

DRO

Deakin University's Research Repository

This is the published version

Clarke, MF and Lumbers, J 2014, Churches and condoms: How Christian Faith-Based Organizations are Preventing HIV/AIDS in Developing Countries, in Engaging the World: Christian Communities in Contemporary Global Societies, Regnum Books International, Oxford, UK, pp.69-83.

Available from Deakin Research Online

<http://hdl.handle.net/10536/DRO/DU:30068288>

Reproduced with the kind permission of the copyright owner

Copyright: 2014, Regnum Books International

Churches and Condoms: How Christian Faith-Based Organisations are Preventing HIV/AIDS in Developing Countries

Associate Professor Matthew Clarke, School of International and Political Studies, Deakin University, 221 Burwood Hwy, Burwood, Victoria 3125, AUSTRALIA, matthew.clarke@deakin.edu.au, + 61 3 9244 3979.

Ms Juliette Lumbers, Deakin University.

Over 30 million people currently live with HIV, with more than 2 million more people becoming newly infected each year. Transmission of HIV occurs through the exchange of bodily fluids, primarily through sexual intercourse, sharing needles containing infected blood, incorrect dressing of infected wounds and from mother to child across the placenta or whilst breast-feeding. To reduce transmission therefore, it is necessary to change people's behavior so that fluids are not exchanged. Not only is this impossible in terms of mother to child intra-uterus transmission, but it is very difficult in terms of other modes of transmission. Certainly education campaigns and supporting individuals to minimize their 'risk' behavior has had some success. However, greater success has been recorded when interventions happen at the local level as is tailored to the very particular circumstances of the target community and individuals. Within some countries, faith-based and mission organisations have assumed an important role in educating and supporting local communities in reducing HIV transmission. This chapter considers the approach of a Christian organization in West Papua in preventing the transmission of HIV and AIDS. Important lessons can be gained by considering how this Christian organisation has successfully undertaken such work

Associate Professor Matthew Clarke is the Course Director of Deakin University's postgraduate program in International and Community Development. Associate Professor Clarke has written on a range of development issues, including the nexus between development and mission.

Ms Juliette Lumbers is a postgraduate student within the International and Community Development program at Deakin University, Australia. She recently completed a lengthy internship within Indonesia (West Papua) working with a Christian faith-based organisation.

1. Introduction¹

Over 30 million people currently live with HIV, with more than 2 million more people becoming newly infected each year. Transmission of HIV occurs through the exchange of bodily fluids, primarily through sexual intercourse, sharing needles containing infected blood, incorrect dressing of infected wounds and from mother to child across the placenta or whilst breast-feeding. To reduce transmission therefore, it is necessary to change people's behavior so that fluids are not exchanged. Not only is this impossible in terms of mother to child intra-uterus transmission, but it is very difficult in terms of other modes of transmission. Certainly education campaigns and supporting individuals to minimize their 'risk' behavior has had some success. However, greater success has been recorded when interventions happen at the local level as is tailored to the very particular circumstances of the target community and individuals. Non-government organisations have played an important role in initiating and implementing the local behaviour change campaigns. Within some countries, faith-based organisations (FBOs) have also assumed an important role in educating and supporting local communities in reducing HIV transmission.

As with many concepts and terms within development, a precise definition of 'faith-based organisations' though does not exist (see Cornwall 2007). Vidal (2001) identifies three typologies of faith-based organisations: congregations affiliated with a physical structure of worship or geographical grouping of worshippers; 2) national networks of congregations, including national denominations and their social services affiliates, as well as other networks of related organisations, such as the YMCA and YWCA; and 3) unaligned or freestanding religious organisations that are incorporated separately from congregations and national networks. Very often in developing countries, these faith-based organisations have missionary work as their geneses. Therefore FBOs are organizations affiliated with a religious structure, doctrine or congregation. However, FBOs are not simply those agencies that have vaguely stated religious motivation (such as World Vision) or geneses (such as Oxfam). Rather, they must have an active relationship with a religious institution (such as Lutheran World Service or Caritas).

While religious groups are primarily concerned with providing spiritual leadership for their communities, for many the interest in physical well-being of their communities has also been a core aspect of their existence for many such groups. Certainly mission groups have a very long history of providing education, health and other welfare services. However, as missionary efforts have matured in many countries and transformed into locally-led Churches, much of the concern with physical well-being is now often delivered through affiliated FBOs that operationalise this outreach.

Despite this long history of service provision, FBOs have long been invisible in discussions of community development. This apparent invisibility though should not be mistaken as nonexistence. More correctly, their invisibility reflects a blindness of the

¹ The authors are thankful to Ms Simon Charnley for her research assistance from which part of this chapter is related

development sector itself in failing to recognize FBOs within communities. This may be partly explained by FBOs being embedded within communities and being less external agents and more 'organic' to the community. It can also be explained by FBOs choosing to position themselves outside the development sector and remaining more closely aligned with the religious body to which they are affiliated.

It does appear though that the invisibility of FBOs in community development work is now diminishing. There has been recognition more recently both within the development sector and by FBOs themselves, that there is importance and synergy to be gained by secular and sectarian agencies engaging with one another in a more purposeful manner. As participatory community focused models of development have become increasing dominant in recent years (see Chambers 2005; Stiglitz 1999; Craig and Porter 1997; Sihlongonyane 2003), FBOs have become increasingly 'attractive' as agents or key stakeholders in the development process due to their strong links to local communities. Moreover, FBOs themselves have also begun to initiate contact with aid donors to seek increased involvement (and funding) in community development interventions. Over the past decade a number of international forums have been developed that have brought together FBOs and large international donors to explore how to leverage the experience and expertise that both groups can bring to improving the lives of the poor.

FBOs are now seeking 'a seat at the policy table, while they are also, in many instances, asking development institutions to work and support faith groups in scaling up their community and social justice operations' (Marshall and Van Saanen 2007, p. 4). Reticence that donors may have had in the past of being seen to be working with FBOs is now being replaced by a clearer understanding that FBOs are a legitimate part of civil society that offer entrée into local communities, networks across countries and regions and (often) expertise in community development processes and interventions. This recent 'acceptance' of FBOs mirrors the 'acceptance' of secular non-governmental organisations during the 1990s by the same donors. Enhancing aid effectiveness requires accessing and engaging with local communities and there is now the recognition that FBOs (like NGOs) can facilitate this access and engagement for donors.

This chapter considers the interventions adopted by a local Christian organization in Papua, Indonesia. The ability of this faith-based organisation to successfully engage with its community around issues of sexuality and sexual practice provides important lessons for other FBOs seeking to reduce HIV transmission through sustained behaviour change. Whilst a single model or approach for HIV and AIDS interventions by FBOs does not exist, this paper does conceptualize a 'wheel' of successful characteristics based upon the experience of this organisation. This paper argues that FBOs are distinct from NGOs and require a FBO-model of HIV and AIDS engagement. Therefore the characteristics discussed should be considered by other FBOs operating within the HIV and AIDS sector.

This paper is set out as following: this section has introduced the paper. Section 2 considers the specific issue of HIV and AIDS in relation to FBOs. The case study is

discussed in Section 3 before eight lessons from these case studies are considered in Section 4. The paper is concluded in Section 5.

2. FBOs, HIV and AIDS

Transmission of HIV occurs through the exchange of bodily fluids. This occurs generally through intimate physical contact between humans. Other than within pregnancy and breastfeeding, transmission of HIV in most instances is associated with ‘sinful’ activity – that is, sexual intercourse with multiple partners or commercial sex workers², prohibited sexual practices such as anal intercourse (including ‘men who have sex with men’), or illegal drug injection. Reducing the likelihood of transmission requires behaviour change – either the (unlikely) abstinence from these activities or a harm reduction approach such as instigating condom usage and the use of cleaner injecting equipment. The involvement of FBOs in preventing HIV transmission or care of those with AIDS is therefore perhaps counter-intuitive to many.

To properly engage with HIV and AIDS prevention requires addressing human sexual activity and illicit drug use. Addressing these activities also requires acceptance of them and an ability to communicate effectively about these activities and how they relate to religious teachings and beliefs. It is reasonable to expect therefore for FBOs to have a natural preference to engage with more appropriate or ‘moral’ community development interventions, such as provision of health care, education services, agricultural extension, water and sanitation or economic enterprise and turn away from involvement with HIV and AIDS prevention and care programs. Indeed, during the early phase of the HIV and AIDS epidemic, religious leaders and FBOs were generally silent, often only breaking this silence to preach against homosexual practices that were considered the main mode of transmission. Due to the stigma that was attached to HIV and AIDS, many religious leaders and FBOs also denied that this was a relevant issue for their own communities, further adding to the stigmatization felt by those affected (including the families of those infected). Denial, silence and stigmatization by FBOs and religious leaders hinders interventions aimed at reducing HIV transmission and the care of those with HIV and AIDS thereby exacerbating the problem.

It might also be expected that if FBOs did choose to engage with HIV care and prevention, they would more likely focus on the preaching of abstinence as this is in line with the theological tenets of their faith. Surprisingly though, many Christian FBOs are now undertaking condom distribution and social marketing in ways that resemble secular organisations. The reasons for this shift include the greater prominence given to HIV and AIDS in national policies, the overwhelming numbers of those infected and affected by HIV and AIDS (particularly within sub-Saharan countries and some parts of Asia), the increasing need for a multi-sectoral response, and pressure from donors, national governments and local communities themselves for FBOs to more adequately address

² This excludes the transmission from (generally) husband to wife as HIV cannot be introduced into a monogamous and faithful relationship. Transmission in this context requires one partner to have contracted the virus via the transmission modes discussed above.

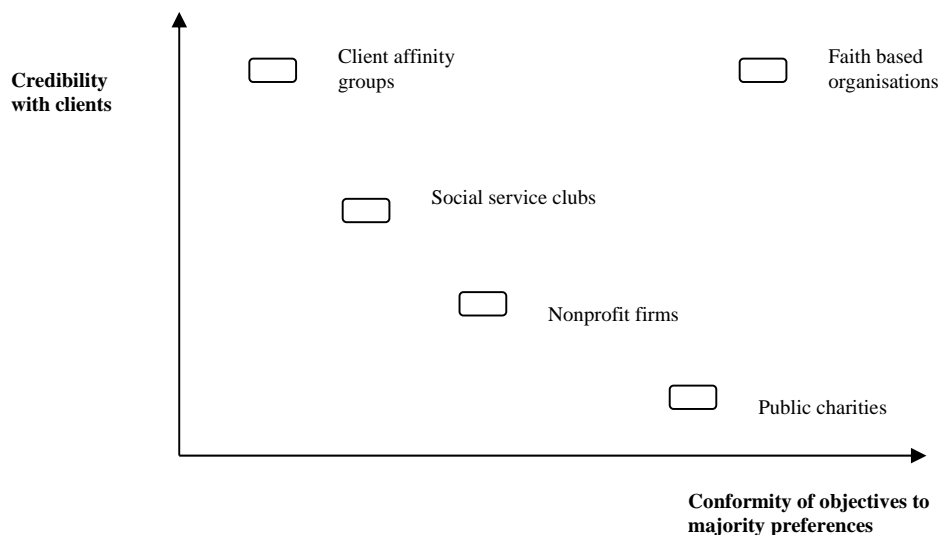
HIV and AIDS, but also their associated problems of orphans, reduced household incomes, and on-going stigmatization. Where once the response of Christian FBOs hindered positive responses to HIV and AIDS and abetted stigmatization, FBOs are now playing a central full in addressing this phenomenon in all its guises.

Clarke (2002) has found though that within care and prevention interventions, more targeted and risk-specific information is required by those who undertake risk behaviours associated with transmission of HIV than that required by the general population. It is not appropriate or efficient to provide explicit information that is relevant to commercial sex workers or injecting drug consumers to the wider population. Such dissemination could, at the very least, further stigmatize these 'at risk' groups. However, it is necessary that this specific information – often specific to small geographic areas or sub-population groups – be prepared and disseminated. As the World Bank (1999) has noted 'although it is highly desirable to focus public interventions on those who are most likely to contract and spread HIV, identifying and reaching these individuals can be difficult, especially when legal sanctions and social stigma cause these people to want to avoid being discovered' (p. 146). It is at this level though that Christian FBOs can be very effective in reaching isolated or illicit communities by drawing on their local community networks and trust within communities.

However, it is simply insufficient to disseminate information and expect that this will result in sustained behaviour change within this 'at risk' groups. It is also necessary to establish peer supports that enable changes to be contemplated, trialed and then sustained. Again, Christian FBOs have natural advantages of working at the local level to assist in building the capacity of peer trainers and peer support to facilitate this. The development of an 'enabling environment' is fundamental to sustaining behaviour change (Parnell and Benton 1999). An enabling environment addresses issues around general employment, health care, access to education, or personal security. Not only must individuals be able to understand the risks to their own health (and life), they must also be supported in changing their behaviour that also includes modifying (including reducing or strengthening) external factors that is linked to these risk behaviours (World Bank 1999).

It is the unique characteristics of Christian FBOs that make them well placed within communities to advance enabling environments that will support sustained behavior change. Unlike secular non-government organizations, Christian FBOs have a natural constituency at the local level but in addition also have organizational networks both nationally and internationally. Utilizing the networks that exist at these different levels supports their ability to undertake effective community development. Feeny and Clarke (2009) describe the different roles that non-government organizations can play at the micro, meso, macro and supra-macro levels in both advocacy and programming. Faith-based organizations are also able to operate in these levels by piggy-backing on the pre-existing structures their associated religious organizations have in place. This therefore aids their efficiency and provides advantages over secular NGOs.

Figure 1 – Differing Strengths of Five Types of Nonprofit NGOs



Source: authors' own work (modified from World Bank 1999)

FBOs can be very powerful advocates in overcoming the moral pressures to further punish or prosecute these risk behaviours through their formal links to religious groups. As a result of these religious ties, FBOs are somewhat unique in terms of other NGOs in that they cross-over between having high credibility with their target beneficiaries but also having support of the wider population due to their religious grounding³. Broad-based public charities have large constituencies drawn from the general public and are therefore likely to have objectives in broad conformity with the general public interest. However, such broad-based public charities are likely to be less credible with the client group than an organization composed of members of that group. While non-profit firms might have higher levels of credibility with their clients, they do so at the expense of public support. This is similar to the further trade-off between credibility with clients and public support experienced by social service clubs and client affinity groups (World Bank 1999). Unlike these organisations that have to trade off credibility with clients to wider population support, FBOs can simultaneously achieve high support with both (see Figure 1) as they are visible at both the local level working with target groups but also because they form part of the social mores upon which the wider society is based.

Yayasan Kesehatan Bethesda (Bethesda Health Foundation) is a small, local Christian organisation based in Papua, Indonesia. Documenting the approach undertaken by this organization provides a clearer understanding of the role FBOs have in relation to reducing the transmission of HIV and AIDS. A wheel of successful characteristics of

³ Presuming that the FBO is of the religious majority for that particular country or region.

HIV and AIDS interventions is then conceptualized by drawing on the experience of this case study.

3. Yayasan Kesehatan Bethesda (Bethesda Health Foundation)

Papua is a deeply religious area, with the majority of Papuans being Christian. Due to the number of Indonesians migrating to Papua (mainly Javanese and Sumatran) there are also increasing Muslims as well as Buddhist and Hindus – though they still remain in the minority. The strong religious affinity of Papuans has resulted in the churches (and other places of worship) being appropriate locations for providing information on the transmission of HIV and AIDS (and other sexually transmitted infections). Whilst the basis of this education is abstinence and faithfulness, many of the religious leaders have recognized the need to promote safer sex and have chosen to work closely with various NGOs and the KPA (the national AIDS commission).

One such Christian FBO is Yayasan Kesehatan Bethesda (Bethesda Health Foundation – YKB). YKB is a local Christian organisation that works with church groups (particularly church leaders), rural communities, people living with HIV and street children in Papua, Indonesia. YKB first opened in 1984. It was set up by nine churches (different denominations – Catholic, Indonesian Evangelist, Papuan Evangelist, Adventist, Reformation, Baptist, The Evangelist Camp, Uniting and Protestant) as a means to distribute medical supplies to Christian communities all over Papua. However, the Catholic Church has been the most consistent and active in its involvement with YKB. YKB currently receives funding and support from numerous other organizations such as AusAID, USAID, KPA (the national AIDS commission) and MCC (Menonite Central Committee). As a result of the changes in funding, the focus and purpose of YKB have changed over time. While medical supplies were once their sole purpose, the main focus is now health training. YKB responds to the needs of the Christian community at the request of the churches. HIV became a priority because it was noted that 70 percent of people living with HIV in Papua were Christian church attendees and the churches did not know how to address the issues or help their people. YKB responded to this through setting up a sexual health program run through church leaders.

While data is difficult to obtain, it is assumed that up to 2.5 percent of Papuans are living with HIV and AIDS. Within Papua, one of the main groups perceived as being responsible for the rapid spread of HIV is the ‘mobile man with money’ (3M) – with often a fourth ‘m’ being added: married. High-ranking government workers and officials are widely believed to have money and transport and pay more to have unprotected sex. These men often become infected by the sex worker, then go home to their wives and infect them. Infected women will then often transmit HIV to their babies across the placenta in the womb or through breast feeding.

In Papua, there is heavy campaigning and numerous governmental and NGO bodies working to raise awareness of HIV and AIDS using different forms of media, including, stickers, posters, badges, billboards, t-shirts, banners and advertisements. However, despite this information campaign, a 2006 survey undertaken by the Indonesian Health Department in cooperation with the Bureau of Statistics and supported by the World

Bank and Family Health International, showed that almost fifty percent of the population had no knowledge HIV and of those that were aware of HIV and AIDS, the majority had poor or incorrect information about what it was and how it was transmitted and there was still heavy stigmatization and discrimination against those known to be living with HIV.

The role that YKB have assumed of providing reliable and relevant information on the transmission of HIV is very important. The Sexual Health Program is YKB's most successful HIV and AIDS program. It was initiated in October 1999 and focused on providing HIV and AIDS training for church leaders and working with young people. It recognises that religion is very strong in Papua and believes that the church is the best way to reach the people. The Sunday Schools were targeted because they meet regularly and the relationships between the leaders and pupils are usually good. YKB provide training for church leaders (Sunday School Teachers) and District Liaison Officers (who act as the intermediate between the church and YKB). DLOs are on-site within local clusters. The program is run in a number of hard-to-reach areas as well as in the cities. Currently, the program runs in 12 sub-districts, but in 2008, this expanded to 15. It involves 99 church congregations from 11 different denominations. There has also been interest from some Muslim groups to join the program. YKB is keen for this to occur and is currently pursuing this partnership.

Church leaders are taught about HIV and AIDS and are given a range of resources (from KPA in conjunction with other international NGOs) and ongoing training and evaluation sessions provided by YKB. YKB helps the church leaders design programs that cover 18 topics for sexual health promotion and pastoral care (topics covered include love, sex, marriage, HIV and AIDS). Whilst there is no record of HIV being transmitted in Papua through the sharing of infected needles, YKB have recognized that injecting drug use is likely to become a risk behaviour in the future. YKB distribute condoms, comics promoting ABC (abstain, being faithful and condom use) and encouragement for people to be tested and talk more openly, posters, pamphlets, DVDs and CDs to church groups. Most communities have enthusiastically accepted the majority of the materials, however there have been some other church members that have opposed it. It should be noted, however, that the church groups that participate in the program have chosen to do so voluntarily. This has meant that the priest/pastor/rector/vicar has supported the program and does not easily give in to public pressure. Most people who were initially against the program now have respect and understanding and support the program's aims and objectives. YKB believe that the acceptance is due to the material covered and the approach used. Addressing HIV and STDs through pastoral care and by combining it with a group of other issues around relationships and love, the church community accept it to be necessary teaching.

The work of YKB has resulted in many positive changes within the local Papuan community. There are now HIV positive street children working in HIV prevention with other NGOs and church groups. The access to information and HIV and AIDS resources in remote areas has become more readily available to communities and more church groups and even Muslim groups are requesting to participate in the YKB sexual health program. The acceptance, changing attitudes and support that the program has brought

about has made a significant difference to the community. So far, the program is proving to be highly successful by changing the attitudes towards people living with HIV and AIDS and individuals changing their own behaviour and lifestyles.

4. A FBO HIV and AIDS Approach?

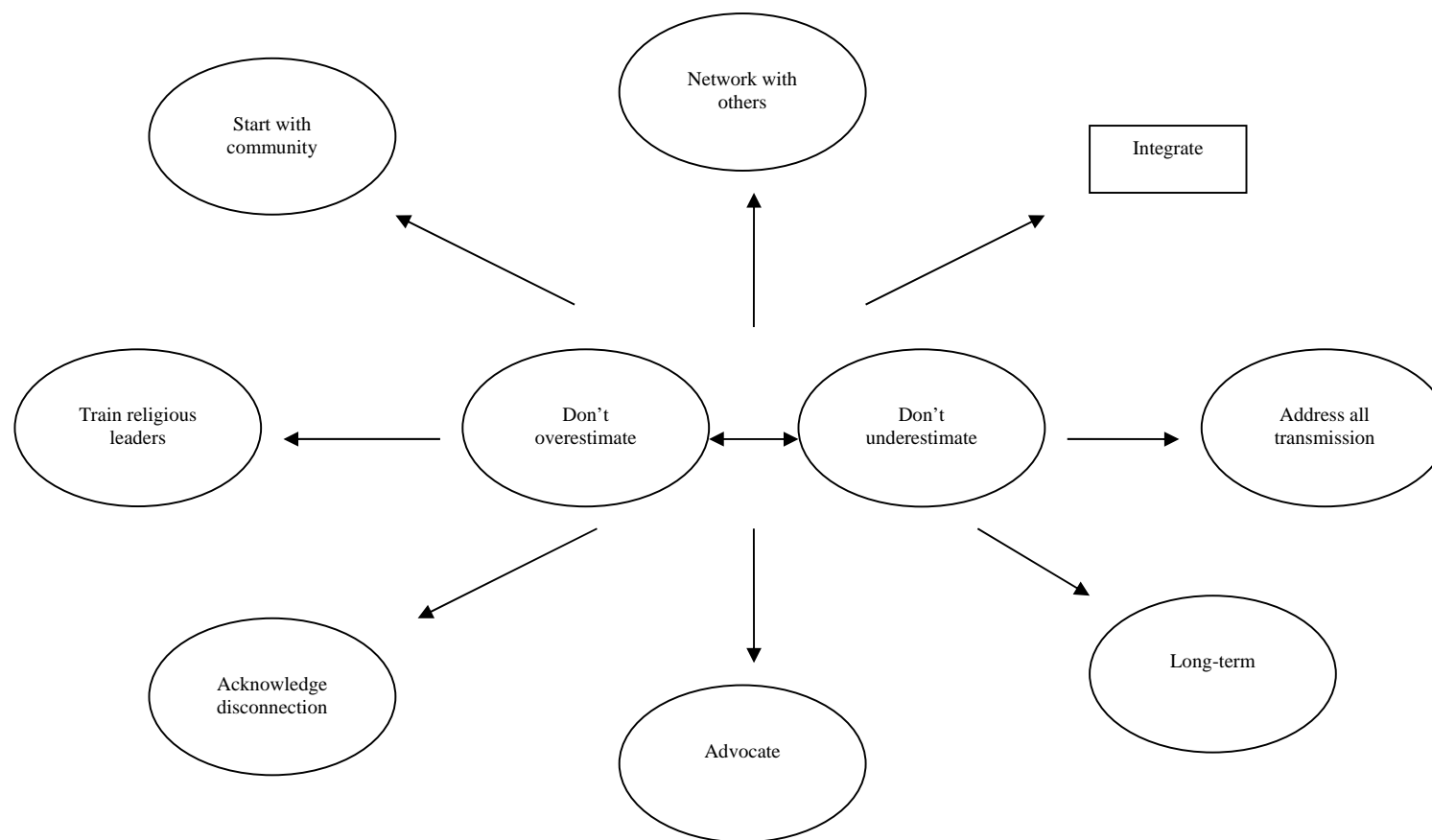
While there is no single approach or model for FBOs to adopt when working with communities to reduce the transmission of HIV or the care of those with AIDS, it is possible to develop a suite of characteristics that underpin successful HIV and AIDS interventions.

Successful HIV and AIDS interventions by FBOs require managing the tension between understanding both the ability and the limits of the FBO in achieving behaviour change within a community. FBOs have both credibility within and access to local communities. This credibility and access is central to effectively disseminating information and increasing knowledge of HIV and AIDS (see Figure 1). FBOs have a natural position of authority with communities based on their links to religious belief systems. While secular agencies would spend considerable time building a reputation and level of trust with a community, by their nature FBOs already have an advantage in this regard. If FBOs disseminate integrated education materials that reflect existing knowledge and align with practiced risk behaviours, they are able to draw on their authority as experts in this field. Whilst FBOs have a natural authority, this does not necessarily translate to individuals changing their own practices at the simple behest of the FBO. Indeed, the authority of the FBO is attributable to their own relationships to a religious belief system, which universally teach against the activities that are risk behaviours for HIV transmission (illegal drug use and non-monogamous sexual intercourse). It is evident though that these teachings have not prevented people from undertaking such risk behaviours. So if the authority of the religious body itself cannot hold sway over personal behaviour, FBOs also cannot expect to simply dictate appropriate behaviour. They must therefore acknowledge their own limitations when seeking to change risk behaviours whilst working with communities.

Acknowledging the strengths and weakness of the YKB approach, eight characteristics can be identified for successful approaches to the provision of HIV and AIDS care and prevention programs. These characteristics are:

1. Acknowledging disconnection between religious teaching and human behaviours
2. Training religious leaders in HIV and AIDS transmission
3. Understanding that HIV and AIDS interventions require long-term commitment
4. Starting interventions where the community are
5. Integrating HIV and AIDS interventions into social and community development activities
6. Addressing all modes of transmission (even those that are not current present)
7. Advocating for better national programs
8. Working with other FBOs and secular organisations

Figure 2 **Wheel of Successful FBO HIV and AIDS Characteristics**



Source: authors' own work

FBOs incorporating these 8 characteristics into their own programs will be better placed to address HIV and AIDS in their local communities.

- 1. Acknowledging possible disconnection between religious teachings and moral tenets and risk behaviour practiced in the community** is essential as HIV is transmitted via the exchange of bodily fluids. This occurs generally through unprotected sexual intercourse, sharing needles containing infected blood, incorrect dressing of infected wounds and from mother to child across the placenta or whilst breast-feeding. While dressing infected wounds and transmitting the virus during pregnancy do not transgress religious teachings or moral tenets, sharing needles and sexual intercourse may very well do so. Injection of illegal drugs and sexual intercourse outside of marriage - including heterosexual intercourse with commercial sex workers or sexual intercourse between men - are risk behaviours associated with the transmission of HIV. FBOs must acknowledge these risk behaviours and incorporate them into their interventions. It is insufficient for FBOs to exclude such consideration because they are in conflict with the religious teachings. FBOs cannot ignore the reality of risk displayed by the communities they work with in preference to the behavior expected from and associated with their religious beliefs and teachings.
- 2. Training religious leaders is necessary** as the primary basis of the FBOs authority is its link to a religious belief system. Whilst separate to, the natural partner for FBOs is the existing religious organisation to which it is aligned. It is necessary that these two organisations work closely when addressing HIV and AIDS. Religious leaders provide very important moral and religious support for a FBOs interventions. Training religious leaders in both the myths and facts of HIV transmission is necessary to ensure they their sermons and actions do not contradict the FBO intervention. Having the imprimatur of the local religious leader adds great weight to the FBO
- 3. Understanding that interventions addressing HIV and AIDS are long-term in nature** is necessary as behaviour change takes time to initiate and takes further time to become entrenched as a new sustained pattern of behaviour. The length of time it takes for this transition differs between individuals, but is substantial. Moreover, given the risk behaviours associated with HIV transmission (ie drug use and sexual activities), new cohorts of potential risk-takers are constantly appearing as children become young adults. Therefore, addressing HIV and AIDS cannot be equated to, for example, installing water and sanitation infrastructure nor even improving gender awareness. There is a necessity therefore for long-term support of behaviour change, but also on-going dissemination of information with new cohorts of young people at risk of undertaking these behaviours. Associated with the long-term nature of these interventions is a constant review of risk behaviours and practices to ensure that the information being disseminated is relevant to current awareness and risk behaviours. Fundamental to this is securing long-term funding (through either secular or sectarian donors).

4. **Starting where the community is** recognizes that each community is different, and therefore so too will their initial knowledge of HIV and AIDS. As behaviour change is the primary means of reducing risk of transmission, targeted information must be specifically tailored to the knowledge, belief and practices of that particular community. Indeed, there is likely to be distinct cohorts within each community requiring distinct integrated education materials that address their own circumstances. FBOs must investigate knowledge of HIV and AIDS transmission and practice of risk behaviours within their communities before implementing interventions. Starting where the community is, also is pertinent to selecting appropriate responses. In order to maintain community support, immediate and aggressive condom social marketing may not be appropriate as an initial intervention. FBOs must challenge their communities, but not threaten them. Over time, FBOs may be able to successfully socially market condoms with the support of the community (including religious leaders), but not if they overwhelm community goodwill in the first instance.
5. **Addressing all transmission modes even if these risks are not currently being practiced within the community** ensures that new transmission modes are not ignored. It is necessary to provide information on all modes of HIV transmission, even if the community does not currently practices certain risk behaviours. Therefore, while injecting drug consumption may not be a known activity, for example, it is still important for the FBO to include information about the importance of clean injecting equipment in their information dissemination activities.
6. **Integrating HIV and AIDS prevention interventions within a wider program of social and community development, which includes care of those living with HIV and AIDS** results in more successful outcomes. HIV and AIDS interventions should not sit in isolation from other community development interventions. Indeed, certain risk behaviours arise due to general issues associated with poverty that can only be properly addressed through wider community development. Moreover, FBOs should use their strong connections and authority in local communities to actively reduce stigmatization around HIV and AIDS by 'mainstreaming' prevention interventions into their normal community development interventions. In addition to this, they should also actively seek to provide care (and social respectability) for people living with HIV or AIDS. These care interventions may include some welfare based activities including provision of food, shelter and health care, but can also include micro-finance opportunities (including skills training) and social events for companionship.
7. **Advocating for better national programs (and funding) addressing HIV and AIDS** across the wider religious institution results in improved HIV and AIDS responses, programs and funding from national governments. FBOs do carry significant political influence in some developing countries, and can draw on their constituents to pressure national governments to enhance responses to HIV and

AIDS. When working in concert with sectarian agencies and other community-based organisations, this influence is multiplied. FBOs advocating on the national stage also has the associated benefit of further reducing stigmatization of HIV and AIDS as it is seen as a 'respectable' development issue worthy of consideration by dint of the FBOs' involvement.

- 8. Working with other FBOs and secular organisations (including national or regional bodies)** will result in a critical mass to better address the difficulties of achieving behaviour change. Changing behaviour is difficult and requires not only knowledge and information, but also an enabling environment to support efforts to change. This enabling environment may include improve sustainable livelihoods, access to education and health services, increased personal security, enhanced gender awareness, and so forth. It is not reasonable therefore to expect FBOs to engender such an enabling environment in isolation. They must therefore work closely with other FBOs, secular organisations and, importantly, with government agencies – especially public ministries of health and law and order. Working in isolation or limiting co-operation with other sectarian agencies will limit their effectiveness.

How the tensions of the potential influence (and lack thereof) and incorporating eight (or part thereof) of the lessons described above are managed will have implications for how FBOs may currently work. There may be some concern that adopting the lessons above will minimize the distinction between FBO and NGO with the former losing their overarching religious identity and secularizing themselves to become the latter. This need not be the case. The religious aspect of FBO makes them quite distinct from secular NGOs, in both their motivation for existence, but also their connection to their communities. Depending on the country or region, FBOs may be embedded in the cultural structure making it easy to seamlessly work at all levels within society and access all community members. In less religious states or where the FBO is associated with a religious minority, connections with the wider community will be weaker but possibly stronger with the specific religious cohort being engaged with. In either circumstance the existing levels of trust and relationships will be more permanent than a relationship with a secular organisation that may be more transitory or motivated by a specific cause or need.

5. Conclusions

It is now increasingly recognized that FBOs are important agents in addressing a wide range of development issues. This sectarian identity provides them with unique connections to both local communities but also national and international networks. Whilst many religious groups may have avoided addressing HIV and AIDS when it first became a development issue in the 1980s and early 1990s, there has more recently been a stronger engagement from FBOs in the prevention of HIV and care of people living with AIDS. The past reticence to work in this field largely stemmed from denial of HIV and AIDS being a problem, and from silence driven by the perception that transmission was through immoral acts and illegal behaviors. However, in line with FBOs becoming

increasingly active as community development agents in other spheres, their involvement in HIV and AIDS has increased also. There has been recognition more recently amongst both FBOs and donor agencies that that FBOs are themselves well placed to inform, educate, motivate and support behaviour change within communities and advocate at national, regional and international forums on behalf of those people affected by HIV and AIDS. This chapter has conceptualized a wheel of successful characteristics of FBO interventions in HIV and AIDS. These characteristics are drawn from a Christian organisation in Papua working to reduce HIV transmission and provide care to people living with HIV or AIDS. While it is unique it does provide insights and lessons for other FBOs seeking to combat HIV and AIDS. Rather than becoming more secular in their operations, FBOs' sectarian identity makes them a powerful and important resource in the on-going campaign against HIV and AIDS.

References

- Chambers, R. *Ideas for Development*. London: Earthscan, 2005.
- Clarke, M. 'Achieving Behaviour Change: Three Generations of HIV/AIDS Programming and Jargon in Thailand'. *Development in Practice*, 12: 5, 2002, 625-636.
- Cornwall, A. 'Buzzwords and fuzzwords: deconstructing development discourse', *Development in Practice*. 17:4-5, 2007, 471-484.
- Craig, D. & Porter, D. 'Framing Participation: development projects, professionals, and organizations'. *Development in Practice*, 7:3, 1997, 229-236.
- Feeny, S. and Clarke, M. *The Millennium Development Goals and Beyond: International Assistance to the Asia-Pacific*. London: Palgrave-MacMillian, 2009.
- Marshall, K. and Van Saanen, M. *Development and Faith*. Washington DC: World Bank, 2007.
- Parnell, B. & Benton, K. *Facilitating Sustainable Behaviour Change*. Melbourne: Macfarlane Burnet Centre for Medical Research. 1999.
- Sihlongonyane, M. F. 'The rhetoric of the community in project management: the case of Mohlakeng township'. *Development in Practice*. 11:1, 2003, 34-44.
- Stiglitz, J. 'The Role of Participation in Development'. *Development Outreach*, Summer 1999, 1-4.
- UNAIDS. *Report on the global AIDS epidemic*. Geneva: United Nations Joint Programme on HIV/AIDS, 2008.
- Vidal, A. *Faith-based organisations in community development*. Washington, DC: The Urban Institute, 2001.
- World Bank. *Confronting AIDS: Public Priorities in a Global Epidemic*. Oxford: Oxford University Press, 1999.