidance in understanding and applying them. Faith leaders often are overworked, and adding further demands to their schedules may seem impossible, even in the face of a major health crisis. In addition, ensuring that what is taught to a few faith leaders will be conveyed to many is key.

But faith-based organizations are the primary place, and in many cultures the only place, to raise such issues and anticipate large and receptive audiences. In particular, faith-based organizations are the principal places where people gain motivation to care for one another and learn the practical dimensions of care. If there is any hope for stemming the advance of HIV/AIDS, that hope relies in part on the work of faith-based organizations. Fortunately, in the battle against this disease, faith-based organizations do some crucial things very well. Religious motivation surfaces in characteristic forms of best practice in the fight against a deadly disease.

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WHAT FAITH-BASED ORGANIZATIONS OFFER HIV/AIDS PROGRAMS

IN ADDRESSING HIV/AIDS, FAITH-BASED ORGANIZATIONS PROVIDE crucial aspects of prevention and treatment. Their prevalence alone does not account for their significance: they do many things well, some even uniquely so. Based on the interviews and observations that inform this report, their strengths include a compassionate perspective, an emphasis on education and training, adaptability, a holistic perspective, leadership, and an on-the-ground understanding of the communities they serve. In this discussion, each quality is illuminated through illustrative stories of faith-based organizations that collaborate with FHI.

A COMPASSIONATE PERSPECTIVE

Under a brilliant sky in northern Namibia, a small van turns off a highway and races across dry, flat terrain that seems to stretch endlessly. Eventually a small building appears and gradually comes into focus. There is a cross on top of it and in front a group of women stand and watch. There are a dozen and they are dressed alike in red T-shirts. Each clutches a black attaché, and at close range it becomes clear that both the T-shirt and the attaché say “Catholic AIDS Action” in bold letters.

Group members erupt in clapping and song as the van stops. They briskly lead the visitors into a small Catholic church. No priest is present, but one woman lights candles and another leads a brief series of prayers

and several more songs. When the group meets, a well-honed spirituality surfaces and helps unite them. With prayers and song concluded, they sit in pews facing their guests and withdraw pens and pads from their attachés. One woman introduces them by saying that they are a home care team for their area. They are volunteers who offered to help because of the suffering HIV/AIDS caused their community. The church mobilized them, another adds. “When the church realized the need to serve persons who were ill, they requested that parish members donate themselves to be trained and to serve.”

They had never done anything like this before, she reveals. Heads are nodding and there is heightened energy in their words. As several describe the training and the initial visits, an intense joy is apparent. “We learned to care for someone who needs physical help, provide counseling to them about their needs, and help with the needs of their children,” one woman summarizes. At first a few people in the community spoke negatively about them, but now the community understands and respects them, and even alerts them when people are in trouble. In turn they feel proud because they see signs of their impact. At first it was difficult for people to speak of HIV/AIDS, one woman reveals. But then homes and lives opened and there were many requests for their visits, another adds. Now the comments are flowing, with several women eager to comment even as another speaks. So many requests came from an increasingly wide area that Catholic AIDS Action gave them bicycles. They proudly show off their yellow helmets and point to the row of yellow bicycles stationed outside.

In northern Namibia, as in many areas where HIV/AIDS is present, women play prominent roles, especially in delivering care. However these women do not see their role as unusual. The training and their ongoing group life equip them and bring them respect. But the greatest recognition has resulted from the regular home visits they make, the support they

offer, and the services to which they link sick persons and those who love them. These women know they are a critical link, for they put the face of care on the delivery of services. Dutifully they record and report their visits, but they have little interest in statistics. There are no abstractions in accounts of their work. Instead they tell of people and communities, the ways they make a difference, and the joy their volunteer role brings them.

When asked about the support they require, the story becomes even more profound. They feel supported by Catholic AIDS Action, including provision of food and supplies to give to their clients. But if the supply chain is interrupted for any reason, they turn to their own pantries and those of their neighbors. Resourceful in various ways, they encourage the local CAA volunteer coordinator to help with local needs, such as vouchers to pay the school tuition of children who are orphaned or living with infected parents. Pressed to name a continuing problem they cite mobility. The bicycles help get them to the homes of clients. But how can they get sick clients to hospitals and clinics? They also need effective ways to transport food and supplies to clients in bulk. Getting people to services and services to people are chronic challenges. Given the vast territory and scant transport, the problem is apparent. It is a situation where weak infrastructure challenges the capacity to provide care.

Still, the women are undeterred. They typify much of FHI's experience with faith-based organizations: they seek and accept opportunities to express compassion and offer care. They are receptive to training and they adapt their personal lives to fulfill their responsibilities. Less apparent is that they serve as volunteers with no anticipation of salaries or advancement. They serve for the sake of expressing compassion and they serve reliably and with little attrition.

Less noticed is that the impact of their service upon their localities far transcends the numbers of visits to infected persons and their families, significant as those are. By learning to care, being organized as caregivers,

and gaining recognition locally, they raise the capacity of their community to respond to crisis. For example, their work helps reduce the levels of stigma and fear associated with the disease, and enhances the ability of a range of people to discuss even the most difficult and intimate situations appropriately. They do this work because they want to better their community, and because they are motivated by faith. “Not all of us are Catholics,” one woman announces. “Some are Lutheran.” The message is clear: faith, not a particular membership, is the crucial category.

EMPHASIS ON EDUCATION AND TRAINING

A group of men proceeds along a dusty, narrow street a few steps off a major boulevard, toward a small building, then up cement stairs to a third-floor series of meeting rooms and offices. All are dressed in white with various kinds of head cover and all have full beards. They speak softly or simply walk in reflective silence. It is early afternoon and having observed midday prayers at a nearby mosque, they will have a simple lunch together and then return to the work of the day. Twenty-five imams are spending the day learning about HIV/AIDS under the auspices of MACCA, the Masjid Council for Community Advancement, and FHI. In the morning they heard presentations on the medical and social facts; now they will practice speaking about the disease in the context of prayers at the mosques they serve across Bangladesh.

Statistics do not tell the full story, but by any estimate Bangladesh is a predominantly Muslim country. Roughly 80 percent of the country’s one hundred and fifty million people are Muslim in this densely populated place. There are estimated to be over two hundred and fifty thousand mosques, and although Buddhist, Hindu, and Christian influence is also apparent, Islam pervades the country and sets the religious tone. To reach the people of Bangladesh, one must reach Muslim leaders. In the battle against HIV/AIDS, FHI is doing precisely that. With the support of

USAID, MACCA and FHI have created a training program for imams. By the middle of March 2007, thirty-five groups with twenty-five imams in each had spent a day learning about the disease and practicing ways to teach people about it. Having listened patiently before pausing for prayer, they will return to test their new knowledge on each other, a rehearsal of what they will proclaim to their followers.

The imams were selected according to certain criteria. Their presence is an honor because regional Muslim leaders have nominated men they consider especially talented and dedicated. They all serve mosques that attract at least eight hundred worshippers to Friday prayers, when the week's principal sermon and teaching are given. Following Muslim custom, the sermon must be in Arabic and must comment on portions of the *Quran*. But the teaching can be in Bengali and may range broadly across questions of faith and contemporary life. In the course of their training in HIV/AIDS, the imams will be given a booklet in Bengali with twelve suggested teachings. But first they will spend a portion of the afternoon divided into small groups, practicing teaching in the mosque based on the presentations and booklet. Each imam in a group will offer a talk and then be critiqued by his peers. Later in the afternoon a few will be asked to give trial presentations before a final plenary session. On returning home they will report on the training to their regional supervisors and make further reports based on use of the MACCA/FHI materials and the response to them.

One imam smiles when asked about the process. His supervisor is very thorough in collecting reports, he muses. He is young and speaks with dedication and energy. Social teaching must be separate from the Friday sermon, he explains. But social teaching should be part of worship, and references from the *Quran* should be incorporated. People listen and believe when what they hear is clearly linked to the holy book. "I realize it is my responsibility as a Muslim to be active for social welfare," he emphasizes.

These imams are remarkably like the women of Catholic AIDS Action in northern Namibia. They are alert to enhanced ways of serving others and they seek to leave a religious imprint on the world by making life better. To do this they not only delve into habitual religious sources, they are alert for timely new ways of extending the religious message. Fresh training on the medical and social realities of the disease is eagerly received. They see connections with basic belief and practice. They take notes and ask questions and when they practice giving teachings their focus and sense of urgency are apparent. They are eager for knowledge because they sense the threat and they want to stop it.

Another imam says he had no clear concept of AIDS until this training. He had assumed it was related to sexual behavior, but the training clarified that needles shared by drug users was also a prominent cause in Bangladesh. He was eager to receive training because people in his mosque had begun talking and asking questions, and he felt he should give accurate answers and stop false information. He notes that he has addressed other social issues such as corruption, terrorism, and conflicts in families and communities. He hopes all the major religions might combine to fight these threats. They all arise from wrong behavior, he notes, just what faith should combat. But he is hopeful that disease and other social ills can be stemmed and people's lives can be changed for the better.

What if people infected come to the mosque? The imam seems ready for this question, especially after the day's training. "Of course all people must come to pray; it is a religious obligation, and all are welcome." But this was only the prelude to what he most wants to say. "Islam does not allow stigma or discrimination against anyone. Muslims must give compassion and service to persons in need. Islam motivates people to give service to others. This is what I must teach." He is not saying that stigma and discrimination do not occur, but that there is no religious sanction for exclusion and this is what he must emphasize in his teaching.

Imam training sponsored by MACCA and FHI reveals the receptivity of religious leaders to new ways of applying their faith to their circumstances. Such training taps an urge to address current social issues in ways that are both informed and faithful. For these imams and their superiors and followers, being faithful entails ongoing learning to extend their patterns of faithfulness and deepen a general sense of the applicability of their faith. The example of imam training from Dhaka, Bangladesh, shows a dynamic faith attuned to its context, prizing education, and alert to its dissemination. As is the case in Namibia, there can be no adequate substitute for the role of these imams. No other leaders reach people as thoroughly as they do. One of the best practices of faith-based organizations in addressing HIV/AIDS is an unparalleled capacity to receive and apply up-to-date training in ways that serve broad populations.

ADAPTABILITY

At all levels the realities of HIV/AIDS are necessitating innovative adaptations in religious life, for the sake of prevention and treatment. Many faith-based organizations understand that to align faith with unprecedented daily realities they must devise innovative processes and products for reaching all segments of society while remaining true to their religious identities.

On Sunday morning in the small city of Naivasha, Kenya, it is not surprising that a large group has come to the local Presbyterian church. East Africa is noted for its religious dynamism, especially the growth of Christianity. The variety of denominations to be found is vast, ranging from historic churches of Western, missionary origin to numerous newer, evangelical varieties and indigenous African churches.

Curious to hear what is being taught in this Presbyterian church, several visitors pause in an adolescent class. One side of a large room is filled, with rows of full seats extending far back from the podium. Several adult

teachers smile and suspend the lesson to introduce the newcomers. They note that the guests represent a joint YMCA/FHI project to combat AIDS. The reference becomes a teaching moment. Basic facts about the disease are recited in summary fashion as if to remind rather than introduce them to the young audience. The nature and work of the YMCA are cited in similar fashion, as is FHI. Then the teachers, citing the theme of being whole and living healthy lives, return to the day's scriptural lesson. Seamlessly they have welcomed guests and used their presence to link biblical themes to a pressing social reality. The priorities of being healthy and being compassionate arise readily and are depicted as central to Christian life. Faith is a ready platform for challenging a deadly disease that threatens their society.

In an adjoining building behind his small desk, the pastor explains his congregation's reliance on the YMCA and its partnership with FHI. He has not been the pastor for long, but the extent of the need has struck him and he wonders what he would do without such cooperation. He hears that the HIV infection rate has fallen in Kenya, but he can tell that there are at-risk populations in town. Some women who are or who have been sex workers come to church, several with children. There were whispers, he says, but all people should be welcomed and the talk has quieted. He is not so worried about the women; they are apt to be open and if they find the right support they are likely to leave the sex trade. They need training and they need jobs. Provided those, they are likely to change.

But men worry him. He knows men may have multiple sex partners other than wives. Getting to the men and simply having them talk openly or join a group is much harder than with women. Women often live openly; men live in the shadows. Trying to get men to speak, especially to one another in a fellowship group, is difficult. So the visitors may find the worship service that is about to begin very interesting. They will be able to judge. There will be a presentation by a leader of the congregation's new

men's group. The other men know him and respect him. It will be brief, but he will encourage others to join the group. They will have some meetings to discuss challenges in their lives. They will also have some social events to put them at ease with one another. The group has a good beginning; perhaps some other men will join.

Sunday worship seems unremarkable on the surface. It is a Protestant blend of hymns, choral anthems, readings from the Bible, a sermon, and a few announcements. The feel of the congregation is warm, and by the time the first hymn has concluded the sanctuary is nearly full. Singing occurs at an impressive decibel level; surely it can be heard far down the nearby streets. Yet the service proceeds without apparent attention to HIV. It can be presumed that the disease is not on the minds of this congregation. But the references of teachers in a youth class and insights from the pastor have given important glimpses beneath the surface. So when a man rises to encourage participation in the new men's ministry, it is clear that his announcement subtly links the church with response to the disease. One woman also comes forward to announce events she oversees in the congregation; it appears that she is a leader and has gained recognition. The church does not stop being the church; but by being the church it addresses the disease in all its ramifications and realities, in concrete terms for the people of this town. In part faith-based organizations attend to HIV/AIDS within the typical scope of their activities.

Extraordinary initiative and adaptation by faith-based groups surfaces frequently. South of Lake Naivasha, there is one such program. It is called Magnet Theatre and it is based in the Vineyard Church, an evangelical Protestant congregation that has spun off satellite congregations in the area. Magnet Theatre, also supported by the YMCA/FHI collaboration, focuses on the circumstances of youth and young adults. It began in 2003, with the ambitious intention of transforming the community. It was named Magnet Theatre because of its intention to attract

attention to its messages. The larger message for youth is to find worthwhile direction. The more focused message has been abstinence from sexual activity before marriage. The public response has been encouraging. Youth involvement in the YMCA has increased, and YMCA sports programs have multiplied as a result. Successful fundraising has meant not only additional sports equipment and events, but programs and discussions, out of which came skits and plays, and then the drama group that offers public performances to teach the realities of HIV/AIDS and related diseases.

Before a late afternoon performance beside a major road, drawing an expected audience of several hundred, five young men from Magnet Theatre and three young YMCA staff members meet at Vineyard Church to describe their work. It is an extension of the church and they emphasize that the church is not only a meeting place, but a place that connects them to people and gives their work public recognition. "Our audiences take things done by churches more seriously," one member observes. Another member then elaborates. "People believe that Christians are truthful and care. Church support for us offers legitimacy. We gain credibility because we are acting on behalf of the church. People see the church as a place of support more than they see a secular organization."

Each week they do street theater based on a theme. The previous week it was malaria. They describe how they wove a message about malaria around a skit that tried to unite humor with an important message. They discussed the risks of malaria for a pregnant woman and the importance of taking medication for malaria, whether one is HIV-positive or not. Recalling the prior theme, the group is energized and spontaneously launches a repartee that soon evolves into a new, improvised skit. They are clever and quick and laughter soon flows. Recalling the last skit is a start, but they must press on. In several hours they must perform anew beside the nearby highway. What will they do and how will they do it?

Suddenly two of the group are on their feet, facing off, launching a new improvisation. They resolve that today's theme will be TB. They take suggestions from the rest of the group and then feel their way into a hypothetical conversation. They shift back and forth between several languages and the dialogue becomes a quick banter, with onlookers laughing heartily. At times they break into improvised songs, now rarely hesitating. "This humor is based on Masai and Kikuyu tribal differences," a YMCA staff member reveals in a whisper. "It's something Kenyans readily recognize. They are even imitating different dialects. People will pay attention to this because this is what they see in their daily lives. And they will laugh as they see themselves presented in a humorous way."

The power of the public drama now becomes clear. It is more than entertainment and it is not in any sense mockery; it is good-natured and reflects the awareness of the insider whose credibility permits a life-giving message. The group simply goes to public places at times when people are likely to be there, and a crowd soon gathers and becomes enthralled by humor and song. These young actors know how to speak to them. They don't lecture or speak in the abstract; they depict life as it is lived in this part of the world. So they can also describe life as it could be lived: healthy and safe. The broad reach and deep respect accorded the church opens this door, and their approach secures their credibility.

In this part of Kenya, most of what happens in the religious life of the area arises from local initiative and is sustained by informal but effective local networks. The secret of the YMCA success in the vicinity is its ability to intersect these networks. Religious groups reach ordinary people, often through innovative programs and forms of collaboration. They are easily the principal place to reach women, for example, and the church and the workplace are the only places to reach men. The churches are doing more to reach people where they live than any other

organization could possibly do. Magnet Theatre goes to places where people are getting off public transport in late afternoon, coming home from work or shopping for the evening meal. The message from the churches is surely saving lives. No one else has the recognition and the respect that is accorded them.

HOLISTIC PERSPECTIVE

Faith-based organizations care for the wholeness of people and communities. They have not been created solely to provide a narrow range of services to those affected by one illness, critical as that need is. They are rooted in culture and in the life of local communities and people. To them HIV/AIDS is horrific and they are mobilized against it. But it is also the latest in a long series of medical, social, and political challenges their faith traditions have been forced to confront over centuries. Yet again people of faith respond, and yet again they bring unparalleled breadth of purpose. Under any sort of circumstances, monks visit homes and teachers promote health. Now they do so with special attention to the circumstances of a particular disease. Under any and all circumstances they see life in holistic terms.

In Cambodia, seven monks attest to the perseverance and holistic perspective of religious leaders and the people they lead. They are sitting, expressionless, on the slightly raised platform area to one side of the interior of the pagoda, the central building used for prayers on the grounds of this monastery. A large gold Buddha at the front of the open space would rivet attention but for the presence of the monks seated on small mats in lotus position. They are young, their heads shaven, their saffron robes covering everything but one shoulder. They actually represent different monasteries in the area, but they have been trained and work together to support people living with HIV/AIDS nearby and foster community education on prevention and treatment.

They began this work in 2004. Kien Kes, originator of the program and the major monastery in the area, trained them and showed them how their new responsibilities were extensions of their obligations as monks. They explain that at least once a week each of them is invited to come to a local home to give blessings for various reasons. These occasions now become teaching moments. They also open further possibilities for service because their hosts often mention other homes where there is need. “And if there are people who do not listen,” says one monk, “we would look for another way to reach them. We would never give up.”

Being part of society, they agree, means holding a responsibility to it. They also are certain that they set an example. “This activity shows monks are involved and people can see religious work is involved in real life. It is not just theory but practice. We are involved in a practical way. The Buddha teaches that one should be faithful, and being faithful protects from HIV. So Buddhist theory is practical and supports being safe,” one monk says. But they do not intend to stop there. They want to develop educational materials and a curriculum that will speak to a range of health issues. They also want to devote more attention to the needs of orphans and other vulnerable children, and they seek more training for themselves. They see prevention and treatment together, and as linked to a broad range of health issues.

The Kien Kes program is already caring for orphans. Close to another monastery a few miles away, several community assistants lead a class for them and other children. The day is warm and dry so the class meets outdoors near a large tree in front of the home of one assistant. There is an easel with large posters and charts and the children gather around it. Pointing to drawings on one chart, an assistant explains basic nutrition. She reviews simple foods and shows how they belong to different groups and do different things. She asks questions often and injects humor, bringing smiles and giggles from the children. Not all are orphans, for part of

the purpose is to integrate children who might have been stigmatized into an ordinary group of peers. In this way orphans feel equal with other children. “Broad health issues affect them all,” an assistant comments.

In Bangkok home care workers representing Mercy Centre give yet another illustration of how a holistic outlook invariably marks programs created by faith-based organizations. They travel in pairs to visit the same set of clients as often as circumstances require. One afternoon the first visit has an urgent air about it. The man and woman representing Mercy Centre are grateful to ride in a van; ordinarily they rely on public transport, sometimes taking hours to reach their destination. Today’s first client lives far back in a slum area, just off a tiny canal. He has been on antiretroviral therapy for three years and has shown physical improvement. But he cannot resume the arduous construction work of his former life and he lacks other skills. Forced to live in one room with his mother, he is reduced to staring at a television for much of the day. Mercy Centre’s team is eager to encourage better circumstances for him. They are worried that his situation will deteriorate.

No description can fully depict the desperate circumstances. This client not only lives in one room with his mother—four other people stay there as well. Worse, it is an area of Bangkok where shanties are crammed together so tightly that a virtual tenement is created. Tiny passageways snake between flimsy dwellings with people literally stepping over one another to enter or exit. On a bright day the narrow corridors block sunlight and conversations among sprawling people refer to drugs and violence. The canal beside the entrance to this maze is filled with trash, including a few syringes floating aimlessly. Lives are on hold here, unless they are going precipitously downhill.

Mercy Centre’s workers know where to find their client and move through the maze directly to him. Indeed he is watching a tiny television but gratefully ignores it to talk. He became infected through needle

sharing as a drug user. The combination of antiretroviral therapy and Mercy Centre's care saved his life. He emphasizes that the home care team makes sure he gets to clinics and checks on him regularly. He has gotten better but he still cannot work and must depend on his mother. She makes a little money selling vegetables but must care for others, who go unnamed. Lately she has been coughing and that worries him; in this dank, filthy place, TB is a threat. Worse there are drug dealers about and he fears he may relapse. The workers listen, reassure him, and emphasize their commitment to him. They discuss job possibilities and the feasibility of training for a new job. The man must become healthier, but there will be regular checkups at a clinic and visits by this team. The man is grateful. Without this team he would have no prospects but dire ones.

The afternoon's second visit presents different realities. The van stops in a small clearing beside several ramshackle buildings just off a major intersection. A woman is just rolling up a large cart filled with a thin layer of ice and beginning to arrange lettuce leaves around the edge. She talks readily, pausing only for translation, sustaining her narrative even when disappearing periodically into a nearby shed to produce more fresh seafood. Arranging it in tightly packed rows buffered by more lettuce, she tells how she began her daily roadside business. She only pauses once to insist that pictures be taken. Otherwise she smiles broadly and plunges ahead with her story.

It has been over seven years since she learned she was HIV-positive and that her husband had infected her. Fortunately Mercy Centre learned of her and began taking her to a clinic where she could receive antiretroviral therapy. Physically she became better. However, what would she do? She had to support herself somehow but she had no skill. Mercy Centre consulted with her and she learned how to operate this seafood stand. She is very proud and describes in detail how she buys fresh catch every morning, and keeps it in a cooler until afternoon when

she arranges it carefully and then heads to a prominent intersection in an upscale area. People going home stop to purchase food for dinner and she has developed regular customers. She wants a few more pictures taken, then apologizes: to keep to her schedule she must leave promptly for her corner. Customers will be waiting.

LEADERSHIP

If, in FHI's experience, faith-based organizations have mobilized quickly to address challenges such as HIV/AIDS, they may have done so in part because leaders of faith communities set examples of understanding, education, innovation and, above all, compassion. At the very least, religious leaders must sanction use of facilities and incorporation of special programs into the practices of faith. But faith-based organizations do much more. In a number of instances FHI has seen them take groundbreaking initiative. Consistently they forge innovative approaches that convey the depth of care that faith inspires.

The Moulana Abul Kalam Azad in Bangladesh is one such leader. By all accounts he is one of the three most influential Muslims in Bangladesh and likely the most visible Muslim leader in the country. Often referred to simply as "The Moulana," an honorific title denoting his senior position, he immediately puts one at ease. He is warm and articulate, breaking readily into smiles and enjoying a hearty laugh when he hears a good story. His demeanor invites conversation, a sign of his effectiveness in a very public role. He is a public figure in part because of the television programs he hosts. One is a question-and-answer program on religious life in which he hosts both local imams and leaders of other faiths. This long-standing program has spun off *Right Path*, a series of broadcasts in which the Moulana has addressed HIV/AIDS. The series is organized around such topics as abstinence, stigma, drugs, voluntary counseling and testing, and other forms of sexually transmitted infection. The number of viewers

is estimated to be one hundred thousand—a notable number because of the relative lack of televisions in the country. The program has also been broadcast by satellite outside Bangladesh.

Television is only one means of combating the disease for this energetic leader. As the head of MACCA, the Masjid Council for Community Advancement, he has taken two significant steps. First, he created a program of training imams in collaboration with FHI. This program fits well with other educational and community development programs sponsored by MACCA. Second, he helped create an interfaith alliance with Buddhist, Christian, and Hindu leaders in the country. More than organizational alignment to address HIV/AIDS, the interfaith initiative embodies the friendship of four men who meet regularly to consider ways of benefiting the people of Bangladesh. Not only do they meet, they enjoy meals together and, while motivated by common concerns, are aware of the example their friendship sets. Because of them the various faith communities have a ready means of thinking and acting together, especially in devising practical forms of compassion.

What is most impressive about the Moulana's leadership, and that of his interfaith colleagues, is the effective way he has broached delicate topics and created programs for difficult social groups such as sex workers and drug users. The infection rate in Bangladesh is low, generally thought to be one percent of the population. But with a population of over one hundred and fifty million and the real possibility of the disease's spread, the prospect of massive numbers of infected persons cannot be discounted. Already facilities for care are limited and resources strained by seasonal flooding and storms that seem to afflict the country annually. Thus the urgency of preventing the disease, as well as caring for persons already infected, is acute.

The Moulana is alert to the realities. On one segment of *Right Path* he receives questions about who is most at risk. "Teenagers and truck drivers,"

**Lucy Steinitz, Regional Senior Technical Officer
for Orphans and Vulnerable Children, FHI/Namibia**

When my husband and I responded to our midlife crisis by moving our family to Africa eleven years ago, things couldn't have been more different from our life in America. We started out as grassroots volunteers. Within that context, we had to get used to new foods, find a new school for our children, and make new friends. In terms of my career, it meant leaving my position as executive director of Jewish Family Services in Baltimore for the virtual unknown. Jewishly, we went from an immense array of Jewish options to a small congregation in Windhoek, Namibia, with twenty families.

Doing research for the Namibian Ministry of Health and UNICEF got me involved with HIV and AIDS. In late 1997, I met a Namibia-based nun, Sr. Dr. Raphaela Händler, who oversaw the country's Roman Catholic-affiliated healthcare institutions. She told me of her dream that Namibia's Roman Catholic Church would start an AIDS project. At the time, none of the churches were doing anything on this issue. I got excited by her ideas and offered to help. I'll never forget her face when I told her I was Jewish, but after getting permission from the bishops, she agreed we could make a team. This is how Catholic AIDS Action (CAA) was born.

I became the first national coordinator and stayed in this position until 2004. Today CAA is Namibia's largest nongovernmental organization working in HIV prevention, care, and orphan support. A few years later, I joined several other religious leaders under the Council of Churches in Namibia and cofounded Namibia's Church Alliance for Orphans, where I served as chair of the board and later as technical adviser. As a natural extension of both experiences, I then worked with FHI as adviser



to nine faith-based organizations doing HIV work under the US President's Emergency Plan for AIDS Relief. With the advent of FABRIC-FHI's three-country USAID project ("Faith Based Regional Initiative for Children")—I shifted my work slightly, with a special interest in quality assurance, to ensure that services provided to children make a difference in their lives.

As I recall the origins of CAA and my initial conversation with Sr. Raphaela, I often wonder what those African Catholic bishops thought when she asked them about teaming up with a Jew to start her AIDS project. Whatever their motivation, they were right when they approved of our partnership. My experience as a Jewish communal professional made me sensitive to issues of religion and identity; to the learning and support that can come from text study and prayer; to the importance and power of community; and to the central tenet that wherever we go and whatever we do, our lives should be about "tikkun olam"—the repair and completion of the world.

he answers, with truck drivers a highly likely source of spreading the infection. They are a mobile population and they are linked in significant numbers to sex workers.

The Moulana has readily assumed a singular role in alerting the public and advocating compassion; perhaps no one else in the country has such recognition and credibility. Not just because of his position but because of his effectiveness in raising compelling issues and galvanizing response, he is widely trusted and admired. Mention of his name brings immediate thoughts of his broadcasts, and people cite a variety of topics he has addressed, including terrorism and poverty, all from the perspective of faithfulness to Islam. His dedication to Islam as a faith of compassion and peace is consistent and profound.

The Moulana recounts how MACCA began addressing prevention issues in 1999. The current work with FHI has been especially gratifying because staff members have worked well together; one MACCA staff member actually works out of FHI offices on the imam training project. He is also gratified that FHI was receptive to faith-based organizations. Collaboration with other faith groups and with FHI has been smooth; he senses a depth of common commitment and respect for one another.

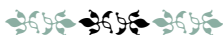
MACCA is dedicated to training that conveys clear information and encourages behavior that adheres to Islamic principles. This includes opposition to stigma and discrimination directed at persons who suffer and their families. Muslims must stand by persons in need, he states clearly. Humanitarian service is at the heart of Islam. Interfaith cooperation is also emphasized. The key in getting out these messages is to reach religious leaders because they reach people, so imam training is crucial. But there are perhaps fifty thousand imams in the country. The current program with FHI will reach about one thousand. It is a fine program, but he worries about reaching more people. "We have made a start and television extends the reach," he says. "Still, not enough people are being reached.

I fear that those most at risk have not heard the message and are in circumstances where changing dangerous behavior is a challenge, because they must change their circumstances.” As he speaks, one feels privy to an internal conversation, to his compassionate instincts wrestling with the realities he must face to make compassion effective. One senses both the high ideals born of his faith, and the situations he must engage creatively to make his ideals tangible.

The Moulana has no hesitation in addressing the most difficult issues. Thinking about reaching people prompts him to consider the difficult topic of behavior change. “It is too soon to tell,” he says in response to questions about the impact of imam training. And the ties with interfaith programs, while warm, are too new to have had much practical result. He senses the most effective change so far concerns the reduction of stigma around the disease. Not only are infected people less discriminated against and shown more compassion, there is thoughtful public conversation about issues once considered too delicate for open discussion. He hopes he has helped shift the public tone from negative to positive, from avoidance to accurate understanding and faithful response. But much work remains to be done.

The breadth of the Moulana’s vision is striking. The situation involves more than addressing a devastating disease, important as that is. The underlying issue is that of development, for development shortcomings create the social situation in which disease proliferates. The challenge of reaching people underscores the need for effective means of training people and the lack of resources and infrastructure to accomplish this readily. Perhaps incidental to teaching people about HIV/AIDS, the door to wider forms of building capacity will open. There are not only challenges in Bangladesh; there are also striking opportunities. He returns to the encouraging level of interfaith harmony. “It is possible to unite all the faith groups,” he muses, “and Islam can encourage this.” He notes that

the heads of major *madrassas* (Islamic academies) are supportive. Then he frowns slightly and ventures an opinion: “Islam is misunderstood in many places. Take the subject of women. We encourage women’s development. We cooperate with professional women’s groups. And we have programs for marriage counseling. In general, we want to show that Islam is peaceful and humanitarian. And we want to draw on our faith to build up our country.” Displaying the holistic outlook that faith leaders readily advance, he locates HIV/AIDS in a wider set of issues. His outlook reflects a search for multifaceted ways his faith can benefit his country.



WELL OVER A THOUSAND MILES AWAY IN SOUTHEAST ASIA, A prominent Buddhist leader speaks in similar terms, and his accomplishments also reflect his efficacy. Khut Ong is regional head of a cluster of Buddhist temples. He is based at Kien Kes, a major temple near the western city of Battambang. The name of this temple graces the extensive program with which FHI collaborates to address HIV/AIDS in Cambodia. Khut Ong smiles broadly and welcomes visitors to his small residence—basically one room—on the temple grounds. His bed is a simple, hard cot, but various notices and clippings posted on the walls and a small television in the corner attest to his engagement with the world and its daunting problems.

Khut Ong began the Kien Kes program in 1997. At first he heard through the media and from the local health department that a disease called AIDS was beginning to kill people. He also heard there was no cure but he was not immobilized by this news. For Khut Ong, the thought that his country would face another desperate challenge after years of war and genocide was intolerable. His refusal to surrender to even intractable circumstances inspired him to act. As cases of HIV/AIDS surfaced

nearby, Khut Ong rejected the idea that affected people would lack care. He was “just a monk,” he muses now, but he would learn what he must know and begin to combat this disease.

His education was both theoretical and practical. As he learned specifics about the disease he also visited homes of people living with HIV/AIDS. It is not unusual for monks to visit, he explains. The occasion of a monk’s visit, especially a senior figure such as himself, attracts neighbors and even entire villages and communities. Trading on his office and recognition, Khut Ong used those visits to model caregiving, teach people about the disease, and dispel misapprehensions. He explains that even now he visits as many homes as possible and teaches about self-care, compassion, and care of infected persons. He takes particular care to visit near the time of death when people have a special need for support. He adds that monks can give spiritual support to women but cannot speak as directly to them as they can to men.

Begun with the broad intention of compassion for people affected by HIV/AIDS, the Kien Kes program developed different dimensions to attend to the disease’s ramifications. In turn these new initiatives suggested still other dimensions demanding attention. For instance, care for people living with HIV/AIDS naturally led to care for orphans and other vulnerable children. The need for a care network prompted creation of the community assistants program and then various educational initiatives, such as ongoing training for monks and classes for children. Then full-time staff members were hired, and now the Kien Kes program is an elaborate organization with criss-crossing program and personnel linkages. As he depicts the extensive set of services his compassion has launched, Khut Ong could be an entrepreneur revealing how he launched a successful, multifaceted corporation. In his case the return on investment can be seen in lives whose quality has been enhanced immeasurably.

He is modest yet proud as he describes the program. Encouraged to say more about what made his initiative succeed, he reveals his efforts to collaborate with government as well as nongovernmental organizations. First, tapping the thirty temples he directs, Khut Ong created a network for education and planning. Temples in turn offered education about AIDS to people living in the vicinity. At the same time he contacted local authorities and was assured of their encouragement. "They wanted monks to help people," he explains. Then he began to work his way up the government hierarchy. He built communication with provincial health-care officials and gained their trust. As his network of temples grew and programs expanded, he was also in touch with the national ministry of religious affairs. He is too modest to suggest the full scope of his accomplishment; clearly he has expanded the role of faith-based organizations in delivering care and has charted a new level of collaboration between the Buddhist hierarchy and government.

Khut Ong does not dwell on strictly organizational matters; he sees them as a means to desired ends. He prefers to discuss other programs he envisions. One senses the instinct of the entrepreneur intent not on enriching himself but on enhancing the quality of life of as many people as possible. He steers the conversation toward other sorts of services that are needed, such as vocational training for young people, small loans to create personal businesses for people living with HIV/AIDS, more literacy classes, music instruction for children, and weaving classes for women. On the grounds of Kien Kes, one finds some of these classes in session. Now Khut Ong wants to expand them and recruit other temples as learning centers in their localities. Yes, he emphasizes, he has some "added thoughts about income-generating projects." His list of ideas and his zest for developing them seems unlimited, hinting at the depth of both compassion and ingenuity in him. He is very grateful to FHI, he adds. However, to sustain these programs and launch new ones, he wants

to build the focus on fundraising capacity. With adequate fundraising ability these needed programs can outlive grants from nongovernmental organizations. “When people in the community get ways to have better lives,” he reflects, “they become polite and courteous and respect one another. They used to fight. But with a sense of possibility things can be different.” He stops, smiles, and welcomes pictures. Then he excuses himself and walks methodically out of his small room onto the temple grounds. He has to teach a class of young monks.

ON-THE-GROUND UNDERSTANDING OF THE COMMUNITIES THEY SERVE

The extent to which leadership has taken an entrepreneurial turn in the faith-based response to HIV/AIDS has not been explored sufficiently. As already mentioned, faith-based organizations can be innovative in how they approach HIV/AIDS prevention and care, and this innovation is often grounded in their intimate understanding of the communities they serve. The legacy of religious leadership includes a long line of innovative, even entrepreneurial, initiatives that often have offered services other sorts of organizations could not offer, or could not provide with the same effectiveness.

One example of contemporary religious entrepreneurialism and community-inspired service provision is the Mercy Centre in Bangkok. In a large slum area, the center provides a range of services that respond to the needs of its locality. The center’s offerings include hospice programs for children and adults, including inpatient care; classes, activities, and training programs; counseling; and a home care program conducted by a team who are all HIV-positive. The staff has built trust with the community. “At one time the community feared that HIV-positive people would pollute the area,” the staff member reveals. “But we persisted and created projects that involved the community. And we worked to educate the community and listen to their needs and involve them in setting

priorities. Now there is very little if any discrimination. We get referrals from the community because people have learned the realities and are able to discuss them.”

This dramatic transformation of sensibilities and service delivery arose from the vision and labors of an American Catholic priest, Father Joseph Maier. He had amassed years of experience in Southeast Asia before launching Mercy Centre in the late 1970s. Leaders not only envision programs; they set their tone by their manner of implementing them. Father Joe knew the urgency of understanding one’s locale. He began what is now an elaborate service center by simply walking the streets of the area and talking to people along his path. “You must listen to what the community has to say. God’s spirit is with the people,” he advises. This spirit, he quickly adds, speaks in all faiths. “We are truly a religious house,” he says in reference to Mercy Centre. “Look at the religious symbols we have about the walls, Christian and Buddhist in particular. Statues of the Buddha here, Mary the mother of Jesus there. We don’t teach religion: we live it.”

What sort of difference does Mercy Centre make? “We live here. The difference we make is that we are here, in this community, on the community’s terms, on their turf and know it is their turf.” Sometimes the values of a faith-based organization collide with street norms. For example, when a young man was found with a girl in the area, neighbors started to rough him up. “We told them not to do it. We try to get people together, to talk, to face the truth, to reach an agreement. That is the Gospel thing to do.” The strategy that applies to HIV/AIDS is an outgrowth of a larger intention, one which requires being in the community in order to lead it to a better life. “We give people dignity. We really emphasize education. We can’t give all the care that needs giving. But we can teach others to care.”

Even more, with antiretroviral therapy controlling the virus, people’s lives are extended. With more time and better health than they had expected, infected people “are asking what the essence of life is.”

“We’re the only ones who can really talk about that question,” he says, referring to the readiness of faith-based groups to engage issues surrounding the meaning of life. Then Father Joe adds an important qualification, one that also illuminates a quality of faith-based organizations. “But we can’t do this just as a Christian or a Buddhist organization. We have to do it together. And we can’t wait for people to come to us, we have to walk with the community.” This is a core conviction for Father Joe and he pauses to lend it emphasis. “You and I as part of the community have to teach people to care for their own. And we have to teach people to talk about the meaning of life, and things of the spirit, and we have to teach them to pray. We religious people think we are only authentic when we separate ourselves from the community. But we are not authentic in our faith by being different or apart. We have to be in the community and we have to listen to the community.”

Ironically his implication is that faith-based organizations are indeed set apart, but in an entirely different manner than might be expected. Not remote from the day-to-day lives of ordinary people, faith-based organizations are attentive and engaged in ways few other organizations can match. They envision better lives and communities, and they exercise leadership in taking practical steps toward realizing these visions, in speaking and acting in ways their localities understand.

In East Africa similar ideals and instances of leadership and service are evident. In the midst of a tour of Biryogo Medical-Social Center in Kigali, Rwanda, a physician comments: “The people who work here do what they do out of a deep spirituality. Their profession is medicine. But their motivation comes out of care for the total wellbeing of the person.” There are few inpatients; most have been admitted to a hospice program. But hundreds of people line up daily for the extensive services that are not easily found elsewhere. Diagnostic and therapeutic services cover not only HIV/AIDS, but also ancillary conditions or various ailments suffered by

HIV-positive persons. A sewing program trains women and offers marketable products, including the uniforms worn by children in Biryogo's early childhood program. Even some farm animals are raised and crops grown, feeding patients and their families and also winding up in a small café run by the hospital. Proudly, Biryogo serves a wide range of patient needs and has a beneficial impact on the surrounding neighborhood.

"It is a different sort of hospital in its conception," says a physician accompanying the tour. She embodies that unique perspective. She is Spanish, and not only a physician but a nun, a member of the Roman Catholic religious order that established and operates the hospital under the aegis of the Catholic Archdiocese of Kigali. "It is different in seeking personnel who have a special commitment to help, and it is different in seeing what we do as more than a job, and more than a set of services. Our goal is to help people in the fullest possible way. We are good at looking for new ideas and good at responding to new needs." Collaboration with FHI, she observes, has allowed Biryogo to enhance its ability to deliver additional services and ensure that care can be given to the neighborhood. The vicinity is significantly Muslim and also quite poor. During the genocide in the 1990s, the neighborhood protected the hospital and even hid some staff members. Even in hiding and under threat of violence, hospital staff continued offering care. Biryogo has become known for unflagging dedication to its locality and to all the people it serves. It exemplifies a key positive quality of faith-based organizations: engagement with their localities and perseverance in the face of challenges.

The tour of the hospital has been extensive, evoking further questions and observations. Discussion continues in a conference room where several other staff members arrive and wish to add their thoughts. Another physician, a Rwandan, notes the difficulty of addressing the circumstances that sustain the HIV/AIDS pandemic. "The major problem is poverty," he declares. "In the face of poverty it is hard to get people to change

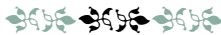
behavior. They are resistant and indifferent because they have little hope. It is only when they have some hope that they have incentive to change.” He pauses to reflect, then shifts to another related challenge. “Because this is a poor area people are constantly coming and going. They are always seeking work and they cannot afford rent here. We do home visits and we do follow-up visits. But it is different to sustain care when people come and go. A few people actually transfer to other health centers. And some move but keep coming here. Others we lose track of. It is hard to find them.”

He smiles before mentioning yet another daunting challenge. “We are a religious center, so there are those who may be surprised that we would have anything to do with sex workers. But they are part of the community and part of its circumstances. So we run a program for them and try to get them out of prostitution. Most are in the sex trade because they need money.” Clearly this program aims to reduce stigma, but even more it is an intervention into difficult social circumstances that aims to rebuild lives, develop personal skills that mean a healthy and better life, and through their individual improvement a better community. He is hopeful, but the situation is not good and Biryogo faces an uphill climb.

Statistics depict the extent of the challenge. Of the one hundred and fifty-one sex workers in the Biryogo program, this physician and several of his colleagues explain, seventy-six are HIV-positive. Most cannot read or write, meaning that any vocational training begins at the most basic level. Only twenty-one have left the sex trade and all have received money to start small businesses. But starting a business requires training, and leaving the trade for vocational training may interrupt income. With poverty as the core issue, the Biryogo program faces a vicious social cycle. Yet there is no hesitation in pursuing the goal of getting women out of the sex trade, just as there is no hesitation in treating infected people, testing persons at risk, caring for children, or understanding the needs of the hospital’s

locality. Through the various services they offer, the staff of Biryogo are undeterred by the realities. Their persistence and their engagement with people enmeshed in complex situations never flag. Such dedication reflects not only professionalism and personal ties to a community; it is the product of conviction born of faith that a life serving those in need is a life of the highest calling.

The dedication that arises from faith does not eradicate frustrations or challenges. The people of faith-based organizations must face intractable situations of various sorts. Their clients and patients are caught up in debilitating personal and social situations. Meanwhile there are chronic shortages of equipment and supplies. At times equipment goes unused for want of parts and repair expertise. Infrastructure can be unreliable, resulting in electricity and water shortages. Problems of transportation have been cited previously. It can be difficult to connect people with services, or simply to get supplies to hospitals and service centers, and then out to people who need them. The difficulty of transportation extends to assembling staff members and volunteers for training, or even to perform their daily duties. At times staff must travel inordinate distances by awkward and difficult means to assist people in need.



WALKING THE GROUNDS OF REMERA-RUKOMA HOSPITAL IN THE countryside west of Kigali, one senses a depth of commitment that has been in place for a long time. Even in rural areas, Rwanda is densely populated, and there is constant demand on facilities and services. Among its campus of buildings are wards for patients of different ages facing an assortment of conditions. Attention to HIV/AIDS touches much of the hospital's work; for example, there are female and male TB wards. Maternity and pediatric care also receive much attention. Precautions

against contracting HIV are well established. Remera-Rukoma appears to be an active district hospital in the nation's healthcare system.

Resources are always stretched thin and infrastructure problems compound the hospital's challenges. The state's electricity grid does not reach here and the hospital must rely on a combination of generators and solar panels. The hospital needs equipment and, indeed, construction is underway to accommodate a new, FHI-supplied x-ray machine. For its water the hospital receives assistance from the nearby Presbyterian church. The church installed a water pump that helps supply the hospital. Water became a problem a few years ago when a landslide blocked the principal water source and necessitated new forms of access. The church helped resolve the problem.

The church's role is not incidental or restricted to supplying water. The hospital is affiliated with the Presbyterian Church of Rwanda, and this association is the most recent phase of a long history. Nearly a hundred years ago, Presbyterian missionaries from Europe founded the hospital and for many years provided most of its medical staff. In the late twentieth century the hospital and the church, following a broad trend, transferred from missionary to indigenous control. But material and financial support from church sources in the Western world continue, and affiliation with the local church is significant. It costs approximately US\$185 a year to run the hospital and only the equivalent of US\$22 comes from the government. The rest must come from the church and other nongovernmental sources. It is a constant struggle but the church has been there throughout to support medical care for the people of the area.

Asked about the history of the hospital a physician on its staff smiles: "It began in 1921, I think, as a dispensary, and then it grew and grew. There was no plan; it simply understood and served the people of this area." He pauses to reflect and assemble the facts carefully. "It was founded by Protestant missionaries from the Netherlands. It grew as an infirmary

and clinic and then became a hospital in 1967. For a while it was still managed by people from the Netherlands but they turned over control. There is still quite a bit of support from the church, in the Netherlands and here. One of our main generators came from the Netherlands.” He then adds a noteworthy thought: “we don’t draw people to this hospital because it is the only hospital in the area. But the hospital is here because of religious people.”

He goes on to explain that there are no religious tests for hospital staff. But the hospital’s legacy and its affiliation are known and respected. These facts are not unique to this hospital. Across Africa and Asia are many hospitals and medical facilities and programs begun by missionaries but long since handed over to local control. Indeed while Biryogo and Remera-Rukoma have different religious backgrounds, social settings, and histories, their legacies converge at two crucial points: they exemplify the capacities of faith-based organizations to engage with the situations of people in local contexts in profound ways, and their dedication is long term—a persistence of focus and commitment whose wellspring is faith.

5

AREAS FOR IMPACT

WHAT CAN BE CLAIMED FOR THE IMPACT OF COLLABORATIVE faith-based initiatives? In FHI's experience, local faith-based organizations' strengths in addressing HIV/AIDS include a compassionate perspective, an emphasis on education and training, adaptability, a holistic perspective, leadership, and an on-the-ground understanding of the communities they serve. How have these strengths been maximized to produce results, and most important, what particular kinds of HIV/AIDS work have proven most compatible with these strengths? In FHI's experience, partnerships with faith-based organizations have been particularly effective in providing care and treatment, promoting prevention awareness, mobilizing and equipping volunteers, and creating networks and infrastructure.

PROVIDING CARE AND TREATMENT

Faith-based organizations deliver services. In this regard they are not unique, and simply reflect high standards of medical and social service delivery. But one of the hallmarks of their services delivery is that they usually pay attention to the personal dimensions of caregiving. Caregivers from faith-based organizations are typically encouraged to take time to build trust and listen to the personal stories of those they visit. The faith-based organizations discussed here show tremendous sensitivity to human beings as individuals and the experiences that

shape their lives. Many see their role as facilitating a personal sense of understanding and purpose of life. Instances of such personalized care have been seen in the stories of home care teams from Mercy Centre in Bangkok, CAA volunteers in Namibia, community assistants trained by the Kien Kes program in Cambodia, and hospital workers at Biryogo and Remera-Rukoma hospitals in Rwanda. The impact of this kind of care is difficult to measure but impossible to mistake. It is arguably the highest form of care because it is powerfully alert to individual circumstances.

Faith-based organizations also have deep understanding of local cultural circumstances. The faith-based organizations discussed in this study are as aware of communities as they are sensitive to individuals. By simply knowing local people and situations, they have extended care in ways few other organizations can match.

PROMOTING PREVENTION AWARENESS

Faith conveys a language of community and shared experience. The language of the faith community creates and sustains community among people of faith and across faith lines into wider cultural settings. It prompts modes of discernment among people about faithful responses to times of uncertainty and threats to individuals and communities.

The outbreak of HIV/AIDS has challenged faith communities to extend their capacity to speak and form bonds of community. As they absorbed accurate information about the disease, the faith-based organizations in this report became key, and often primary means of raising public awareness and initiating public response. In places where the infection rate remains low and there is focus on preventing the disease, faith groups draw on their religious language and on the linkages it sustains to disseminate information and engage people in education and caregiving. In this report, the YMCA's Magnet Theatre

in Kenya, interfaith collaboration in Guyana, and the work of Muslim imams in Bangladesh provide just three examples of how faith groups promote prevention awareness. Habitually faith groups tap this nexus of religious ideals and social networks to encourage preferred forms of behavior. They draw on this intention to promote behavior that can prevent the spread of HIV/AIDS.

MOBILIZING AND EQUIPPING VOLUNTEERS

The faith-based organizations depicted in this report excel at providing care and mobilizing volunteers to offer care. Moreover, their caregiving builds on an interest in education and training that is integral to the work of many faith communities. In their local areas, faith-based organizations set an example for learning linked to caregiving. They teach people and encourage them to apply their learning as teams of caregivers. One impact of the faith-based organization's role in addressing HIV/AIDS is enhanced local initiative to learn and function collectively, as evidenced by the work of CAA volunteers in Namibia and community assistants in Cambodia, to cite just two examples.

People mobilized by faith-based organizations encourage an enhanced sense of community in their localities. Their faith promotes a sense of shared responsibility that must be applied to the challenge of a major disease. An enhanced sense of common bond arises as people begin to speak openly and gain the knowledge and skills to offer care. The links between individuals that are created and deepened by offering care can extend across all the people of an area to foster a deepened sense of being a people together. These bonds also open up discussion of issues that derive from HIV/AIDS, beginning with other diseases such as TB and malaria, and moving to underlying social circumstances that foster illness, such as poverty. Faith injects a motivation to address challenges to providing care.

CREATING NETWORKS AND INFRASTRUCTURE

Faith creates formal organization. The most highly organized faith-based groups derive strength in associations between people who share their particular faith. In addressing a major disease, faith-based organizations are powerfully positioned to collaborate with governments and nongovernmental organizations alike. Such collaborations represent ideal meeting grounds for those who have necessary material and expertise and those best positioned to disseminate them.

In this report, it has also become clear that there are situations where faith-based organizations not only coexist but collaborate effectively with one another. To judge from daily headlines this would not seem likely. In this report, we have observed instances where faith groups have created important linkages because of the vision and capability of gifted leaders. A notable case is found in Bangladesh. Another instance is the work of the YMCA in Kenya's Rift Valley.

In other instances, faith-based organizations come together around common concerns when facilitated by a religiously neutral organization like FHI. There is a notable example in Guyana, where creation of the peer education manual, *Faith Matters*, has generated a high level of cooperation and conversation. It is important to emphasize that in most cases there is little or no inherent resistance to secular collaboration among faith groups to be overcome. In religiously diverse situations at local levels, there are more examples of coexistence and common social culture than of conflict. But whether at local or wider levels, informally or formally, the energies of faith-based organizations are typically turned inward and focused on their core activities and followers. Their response to HIV/AIDS has had the broad impact of creating new patterns of public engagement and of collaboration with various organizations, including other faiths.

CHALLENGES

The norms and intentions of faith-based organizations may sometimes be at cross-purposes with their cultural contexts. This is to be expected given the dedication of faith-based organizations to changing patterns and promoting behavior change. At certain times around certain issues, faith-based organizations face profound tension with cultures where they otherwise find themselves at home. In the face of such tension, the faith-based organizations covered in this report consistently have sought constructive change of the world around them.

For instance, occasionally there are matters of belief and practice that conflict with aspects of preventing HIV/AIDS. The notable instance is condom use. While some faith-based organizations resist advocating use of condoms on religious grounds, others are willing to advocate any means that might hinder disease transmission. In the familiar “ABC” approach to preventing HIV/AIDS, some faith-based organizations emphasize abstinence and being faithful. Others include condom use in their advocacy. On this point, faith-based organizations differ among themselves. In any case, however, the intention is the same: to prevent the spread of disease in ways that are both effective and congruent with the convictions of a particular faith tradition. Religious norms do not necessarily impede efforts at prevention and treatment, but may rather contour the ways in which effective forms of prevention and treatment are pursued. In FHI’s experience, faith-based organizations have proven amenable to a range of programs and forms of collaboration guided principally by the depth of their compassion and their focus on preventing and mitigating the disease.

6

CONCLUSION AND LESSONS LEARNED

THIS REPORT HAS SHOWN THE MOTIVATION AND CAPACITY OF local faith-based programs to provide sustainable care. However, to be scaled up, these programs require resources. The most obvious kinds of resources they need are material, such as the supplies required to deliver care. But funding is also requisite in that specialized programs to combat HIV/AIDS must be housed and staff must be paid. The ability of any one faith group to grow a program—including securing staff, facilities, and supplies—is often dependent on donations, grants, and collaboration.

Less apparent but no less important, local, indigenous faith-based organizations often require assistance in the management and assessment of their programs. Many operate with too few staff, minimal office equipment, and few conveniences. They rarely have time and resources to assess and refine programs and management structures. Simply keeping up with the latest developments in treating the disease and those it affects can be daunting. Faith-based staff also rarely have time to meet and learn from one another, and thus operate in isolation. Needless to say their compensation is minimal, and some work as volunteers.

Consistently it is clear that faith-based programs can better grow with resources that can be secured through partnerships with non-governmental organizations and government agencies. The scale-up of programs launched by faith-based organizations often rests on

their ability to link to resources that tap their inherent capacities. Collaboration can provide linkages that help grassroots faith-based programs thrive.



FHI HAS FOUND THAT KEEPING A FEW CONSIDERATIONS IN MIND has greatly enhanced our ability to collaborate effectively with faith-based organizations. Many of the suggestions laid out in this chapter could generally be applied to collaborative work with any other type of community-based organization. However, we believe there are still some specific steps that make particular sense for work with faith-based groups.

We have learned that taking the time to develop a thorough understanding of the role of faith and faith-based organizations in the places we work is tremendously beneficial. First, it is important to have a sense of how faith-based organizations intersect with their host cultures. We have seen that faith-based groups sometimes stand in paradoxical relation to culture. But in a strategic sense, faith-based organizations are deeply rooted in their cultural settings and thus possess unparalleled credibility in the eyes of the people we would serve. As a result, faith-based groups can become the doorways for HIV/AIDS programs. Moreover, for programs operating within the timeframe of a grant period, alliance with a faith-based organization can expedite their design and operation.

We have learned that working with faith-based organizations also requires understanding their internal cultures and the processes and values inherent in them. This does not require immersion in beliefs and practices, or acceptance of them. But it does require awareness of core beliefs and respect for the people who adhere to them. Rarely will matters of belief be barriers to collaboration, but insensitivity and disregard for religious life and identity will.

With this in mind, it is also important to acknowledge that faith-based programs come in various forms and from different faith traditions. In this report, we have examined HIV/AIDS programs such as Catholic AIDS Action in Namibia, the Kien Kes program in Cambodia, and the MACCA program in Bangladesh—all outgrowths of individual faith traditions that engage leaders of those traditions in creative ways. Mercy Centre in Bangkok is an outgrowth of one tradition, and the YMCA in Kenya is an outgrowth of several. The hospitals visited in Rwanda have been institutions run by particular traditions. In Guyana, FHI staff encouraged a new and unprecedented level of collaboration among many faith traditions. It is important to begin working with faith groups like these by first understanding the faith traditions from which they originate. Armed with this understanding, a nongovernmental organization can embark on designing programs tailored to specific cultural contexts that take advantage of a local faith-based organization's strengths.

Based on the experiences of countries visited for this report, we have come to recognize strengths shared by many faith-based organizations around the world that enable them to excel in addressing HIV/AIDS: a compassionate perspective, an emphasis on education and training, adaptability, a holistic perspective, leadership, and an on-the-ground understanding of the communities they serve. Considering these qualities, one might decide to engage a faith-based organization in opportunities to provide care—perhaps through community volunteer programs like the one in Cambodia based at Kien Kes. Or charismatic faith leaders prominent in the community could be identified and later invited to learn about HIV/AIDS so they could teach their adherents prevention strategies in line with their religious beliefs. Because several strengths of faith-based organizations stem from their integrated role in communities, it would also be tremendously valuable for a nongovernmental organization to tap

a faith-based group's knowledge of and integration among those in need of HIV/AIDS services—perhaps by consulting with faith leaders about attitudes and behaviors among their adherents with regard to the disease and seeking their help in developing communications products that are more likely to be well received.

We have learned there are significant individuals and leverage points in the structure of all faith-based organizations where it is likely that a nongovernmental organization will find people receptive to collaboration. Similarly, faith-based organizations are able to exert influence in their settings at certain social and cultural points because of their roles and networks. Nongovernmental organizations also likely possess staff able to grasp quickly how a particular faith-based organization functions and what role it plays in its setting. Although it is not necessary for the nongovernmental organization staff who work with faith-based organizations to be religious, it can be helpful if this is the case. At the very least, it is important for staff to have a basic understanding of the beliefs of the faith group in question.

We have learned it is important to remember that outside the Western world, faith often does not exist as a privatized and distinct realm set apart from social, political, and scientific matters. Instead the realm of faith often suffuses all of society and is both public and pervasive. For collaboration between faith-based and nongovernmental organizations this may mean that initiatives are seen less as discrete, time-bound projects focused on particular outcomes, but instead as broad and ongoing, reflective of their roots in the life of a people and a place. Faith-based organizations see themselves as committed to long-term sets of relationships and patterns of adapting to culture even while seeking changes in aspects of it. With proper support, local faith-based organizations are in an excellent position to extend and sustain programs launched with a nongovernmental organization.

We have learned that, because their initiatives often focus on particular ends, nongovernmental organizations are well equipped to encourage the programmatic direction faith-based organizations can follow, including help in defining program priorities and strategies. The strengths of nongovernmental organizations usually include defining, launching, resourcing, managing, and assessing programs that educate, publicize, and provide care. In turn, because of their strengths, faith-based organizations readily respond to effective means of planning and allocating resources. Guided and resourced, faith-based groups know how to reach people, and that capacity is crucial. To mesh these compatible strengths, nongovernmental and faith-based organizations often use a variety of approaches. In some instances they have staff who serve both, providing key links in program execution. To some extent they must blend organizational cultures and staff who assist that process. In addition, they must organize joint forms of planning and assessment, especially around program initiatives that embody collaboration. Joint forms of training and publicity also help, as do joint efforts to link with other organizations for information and comparison. The HIV/AIDS crisis has produced a large number of organizations and groups; simply knowing them and understanding the contributions they make is crucial. Again, since they know their cultural settings, faith-based organizations can chart a course for the application of nongovernmental organization resources and abilities. With mutual respect, the two can work together effectively. As this report has revealed, more often than not, they do.

APPENDIX: OTHER POSITIVE FHI COLLABORATIONS WITH FAITH-BASED ORGANIZATIONS

FROM THE EDITORS

Although this study presents programs in seven countries where FHI successfully works with faith-based organizations, these are not the only places where FHI has benefited from positive interactions with religious groups. Work with faith-based organizations has been critical to many of our other effective programs throughout the world, past and present.

We would like to thank other FHI country offices who took the time to submit information about their work for possible inclusion in this report. While we wish the author could have visited these country offices as well and written about their programs in detail, time and limited resources did not permit him to do so. Nonetheless, the programs mentioned here also represent some of our strongest and most effective collaborations with faith-based organizations.

DOMINICAN REPUBLIC

In the Dominican Republic, the FHI/CONECTA Project worked with World Vision–Dominican Republic (Visión Mundial República Dominicana), a well-known Christian development and relief organization. Together we carried out community-based activities in HIV/AIDS prevention; provided community and home-based care for people infected with HIV/AIDS and orphans and other vulnerable children; and

improved access to sexual and reproductive health services for adolescents and youth through behavior change communication and peer education in four high-priority geographical zones.

We also collaborated with Clínica Esperanza y Caridad, a ministry of the Dominican Episcopal Church, to improve the quality of life of five hundred orphans and other vulnerable children and seven hundred persons infected and affected by HIV/AIDS in the province of San Pedro de Macorís. The project's specific objectives included increasing the number of persons who received voluntary HIV tests with pre- and post-test counseling; strengthening the capacity of community organizations to provide care and support to orphans and other vulnerable children and persons infected and affected by HIV/AIDS in the intervention areas; and increasing access to health and psychosocial support services for these groups.

Although both partnerships have formally ended, FHI continues to provide technical support.

INDIA

In India, FHI worked with SAHARA, a Christian faith-based organization, to provide comprehensive HIV prevention, care, and support services to injection drug users and people living with HIV/AIDS in Delhi. Through SAHARA–Michael's Care Home, people living with HIV/AIDS received facility-based clinical care, psychosocial support, and linkages to socioeconomic support. We also worked with the Christian organization, the Salvation Army in Mumbai, to implement a community and home-based care and support project for people living with HIV/AIDS and their families in Mumbai city. Activities included provision of psychosocial support; home-based care; clinical care; referrals for opportunistic infection management and antiretroviral therapy; linkages to socioeconomic support;

community mobilization; and training of community volunteers and peer educators.

The partnership with the Salvation Army ended in September 2006 while the partnership with SAHARA–Michael’s Care Home continues with USAID support.

NAMIBIA, SOUTH AFRICA, AND ZAMBIA

FHI partners with three umbrella faith-based organizations in Namibia, South Africa, and Zambia through the Community Faith-based Regional Initiative for Orphans and Other Vulnerable Children (FABRIC). FABRIC strengthens and expands services for orphans and other vulnerable children using sustainable strategies to provide comprehensive care and support. The Church Alliance for Orphans, already discussed, is our FABRIC partner in Namibia. Others include the Southern African Catholic Bishops’ Council in South Africa and Expanded Church Response in Zambia.

NEPAL

In Nepal, FHI worked with the Anugraha Welfare Society (AWAS) in Eastern Nepal to mainstream HIV/AIDS issues in the general population by working with church communities. AWAS conducted presentations and orientations for members of these groups that focused on increasing general knowledge of HIV/AIDS; reducing HIV-related stigma and discrimination; and raising awareness of care and support issues for people living with HIV/AIDS. AWAS is affiliated with a branch of the Anugraha Church in Dharan Municipality.

We currently partner with the International Nepal Fellowship/Paluwa, a Christian faith-based organization that has been working with FHI to provide voluntary counseling and testing in Western Nepal for female sex workers, their clients, and migrants.

NIGERIA

In Nigeria, FHI's Global HIV/AIDS Initiative (GHAIN) partnered with the Muslim Action Guide Against AIDS, Poverty, Illiteracy and Conflict (MAGA-APIC) in Lagos. The program aimed at reducing the spread of sexually transmitted infections and HIV among Muslim youths in Lagos State. MAGA has succeeded in networking with other Islamic organizations in creating awareness about HIV within the local Muslim community, which is known for its superstitious beliefs about HIV/AIDS. It has also developed a strategic framework on HIV/AIDS for the Muslim Ummah.

We worked with the Redeemed AIDS Program Action Committee (RAPAC) in Lagos. RAPAC is a faith-based organization that coordinates the Redeemed Christian Church of God's (RCCG) response to HIV/AIDS by providing education to members. We helped RAPAC implement prevention, education, awareness creation, and spiritual counseling in the church. RAPAC advocacy activities with the church leadership gave rise to development of an HIV/AIDS policy document and a five-year strategic framework for the church. Project efforts also resulted in the inclusion of an HIV/AIDS campaign in church doctrinal teachings. As a result of RAPAC's intervention, the general overseer of the church now regularly makes altar calls to people living with HIV/AIDS and provides them with prayer support.

We also supported the Christian Health Association of Nigeria (CHAN) in Jos. FHI helped CHAN manage large-scale comprehensive HIV/AIDS programs (including ART) among its more than 4,000 member institutions in Nigeria. Capacity-building activities included program and financial management and various HIV/AIDS technical areas (including ART, prevention of mother-to-child transmission, and counseling and testing).

PAPUA NEW GUINEA

In Papua New Guinea, FHI partners with HOPE worldwide, a faith-based organization, through the Helvim Bilong Yumi Project (“Our Help”) to provide HIV/STI education, prevention, care and treatment targeting most-at-risk groups, particularly female sex workers, their clients, and men who have sex with men at the Eight and Nine miles settlement areas of the Northeast electorate of the National Capital District and a few other settlements in Port Moresby city. Men who have sex with men take part in the project as outreach volunteers. They promote HIV/AIDS awareness among other men who have sex with men and encourage greater openness among this hidden population.

HBYP has also teamed up with the Sirius Naraqí Project (SNP) of the National Spiritual Assembly of the Bahá’ís to provide services to those most vulnerable from Central Province and National Capital District. SNP’s community outreach programs often refer clients to HBYP’s sexually transmitted infection and voluntary counseling and testing services. The two have developed referral tools and strategies that ensure new patients are appropriately counseled, diagnosed, treated, and reviewed.

SOUTHERN AFRICA: FHI’S REGIONAL HIV/AIDS PROGRAM

In Southern Africa, FHI’s Regional HIV/AIDS Program helped establish ANERELA+ as a functional network for religious leaders living with or personally affected by HIV/AIDS. In the program’s early days (it was founded by Canon Gideon Byamugisha and a group of religious leaders in 2002), FHI strengthened ANERELA+’s project management capacity by supporting key staff and providing ongoing management and financial technical assistance in South Africa. We also advised them on reducing HIV/AIDS-related stigma and discrimination in their communities. ANERELA+ has evolved into a nonjudgmental ministry of care and support. Affiliates are trained

to be agents of change to their immediate faith communities and surrounding communities.

TANZANIA

In Tanzania, FHI (through the YouthNet Project) developed a series of three global family life education materials. Two were designed to teach adults to communicate with youth, one each from a Christian and a Muslim perspective. Participants practice communication skills and learn factual information, using religious teachings and appropriate Bible and Quran verses as a context for reflection on the public health information. Both tools were field-tested in Tanzania, where Christian and Muslim leaders helped identify appropriate verses. The World Council of Churches Ecumenical HIV/AIDS Initiative in Africa endorsed the curriculum. The third tool, designed for working directly with youth, was adapted from curricula developed in Namibia. The manual contains twelve sessions covering topics regarding sexuality, healthy relationships, values, communication, and related topics.

In addition, YouthNet supported a Catholic group called Family-Based Health Care Promotion Program (FABAHECA) and the Evangelical Lutheran Church of Tanzania (ELCT). FABAHECA reached some thirty-seven thousand youth and community members, working through Catholic priests, councils, and schools, using peer educators as well, using the “Stepping Stones” curriculum with fifteen topics. The ELCT leaders focused on training pastors, choir leaders, youth leaders, and couples. It provided HIV information to nearly one thousand youth through schools, almost five hundred couples through the twenty-six churches in the district, and more than eight hundred parents through community and church activities.

Also through YouthNet, FHI collaborated with the Evangelical Lutheran Church in Namibia (ELCIN) and the German Evangelical

Lutheran Church (GELC) to develop a new youth reproductive health/HIV educational curriculum, now translated into three languages. More than two thousand parents from participating parishes have been introduced to the program, and master peer educators, trainers, and church mentors have been trained in using the curriculum.

WEST AFRICA

In 2005, FHI's Action for West Africa Region HIV/AIDS (AWARE) Project supported a four-week expedition of faith leaders who traveled their region as part of a caravan conducting a vast, six-country HIV awareness campaign. The Cross-Border Caravan Against Stigma and Discrimination helped individuals, communities, and countries commit to stopping AIDS by improving HIV awareness and attitudes toward people living with HIV/AIDS in towns along the caravan route. The caravan set out from Nouakchott, Mauritania, on a month-long journey that took it through Mauritania, Senegal, Mali, Burkina Faso, Niger, and Nigeria. It ended its travels on December 4, 2005, at the opening of the International Conference on AIDS and sexually transmitted infections in Africa (ICASA) in Abuja, Nigeria. By then it had shared its messages of tolerance and support in twenty-six towns along the way. Caravan members included religious leaders, members of groups for people living with HIV/AIDS, journalists, a medical doctor, a technical advisor, a logistician, and five drivers. All of the participants received specialized training in combating HIV stigma and discrimination.

The caravan was conceived at an AWARE-sponsored regional workshop to reinforce religious groups' commitment to fighting AIDS. While other groups have conducted country and regional caravans, this was the first to take place with religious leaders in the West Africa region. The special mission of the five religious leaders in the

caravan was to reach out to the local priests and imams in each town the caravan visited and provide them with HIV stigma and discrimination training. The goal was to train thirty to fifty religious leaders in each town. More than fifteen hundred religious leaders were educated on HIV-related stigma and discrimination during the caravan.

In addition to training religious leaders, the caravan directly sensitized an estimated thirty thousand persons about HIV-related issues through talks and entertainment, and millions of people were indirectly reached through the media.

Although some time has passed since the Cross-Border Caravan took place, it still marks one of FHI's strongest collaborations with people of faith.



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January 2008

PN-ADK-464



In rural Cambodia, two members of a home care group visit a woman and two of her children, all of whom are HIV-positive. Another child is not infected. The woman tells her story in matter-of-fact terms. The Kien Kes Health Education Network, launched and run by Buddhist monks, has given her emotional support as well as education that opened a new opportunity to work. When she was first sick, she recalls, program staff took her to a nearby hospital for antiretroviral therapy and she began to feel better. Then they helped her start a vegetable stand, which has gone well because she lives on a busy road. Her treatment is succeeding and so is the business. She now earns three times the average daily wage in Cambodia and wants to expand the business since she is the family's sole wage earner. Nine people live in her house because her income permits her to support an extended family. The tangible improvement she has experienced, she emphasizes, has come from the intangible care Kien Kes has provided.

Kien Kes is one of many faith-based groups that partner with the public health nonprofit Family Health International (FHI) to care for people living with HIV/AIDS in resource-constrained settings and teach those not infected how to prevent the disease. As integral parts of society that can mobilize volunteers quickly, faith-based organizations are often uniquely positioned to provide grassroots support in stemming the disease's spread. Marrying their resources and expertise with those of FHI has enhanced the effectiveness of both groups.

Empowered by Faith presents compelling stories of compassion and care that have resulted from these invaluable partnerships. It offers practical guidance on how nongovernmental organizations and faith-based groups, on common ground, can address their critically important shared goals: improving lives and making the world a better place.



SARAH BARTENSTEIN

WILLIAM L. SACHS

is director of the Center for Reconciliation and Mission at St. Stephen's Episcopal Church in Richmond, Virginia. In this position he develops programs to build Christian-Muslim understanding in the United States and abroad. Previously he served as vice president of the Episcopal Church Foundation in New York. He has also been a visiting faculty member at Yale Divinity School and other seminaries and colleges, and has served as a consultant to several foundations.

The author of four books and over 150 articles, chapters, reviews, and editorials, he is a frequent speaker at conferences, conventions, and seminars before professional, religious, and community groups. As an Episcopal priest he has served churches in Virginia, Connecticut, and Chicago. He holds a PhD from the University of Chicago as well as degrees from Baylor, Vanderbilt, and Yale. He is married to Elizabeth Austin Tucker and lives in Richmond.