BACKGROUND PAPER

East Asia and Pacific Region

INTERFAITH CONSULTATION: CHILDREN and HIV & AIDS

15-17 January 2008
Bangkok, Thailand

unite for children

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This background paper of the UNICEF East Asia and Pacific Regional Interfaith Consultation: Children & HIV presents regional strategies to strengthen the role of faith-based organizations (FBOs) in responding to HIV & AIDS. It brings attention to four key areas: access to essential services, building a supportive environment, strengthening the capacities of families and mobilizing and supporting community-based responses in addressing the needs of children affected by HIV and other vulnerable children in the East Asia and Pacific region.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
AINA	Asian Interfaith Network on HIV & AIDS
AMAN	Asian Muslim Action Network
ART	Anti-retroviral treatment
BCC	Behaviour change communication
BLI	Buddhist Leadership Initiative
BUPNG	Baptist Union Papua New Guinea
CPP	Church Partnership Programme
CRC	Convention on the Rights of the Child
FBO	Faith-based organization
GIS	Geographic information system
HIV	Human immunodeficiency virus
IEC	Information, education, communication
IMMIM	Indonesian Mosque Association Mushallah Muttahidah
IR	Islamic Relief
MSM	Men who have sex with men
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PLHIV	People living with HIV
PLWHA	People living with HIV & AIDS
PMTCT	Prevention of mother-to-child transmission
PNG	Papua New Guinea
SAPNG	Salvation Army Papua New Guinea
STI	Sexually transmissible infection
UNICEF	United Nations Children's Fund
VCT	Voluntary counselling and testing
WHO	World Health Organization
YWCA	Young Women's Christian Association

1 Introduction

East Asia and Pacific is the most diverse region in the world. Geographically, it spans small island states to landlocked nations. It includes the world's most populated country – China (population 1.3 billion) – and the least populated – Nieu (population 1,700). Across the region and within countries, there is ethnic diversity. Countries are at different stages of socio-economic development, but in almost all countries, faith-based organizations are among the most important social and cultural forces.

The East Asia and Pacific region has not been spared from the ravages of HIV and AIDS. In 2007 in Asia there were an estimated 4.9 million people living with HIV (PLHIV), including 440,000 people who became newly infected in the past year; approximately 300,000 died from AIDS-related illnesses.[1] Also in the same year, East Asia had an estimated 800,000 adults and children living with HIV, 92,000 adults and children newly infected with HIV, and 32,000 adult and child deaths from AIDS.

While overall prevalence is still relatively low, the conditions exist for a rapid increase. Furthermore, some countries already have reached the level of a generalized epidemic (Thailand, Myanmar, Cambodia and Papua New Guinea).

In responding to the needs of children affected by HIV & AIDS and other orphans and vulnerable children (OVC), UNICEF is committed to minimizing the further spread of HIV in the region and ensuring that the highest possible level of care, treatment and support is available for those already infected. Within the context of its broader mission to advocate for the protection of children's rights, to help meet children's basic needs and to expand children's opportunities to reach their full potential,[2] UNICEF's Unite For Children, Unite Against AIDS Programme priorities, as outlined in *Children: the missing face of AIDS. A call to action* (2005),[3] known as the "4 Ps", are to:

- Prevent mother-to-child transmission of HIV (PMTCT)
- Provide paediatric treatment
- Prevent infection among adolescents and young people
- Protect and support children affected by HIV & AIDS[4]

Faith-based organizations (FBOs), regardless of religion or denomination, have particular attributes that can strengthen the HIV & AIDS response and contribute more broadly to the protection, care and support of OVCs. They include:[5]

- Strong roots within communities
- Depth of networks and breadth of infrastructure
- Respect and trust of their constituents
- Moral and ethical competence to work for positive social change

FBOs are already extensively involved in HIV & AIDS related initiatives. These initiatives span all response areas from prevention to care, treatment and support. Specific factors within countries are important in determining priorities for FBO involvement (e.g. the stage of the HIV epidemic, existing health service infrastructures, socio-cultural factors, existing capacities of FBOs and so on).

The UNICEF East Asia and Pacific Regional Office (EAPRO) is organizing a regional meeting in Bangkok, in January 2008, to discuss strategies to strengthen the role of FBOs in responding to HIV and in addressing the needs of children affected by HIV and other vulnerable children in the region. This document provides background information for the Interfaith Consultation on Children and HIV as follows:

- Section 2 provides a brief overview of the role of and rationale for FBOs in the response to HIV & AIDS.
- Section 3 includes information on HIV & AIDS and children in the East Asia and Pacific Region.
- Section 4 provides an outline of UNICEF's key policy frameworks relevant to HIV & AIDS.
- Section 5 explores the rationale for and current activities in the strategic areas of building a supportive environment, mobilizing and supporting community-based responses, strengthening the capacities of families and access to essential services.
- Section 6 discusses support for FBOs to build partnerships, develop capacity and utilize strategic information (including monitoring and evaluation).

Faith-based Organizations and HIV & AIDS

2

2.1 What are faith-based organizations?

Faith-based organization (FBO) is a general term used to refer to religious and religious-based organizations, places of religious worship or congregations, specialized religious institutions, and registered and unregistered non-profit institutions that have religious character or missions.[6] FBOs may be related to a specific religion, a specific denomination or sect, or have a membership base from different religions. FBOs range from largely autonomous local groupings to large multi-national institutions.

2.2 Why faith-based organizations should be involved in HIV & AIDS responses targeted at children and families

FBOs should be involved in HIV activities focusing on children and families because:

- All religions have ethical and moral precepts (e.g. compassion) that address the fundamental experiences of life, including illness and death;
- FBOs are major service providers of health services in many countries;
- Leaders and followers have direct experience of interacting with people living with HIV & AIDS; and
- FBOs are at the centre of community life and are a key point of reference for families.

Although approaches to HIV are different across religions, most have moral and ethical principles to provide care and support for vulnerable community members. "All religions provide important ethical and moral precepts for living, for interpreting and coping with life's celebrations and milestones, joyous and sad, from birth to death."[7] Issues of guilt, compassion, salvation and forgiveness are framed by religious beliefs. These issues and beliefs deeply affect the attitudes of many people towards those living with HIV and the experiences and feelings of many people directly affected by HIV.

2.3 What faith-based organisations are doing regarding HIV & AIDS

FBOs from the local to international level have responded at policy, programme and service levels to HIV. Section 5 of this report provides further details of some of those activities at the country and local level. Outlined below are some of the key initiatives undertaken internationally and regionally.

2.3.1 International programmes

At an international level, the International AIDS Conference held every two years provides a forum for representatives of different faiths to come together. Interfaith dialogues had been conducted prior to the conference for several years. They had provided an opportunity for FBOs to share experiences.

There are interfaith programmes operating that mainly focus on a particular region (e.g. Africa). There also are cross denominational/sect programmes within specific religions. They include:

- The Ecumenical Advocacy Alliance, a broad ecumenical network for international cooperation in advocacy on global trade and HIV & AIDS. More than 100 churches and church-related organizations have joined the alliance.

- Islamic Relief (IR), an international relief and development charity that aims to alleviate the suffering of the world's poorest people. In November 2007, IR held an international conference to generate practical responses to the HIV & AIDS pandemic from an Islamic perspective.
- Many Christian church organizations have international HIV & AIDS programmes. They often involve financial assistance and/or partnering arrangements between wealthier and poorer nations.

2.3.2 East Asia and Pacific programmes

Within the East Asia and Pacific region, there are interfaith, interdenominational and denomination-specific networks and organizations working across countries on HIV & AIDS. Most of these organizations are Christian-denomination specific.

The Asia Interfaith Network on HIV & AIDS (AINA) is currently the most active organization in the region that brings together FBOs from different faiths working on HIV & AIDS. It was formally launched in 2005. Its mission is:

> *To work together with people living with HIV and AIDS to build caring communities, ensuring promotion and protection of human rights, with support from governmental, non-governmental agencies, organisations, international agencies and multi-sectoral organisations.*[8]

Interdenominational faith-specific organizations working across countries in the region include the Asian Muslim Action Network (AMAN), which has a specific HIV & AIDS programme, and the HIV & AIDS Buddhist Leadership Initiative (BLI).

The principle goal of the AMAN HIV & AIDS programme is to build awareness and capacity among Muslim communities in Asia so that they may effectively respond to the growing problem of HIV & AIDS.

The Buddhist Leadership Initiative is a regional strategy to build Buddhist involvement in the response to HIV. It was initiated by UNICEF in 1998 and currently operates in Cambodia, Lao PDR, Mongolia, Myanmar, Viet Nam and Yunnan province in China (See section 4.4).

3 HIV & AIDS and Children

3.1 HIV & AIDS in East Asia and Pacific

While overall prevalence is still relatively low, the conditions exist for a rapid increase. Furthermore, some countries already have reached the level of a generalized epidemic (Thailand, Myanmar, Cambodia and Papua New Guinea).

- **Concentrated and expanding epidemic.** Sex work and injecting drug use are fuelling the epidemics in most countries in the region. However, individuals at high risk are not isolated from the general population. Clients of sex workers pass the virus on to partners and wives, who can then infect their babies.
- **Rising risk behaviours among young people.** More young people are taking drugs, engaging in commercial or transactional sex, having sex at younger ages and having sex with multiple partners.
- **The younger face of AIDS.** The region has around 39,000 children younger than 15 living with HIV & AIDS – most without access to proper treatment and care.
- **Children affected by AIDS.** Nearly half a million children in the region have lost one or both parents to AIDS.
- **Stigma and discrimination.** Stigma and discrimination do nearly as much damage as the HIV virus. For example, in Lao PDR, people living with HIV and their children have been denied access to essential services, forced to leave their homes and been retrenched from their jobs.[9]

However, while applicable at a regional level, the above statements mask important differences between countries. Although the potential for an expanding epidemic exists in all countries, HIV prevalence is still low (none of the countries have HIV prevalence higher then 2 per cent) and/or concentrated in many countries. Risk behaviours vary between countries (e.g. injecting drug use is largely absent from some countries). Most countries (e.g. most Pacific countries other than Papua New Guinea) have very few children living with HIV or affected by AIDS, although some have significant numbers of children affected by HIV. For example, in 2005 in Thailand it was estimated that the total number of orphans (loss of one parent or both) due to AIDS had reached 380,000 or 35 per cent of all orphans.[10]

It must also be noted that the quality of data available, though improving, is still inadequate in most countries to draw firm conclusions regarding specific issues and to take appropriate actions. For example, data on the number of children infected with and affected by HIV is still being revised.

If the proportion of women infected with HIV increases, the risk of mother-to-child transmission increases and, given the primary care role of women, potentially the vulnerability of children to many other impacts of HIV is also increased. There is evidence that in many countries in this region (e.g. Thailand) an increasing proportion of those infected with HIV are women.[11]

Differences in strategic response

There are significant differences in the strategic responses to HIV in the region. These differences reflect the variation in the pattern of HIV infection, government commitment, and available resources, as well as social and political factors.

In many countries HIV prevalence is still low and/or primarily concentrated in specific population groups. In these countries, the proportion of children directly affected (e.g. infected with HIV, living in a family where a member has HIV or orphaned as a result of HIV) is small. Issues of HIV vulnerability for children living in these countries might be best addressed through programmes that focus on the broader issues of social protection or poverty reduction. Services for children directly affected by HIV may be most effective when integrated into broader programmes that provide family and community support or care for vulnerable children (while recognizing that some issues do require a response specific to HIV, e.g. provision of anti-retroviral treatment).

Roles and responsibilities of different sectors vary across countries. Many countries do not have strong civil society organizations that represent the rights of PLHIV, children affected by HIV and most-at-risk groups (e.g. men who have sex with men, drug users and sex workers). In some of these countries, government organizations play a direct role in civil society leadership, including the faith-based sector, that may limit the capacity of these groups to advocate for their rights.

4 UNICEF Policy and Programme

UNICEF's HIV activities, especially care and protection of children affected by HIV, are mainly guided by two key strategy documents:

- *Children: the missing face of AIDS. A call to action*. Unite for Children, Unite Against AIDS Campaign (2005)
- *The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV & AIDS* (2004)[12]

UNICEF's HIV programmes are positioned in the context of UNICEF's broader mission to advocate for the protection of children's rights, to help meet their basic needs and to expand their opportunities to reach their full potential. UNICEF is guided in doing this by the provisions and principles of the Convention on the Rights of the Child (CRC).

Risk and vulnerability related to HIV are in many cases directly related to factors that threaten the broader protection of children's rights and capacity to meet basic needs. Consequently, actions to address HIV need to be integrated where appropriate with wider strategies to protect the rights of children, address basic needs and provide care and support.

4.1 Convention on the Rights of the Child

All countries in this region have ratified the CRC.

The CRC sets out these rights in 54 articles and two Optional Protocols. It spells out the basic human rights that children everywhere have: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life. The four core principles of the Convention are non-discrimination; devotion to the best interests of the child; the right to life, survival and development; and respect for the views of the child. Every right spelled out in the Convention is inherent to the human dignity and harmonious development of every child. The CRC protects children's rights by setting standards in health care, education, and legal, civil and social services.

UNICEF's broader mission and approach to supporting the CRC frames its more specific work on HIV. For example, the development of life skills builds capacity to adopt safer behaviours (including those that prevent HIV transmission). Addressing the needs of vulnerable children and orphans in a context broader than HIV can minimize HIV related stigma and discrimination. FBOs can play an important role in promoting the CRC.

4.2 Unite for Children, Unite Against AIDS. A call to action

Unite for Children, Unite Against AIDS is a global campaign of the Joint United Nations Programme on HIV & AIDS (UNAIDS) and UNICEF to reduce the impact of HIV & AIDS on children. The four priorities, or 4 Ps, of the campaign are to:

- Prevent mother-to-child transmission of HIV
- Provide paediatric treatment
- Prevent infection among adolescents and young people
- Protect and support children affected by HIV & AIDS

Partnerships between all stakeholders are an underlying approach to achieving the above priorities. FBOs are uniquely based to contribute to the achievement of the campaign objectives, particularly the protection and support of children affected by HIV & AIDS.

4.3 The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV & AIDS

In 2004, UNICEF and UNAIDS and other partners in the Global Partners Forum on Children affected by HIV and AIDS endorsed "The Framework for the Protection, Care and Support of Orphans and Vulnerable Children Living in a World with HIV & AIDS."[13] The Framework identifies five key strategies and key actions in the following areas:

- Strengthening the capacities of families (prolonging the lives of parents and providing economic, psychosocial and other support)
- Community-based responses
- Access to essential services
- Improved policy and legislation
- Bulding a supportive environment

Strategies and actions are discussed in more detail in Section 5 of this report.

4.4 Buddhist Leadership Initiative Strategy

The Buddhist Leadership Initiative (BLI) is a regional strategy to build Buddhist involvement in the response to HIV. It was initiated by UNICEF East Asia and Pacific Regional Office in 1998, based on lessons learnt from the Sangha Metta Project in Thailand. Countries initially covered were Cambodia, Lao PDR and Yunnan province in China. It was further expanded to Viet Nam, Mongolia and Myanmar in 2002.[14]

4.4.1 The role of Buddhism in strategy countries

In many countries in East Asia the religion with the largest number of followers is Buddhism. Buddhism was first introduced in the region over 2,000 years ago. For many people and the communities in which they live, it is the key point of reference for their beliefs, attitudes and social practices.

4.4.2 Objectives

BLI aims to mobilize Buddhist monks, nuns and lay teachers to lead their communities to:

- Increase access to care and support for adults and children living with HIV & AIDS and children affected by AIDS;
- Increase community acceptance of adults and children living with HIV & AIDS; and
- Build HIV resilience in communities, particularly among youth.

Other objectives of the Buddhist Leadership Initiative are to build capacity in monks and nuns and to manage the Initiative effectively.[15]

4.4.3 Activities

At the regional level, activities include:

- Provision of regional forums for sharing experiences
- Advocacy with national counterparts via UNICEF Country Offices
- Technical assistance in training and strategy development through a number of international and national specialists
- Development and sharing of materials, training curricula and manuals[16]

At the country level, activities range from prevention to care and support.

BOX 1. BLI ACTIVITIES AT THE COUNTRY LEVEL

In 2007, in terms of care and support, the BLI reached over 3,000 people living with HIV in Cambodia with peer-support and meditation training and over 2,000 children with food and school supplies. Nearly 2,000 HIV-affected adults and children had access to medical care with the help of donation boxes, augmented by UNICEF funds. In Lao PDR, where the BLI supports projects in five provinces, anti-stigma outreach teams reached over a hundred villages, while about 200 HIV-positive adults and children received spiritual support and care. In Viet Nam, pagodas supported thousands of children and adults with HIV/affected by AIDS through home visiting and counselling. In HIV prevention, monks reached over 11,000 school students in Lao PDR and over 10,000 young people in Cambodia with Buddhist life skills activities.[17]

4.4.4 Monitoring and evaluation

A comprehensive monitoring and evaluation (M&E) framework has been developed for BLI. Outputs have been identified for each objective with indicators, means of verification, responsibility and frequency of measurement described.

Quantitative and qualitative baseline data was collected in each country. These data provide a basis to measure progress over time. Because common measures were used across countries, the information collected also provides the basis of a quality improvement framework. Inputs and outputs were compared, return on investment analyzed and variations identified and further investigated.

The evaluation to date demonstrates that the BLI training of monks has been effective. As a result of training, monks are more knowledgeable and exhibit less discriminatory attitudes toward PLHIV. As a result of training, monks are more likely to implement care and prevention activities. PLHIV's satisfaction with the services provided by monks among people living with HIV is high. The reach and impact of community education, however, is uneven and requires further improvement.[18]

5 The Role of Faith-based Organizations

5.1 Building a supportive environment

Supportive environments are those in which institutional and individual practices, values and social/cultural norms facilitate healthy behaviour. In relation to HIV, a supportive environment is one in which people can access the knowledge necessary to protect themselves against infection, the negative consequences of testing HIV positive are minimized and access to necessary medical, care and support services is maximized. For orphans and other vulnerable children, a supportive environment is one which will ensure the same basic human rights that children everywhere have: the right to survival; to develop to the fullest; to protection from harmful influences, abuse and exploitation; and to participate fully in family, cultural and social life.

Priority issues in building a supportive environment are:

- Reducing stigma and discrimination
- Changing social taboos regarding open discussion of sex, sexuality and other aspects of risk
- Promoting leadership at all levels and across sectors
- Advocating policies, laws, and organizational practices that provide protection for people affected by HIV and their children and other OVC

Reducing stigma and discrimination

Reducing stigma and discrimination associated with HIV is a key challenge in building a supportive environment. Fear by association is a barrier to people accessing information about risk behaviour. "Fear of stigma amongst PLHA, or people who believe they are HIV positive, has been found to be a barrier to accessing voluntary counselling and testing (VCT) and other HIV & AIDS-related support services. This may include fears of disclosure, fears of judgmental attitudes of health workers and fears of confidentiality."[19] The BLI assessment also showed a correlation between community members' level of knowledge about HIV transmission and their discriminatory attitudes toward PLHIV.[20]

Children affected by HIV and other vulnerable children, as well as their families, are frequently victimized as a result of stigma and discrimination. Stigma and discrimination give rise to rejection, hostility, isolation and human rights violations.

Reducing stigma and discrimination will require increasing access to information, challenging myths and transforming the public perception of HIV & AIDS.[21]

Changing social taboos regarding open discussions of sex, sexuality and other aspects of risk

HIV transmission is associated with highly sensitive behaviours. This is further compounded in low prevalence and concentrated epidemics (which is the current situation in most countries in the East Asia and Pacific region) by association with population groups that are highly stigmatized (e.g. sex workers, drug users, MSM).

HIV-prevention programmes cannot be effective without discussing risk factors. An environment needs to exist where people can access clear and concise information that allows them to make choices regarding their behaviour.

Promoting leadership at all levels and across sectors

An effective HIV response requires leadership at all levels of society and across sectors. Sectors include government, non-government and faith-based among others, as well as sectors such as education, health and so on.

Advocating for policies, laws, and organizational practices providing protection for people affected by HIV and OVC

At the national level, legislation and policies need to be enacted that provide protection for people affected by HIV (e.g. anti-discrimination) as well as children affected by HIV and other vulnerable children. The areas to be covered are extensive, and there is clear guidance provided through international agreements and conventions. Organizational practices also need to be considered in creating a supportive environment. Issues such as practices to protect confidentiality are important in maximizing access to HIV-related services.

5.1.1 Rationale for FBO involvement

FBOs are potentially among the most powerful and influential social forces in most countries. They play a significant role in influencing the values of most societies. FBOs can be powerful allies or significant obstacles to the implementation of HIV programmes.

Some FBOs also have political influence, and many are active in public policy advocacy. In many countries religious beliefs are explicitly endorsed in constitutions and other legal instruments. FBOs often mobilize their membership in political movements.

The influence of FBOs is felt at both the institutional level and through individual leaders. In some countries, membership in various decision-making bodies is reserved for FBOs, and government departments exist that regulate or support religious activity. FBOs are often key service providers in social sectors that have a key role in HIV programming (e.g. health and education). They employ significant numbers of staff.

The extent to which they adopt employment practices such as non-discrimination, protection of confidentiality, and provision of sick leave not only creates a supportive environment for their own staff who are living with HIV but also sets an important example for other employers.

Perhaps the most important role of FBOs in building a supportive environment relates to their role in setting community values. HIV transmission is associated with highly sensitive behaviours. This is further compounded in low prevalence and concentrated epidemics (which is the current situation in most countries in the East Asia and Pacific region) by association with population groups that are highly stigmatized (e.g. sex workers, drug users, MSM).

FBOs are in a unique position to provide leadership in challenging stigma and discrimination. In many places, they have the moral authority to declare that stigma and discrimination against PLHIV are contrary to the tenets underlying religious teachings. Where they choose to do so, they can also facilitate access to the information people need to make informed decisions regarding risk behaviours. This requires facilitating an environment in which open discussion can occur around what may have been taboo topics and in which organisations can work with most at risk groups. The experience of the BLI in Lao PDR, where anti-stigma outreach teams have reached over a hundred villages, provides practical evidence of how this can be achieved.[22]

5.1.2 Existing Policies and Programmes

The important role that can be played by FBOs in building a supportive environment is well recognized by national HIV & AIDS authorities and FBOs themselves. Examples of high level policy statements and initiatives are outlined in Box 2.

BOX 2. FBO SUPPORTIVE ENVIRONMENTS: POLICIES & PROGRAMMES

ORGANIZATION	POLICY/PROGRAMME
Asian Interfaith Network on HIV & AIDS: **Advocacy Statement**	■ To create a supportive environment at country, regional and international level for faith-based responses to HIV & AIDS ■ To promote the rights and well being of children, women and adults living and affected by HIV & AIDS
Ecumenical Advocacy Alliance: **Keep the Promise Campaign**	■ To protect the rights of people living with HIV & AIDS ■ To promote an attitude of care and solidarity which rejects all forms of stigmatization and discrimination ■ To advocate for access to necessary forms of treatment, as well as to expand efforts for education and prevention
Pacific Church Members of the World Council of Churches: **Nadi Declaration**	"We the churches are encouraged to seek forgiveness from God and from Positive People, for not doing what we ought to have done, and for contributing to their pain and suffering." The declaration commits: ■ To tackle stigma and discrimination ■ To empower congregations to engage actively with HIV
Malaysian AIDS Council: **Interfaith membership**	The Malaysian AIDS Council from its foundation in 1992 has engaged with FBOs. Among its 37 partner organisations, five are faith-based, representing Islam, Christianity, Hinduism and Buddhism.
Cambodia: **National Policy on the Religious Response to HIV & AIDS**	The National Policy on the Religious Response to HIV & AIDS was approved in May 2002 by the Minister of Cults and Religion and the National AIDS Authority. The main objective of the policy is to ensure that the religious sector fulfils its role in the response to HIV & AIDS through community mobilization aimed at effective multi-sectoral HIV prevention and HIV & AIDS care.
Asian Muslim Action Network: **HIV & AIDS Programme**	Specific long-term objectives of the programme include: ■ Developing and distributing resource materials from an Islamic perspective ■ Raising mass awareness among Muslim communities, including highlighting issues such as addressing social vulnerabilities to HIV & AIDS, stigma and discrimination ■ Facilitating the empowerment of people living with HIV & AIDS (PLWHA) in Asia through programme participation and providing support to those infected and affected by HIV & AIDS ■ Building networks with other faith communities in order to respond to common challenges and participate in policy advocacy
Papua New Guinea: **Church Partnership Programme**	The PNG Church Partnership Programme is a collaboration between seven Christian denominations and AusAID. HIV & AIDS is a priority issue. One of the Programme's key areas of action is to develop the Churches' governance structures, quality of Church leadership, and ethical management in order to enable the Churches to engage with government on issues of public policy and practice.

Evidence from Africa, where HIV reached epidemic proportions some years ago, shows that FBOs can play a major role in developing a supportive environment. Uganda is one of the few countries that have experienced a dramatic decline in HIV prevalence and incidence. In the 1990s, churches and mosques were part of a broad-based coalition with government structures, non-government organizations and community networks to mobilize a response to HIV. Religious groups took a leading role in the provision of care and support services which helped de-stigmatize HIV and promote inclusiveness of people living with HIV. In terms of prevention, if for religious reasons they could not promote condoms, they focused on abstinence, partner reduction and monogamy. They also agreed, however, not to undermine the provision of information about and delivery of condoms by other organizations.[23]

Papua New Guinea is now in the early stages of a generalized HIV & AIDS epidemic. The Anglican Church, among others, is using its influence to break down taboos associated with talking about risk behaviours. (See Box 3)

BOX 3. ANGLICAN CHURCH PAPUA NEW GUINEA HIV ACTIVITIES

Church leads the fight against AIDS

Church development officers John and Della Rea – who are funded by the Papua New Guinea Church Partnership, USPG and the Scottish Episcopal Church – sent the following report looking at HIV & AIDS in PNG:

"We heard of a man who was chased from his home into the forest because he was known to have HIV & AIDS. His family placed food out each day until it was no longer collected. They guessed he'd died. In one of the country's 'settlements', a man was left in the hot sun on the street to die because nobody knew what to do and everybody was too scared to touch him.

Last week we saw a 19-year-old girl who was just skin and bone. She had been deserted by her entire family. She had no clothes or money and was unable to eat hospital food. She was just a skeleton sitting on the bed, trying to breathe, waiting to die."

Nobody is sure of the extent of HIV & AIDS in Papua New Guinea (PNG). Many rural communities do not have access to health care, and statistics are notoriously inaccurate. But one thing is certain: HIV & AIDS are rapidly on the increase, and the confident prediction is that, within five years, AIDS will eclipse local killer diseases like malaria and tuberculosis as the country's major health concern.[24]

HIV & AIDS is being spread by lorry drivers who visit sex workers along the Highlands Highway, the only road linking PNG's main towns. Other factors include men who catch the virus in towns then take it back to rural communities and traditional practices which make it unacceptable for girls to refuse sex with tribal leaders.

The Anglican Church is making a determined effort to help. In PNG, it is not culturally acceptable to talk about sex or sexual behaviour, but the church is recognizing the importance of breaking down this taboo, with HIV & AIDS always a major agenda item at the Provincial Council, diocesan synods and in parishes.

The church is concentrating on a basic 'ABC' of awareness-raising: Abstain, Be Faithful, Use Condoms. The latter may be controversial, but in recognizing the reality of people's behaviour in a life-and-death matter, the Archbishop James Ayong is giving clear support for the use of condoms in some situations.[25]

In some countries, governments and FBOs have worked in partnership to enable faith-based leaders to contribute to building a supportive environment. In Cambodia, following the adoption of the national policy on the religious response to HIV, a national workshop was held to disseminate the policy. 63,000 booklets containing the policy were distributed to Provincial Departments of Cults and Religion and NGO partners. Following this, a study visit to Thailand was organized for senior monks, including the two Supreme Patriarchs, as well as government representatives and UNICEF officers. By mid-2003, eight Provincial Departments of Cults and Religion had trained 985 monks in Training of Trainer courses. In addition, 12,150 monks were trained by the Ministry of Cults and Religion in HIV & AIDS knowledge, and a further 3,831 monks were trained in Buddhist Morality Education. Some 1,989 lay Buddhist leaders and nuns were trained in HIV & AIDS knowledge by monk trainers.[26]

Involvement in activities such as World AIDS Day and Candlelight Memorials has been used by FBOs to publicly demonstrate their commitment to HIV and encourage understanding among their members. Some FBOs have also used these activities as an opportunity to build partnerships with marginalized populations.

5.1.3 Review of Evidence

Despite the possible role that FBOs may have played in contributing to HIV & AIDS-related stigma and discrimination, particularly in the early years of the epidemic, over more recent years they have been extensively engaged in providing support for PLHIV. In South Africa, a review of FBOs listed in the national HIV & AIDS database found that FBOs that had AIDS activities at local levels predominantly worked with PLHA (33%) and orphans and vulnerable children (27%). The direct and concerted support for PLHA and persons affected by HIV & AIDS suggests that the central tenets of compassion and shared humanity within FBOs are frequently applied to the epidemic and that these in turn contribute to mitigating stigma and discrimination.[27]

5.2 Mobilizing and Supporting Community-Based Responses

A community-based response is one that builds upon a community's understanding of an issue or problem and involves a community in the development and implementation of a response. Generally, a community is defined by its membership (a particular group, location or a combination of both). FBOs can be considered as communities in that members share common beliefs and participate in shared practices and rituals. At a local level, FBOs are also part of local communities.

Locally-based community responses are effective in so far as members are aware of an issue, adversely affected by it directly or indirectly, and potentially possess the motivation and capacity to engage in a planned response to the situation. Community education, designed to provide knowledge and understanding (and often change prevailing negative attitudes frequently rooted in strong cultural belief systems), is an essential component in building motivation and capacity.

Effective HIV & AIDS strategies need to engage communities defined by both membership of particular groups and locality. Population groups that have been socially marginalized (e.g. PLHIVs, sex workers, drug users, MSM) need to be engaged through processes that recognize group social and cultural dynamics (sometimes resulting from marginalization). Support for such groups to organize among themselves is generally seen as an effective strategy in addressing HIV prevention, care and support goals.

Locally-based community responses have the potential to maximize the number of people reached by HIV strategies, address the real understandings people have regarding issues, mobilize human resources beyond those available through employed staff, and have credibility through their involvement of people who are already respected and have influence. These attributes are necessary in addressing HIV, given the magnitude of the problem and the particular sensitivities of the issue.

In relation to OVC, when families cannot adequately meet their basic needs, the community is often a safety net in providing essential support. In addition to the provision of material support, the community can ensure access to other necessary services and be a source of psychosocial support. Reinforcing the capacities of communities to provide support, protection and care is the foundation of a response that will match the scale and long-term impact of the HIV & AIDS crisis for children.[28]

Key actions are to:

- Build partnerships between FBO communities, local communities and affected communities
- Mobilize community resources to enhance access to essential services
- Engage local leaders in responding to the needs of vulnerable community members
- Organize and support activities that enable community members to talk more openly about HIV & AIDS
- Organize cooperative support activities
- Promote and support community care for children without family support

5.2.1 Rationale for FBO involvement

In many local communities, FBOs are the cornerstone of social networking and organisation. "Faith-based organisations (FBOs) and communities are present literally everywhere people live their lives, with enormous outreach as well as 'inreach'."[29]

Faith-based institutions have unique means of communication to share what is known about HIV, care for those affected by the virus, and deliver health services. They embrace a shared understanding of the world among their members and consequently speak with authority and credibility. "Churches, synagogues, temples, mosques have weekly or even daily access to congregations and communities. This direct communication with people, who gather regularly at one time in one place, is an ideal way of sharing ideas among literate and illiterate people."[30]

FBOs can call upon the goodwill of their members to participate in community service. They represent an enormous human resource.

In many countries, FBOs are in the unique position of being the only civil society-based organizations able to operate on a significant scale. This is due to the constraints of the political system, limited social capital due to civil wars and other reasons and the lack of a history of civil society organizations.

5.2.2 Existing Policies and Programmes

There are numerous examples of FBOs playing a key role in mobilizing community-based responses. These responses range from addressing issues of stigma and discrimination to the provision of care and support for PLHIV.

Thailand was the first country in the East Asia and Pacific region to experience a generalized HIV epidemic. Buddhist monks were among the earliest providers of support to PLHIV in that country. A small number of monks began to accept HIV positive people and terminally ill AIDS patients into their temples where they received care and support from monks and temple followers. Initial responses, however, did not generally receive community support.[31] Perhaps symbolizing the early response is Wat Phra Baht Nam Phu. People living with HIV from all parts of Thailand were (and, to an extent, still are) drawn to this Wat as a place where care would be provided. Indeed, the Wat has become popularly known as the 'AIDS Temple.'

Over the past decade, a more community-based response has emerged in Thailand. For example, the Sangha Metta Project, established in 1997, has been instrumental in facilitating the capacity of Buddhist clergy to contribute to this response. In its first five years, Sangha Metta trained 2,142 monks, 1,799 novices and 82 nuns as well as 2,925 community leader and local youth on HIV & AIDS.[32] An evaluation of the project in 2003 showed that post-training, participants conducted a range of activities once they returned to their communities (e.g. counselling and support for PLHIV, awareness raising and dissemination of information on HIV, PLHIV vocational training and/or income generation, and student scholarships for children affected by HIV).[33]

The lessons learned from Sangha Metta were referred to in the development of the Buddhist Leadership Initiative. UNICEF's Buddhist Leadership Initiative which commenced in 1998 is now operating in Cambodia, Lao PDR, Myanmar, Viet Nam, Southern China and Mongolia. To enhance sustainability, during its next phase, the BLI will strengthen links with government agencies, local counterparts, and other FBOs, as well as integrating its work into the broader framework of community-based strategies for care and protection of children affected by HIV & AIDS, as well as HIV prevention.[34]

In Papua New Guinea, FBOs are also developing community-based responses that address some of the underlying factors contributing to HIV vulnerability. These factors include material poverty, alcohol abuse and violence.

5.2.3 Review of Evidence

Major reviews consulted in preparing this report have all noted the scarcity of objective documentation in evaluating the effectiveness and impact of FBO efforts to address HIV. Consequently, most are based on qualitative research which largely presents the viewpoints of participants and key informants.

A study conducted on behalf of WHO in 2005/06 based on participatory workshops attended by 358 people and GIS mapping examined FBO responses in Zambia and Lesotho. That report emphasized the importance of local context in scaling-up HIV responses:

> *"Our study confirms that religion, health, and well-being are contextually driven, and that local context is most significant. As one of our researchers put it, 'You can't talk to one bishop and think you've dealt with the whole religious community.' Another added, 'If you are in Zambia, you must go through the pastor; if you are in Lesotho, you must go through the chief.' These contextual realities have significant implications for mass scale-up of HIV & AIDS and other health interventions and for replicability of research and programmatic approaches and strategies."*[35]

An important theoretical hypothesis by the organization that undertook the review is that religion contributes to health in both tangible and intangible ways. The report identified spiritual encouragement and compassionate care (the delivery of care motivated and characterized by compassion and love) as among those intangible attributes. The report states that the findings of the study confirm this hypothesis.[36]

BOX 4. PAPUA NEW GUINEA FBO RESPONSES TO HIV-RELATED VULNERABILITY

Baptist Union Papua New Guinea (BUPNG)

From the start of the Church Partnership Programme (CPP), the BUPNG focused on improving its own management and that of its health, education and community development sections as well as focusing on the establishment and coordination of HIV response across its 3 regional unions and town churches. Over the last two years, providing training to members of Boards of Governance from the national to local health centre and school levels, along with building up capacity for facilitating community drought preparedness in water and sanitation projects, have become CPP objectives. At a local level, Baptist leaders are important mediators who broker ceasefires in inter-clan conflict. The BUPNG's Community Development team has therefore supported the facilitation of conflict resolution skills at a household and community level to strengthen the mediation skills of local leaders and church workers and to pre-empt fighting. At the same time, these community level seminars also aim to raise the status of women by working for gender equity and to give men and women the skills to cope with expectations from their relationships in a time of rapid cultural change.

Salvation Army Papua New Guinea (SAPNG)

About four years ago, The Salvation Army PNG had a vision to develop its officers (ministers) and staff to better serve the community in a holistic way. The CPP has enabled SAPNG to do that. Salvation Army officers have been trained in computer skills, basic accounting, in basic needs assessment and to teach their congregations and communities about HIV & AIDS. They have established a development office and trained a qualified Papua New Guinean to take on the role of CPP Coordinator. The Salvation Army Community Health Worker Training School has been upgraded in terms of materials and programmes and is now trialing a programme for the Government of PNG. With a long tradition of recognizing the value of women's groups, The Salvation Army PNG through the Home Leagues has run training and capacity building programmes for women and girls and has encouraged and supported them to form support networks. In the Eastern Highlands, a coffee cooperative has been established to assist small coffee farmers in getting a good price for their coffee. In return, farmers commit to reduce (or even stop) their alcohol and drug consumption, refrain from participating in tribal conflicts, stop violence in the home and contribute to health and hygiene of their village.[37]

A study of the response by FBOs to the needs of orphans and vulnerable children was conducted in East and Southern Africa in 2002/03. The study, which included the collection of data, was based on interviews with key informants and other participants from FBOs. Among the findings of the study was that the majority of FBO activities are implemented by volunteers.

In relation to volunteers, the report found the following:

> *A majority of volunteers involved in HIV prevention activities were youth. Volunteers managed and implemented OVC projects and offered their services free. Most volunteers received no incentives, though a few received material support, transport and meal allowances from their community or congregation. Other incentives included certificates of appreciation, attendance at workshops or exchange visits to other OVC initiatives. Most volunteers received no training on HIV & AIDS and orphan care. Some gained knowledge about HIV & AIDS through attending workshops, seminars, talks and exchange visits. In some congregations, training was facilitated by RCBs and NGOs covering issues such as the role of committees in programme management, child development, home-based care, counselling and the impact of HIV & AIDS. Volunteers were motivated by good will, compassion, the plight of seeing vulnerable children, the necessity of helping the needy and a calling to serve God.*[38]

5.3 Strengthening the Capacities of Families

Family is the fundamental link between children and the wider community and plays a fundamental role in the provision of a protective environment. Children are perceived as "born with ties of blood, love and law to their families: parents, brothers and sisters, grandparents and other family members … Such ties may be created outside of lineage groups, by street children, by adoptive families and by others."[39]

"The forms that families take vary within and across cultures and generations. They are affected by increasing urbanization, by poverty, by political and economic migration, by changes in labour market structures, by the changing role of women and other factors."[40] Each of these factors impacts the capacities of families to protect and support children. HIV places an additional layer of stress that without appropriate attention can undermine the capacities of families.

"Parents are children's first line of protection."[41] HIV increases the likelihood of parents or caregivers being absent due to illness or death, thereby increasing the child's risk of exploitation or abuse. Other ways in which HIV impacts the capacities of families and children's development include:

- Loss of income, thereby reducing the capacity to meet basic needs
- Emotional and physical demands on children as care providers
- School absence due to care and financial demands
- Reduced capacity of parents to provide love, support and reassurance (psychosocial support)

Within families, children affected by HIV & AIDS generally fit into one of the following categories:

- Children infected with HIV or HIV-positive children;
- Children directly affected because one or both of their parents have died from HIV-related illnesses;
- Children directly affected because one of their parents and/or caretakers is infected with HIV; and/or
- Children indirectly affected by HIV & AIDS because they are living in families that foster children directly affected by HIV & AIDS.[42]

However even within the above categories there are significant variations that impact vulnerability. For example, migrant labourers account for 35 per cent of the HIV-infected population in Lao People's Democratic Republic (Lao PDR), and in some provinces in China, migrants accounted for up to 50 per cent of those found to be HIV-positive.[43] Parents who are HIV-positive and their children in this context are likely to have more fragile links with local communities and with extended families and be more likely to experience stigma and discrimination.

Particular attention also needs to be given to the gender dimension of vulnerability. Girls are more likely to experience exploitation and abuse than boys. Girls are also more likely to be placed in the role of caregivers for chronically ill parents and be burdened with other domestic household responsibilities. As such, they are also at greater risk of having their education disrupted.

The gender dimension in families is also important in relation to the role of mothers:

> *Women are almost invariably left bearing even bigger burdens – as workers, caregivers, educators and mothers. At the same time, their legal, social and political status often leaves them more vulnerable to HIV & AIDS. The health and life situation of any woman is critical to the health and life chances of her children, not only during pregnancy, childbirth and the early months of life but throughout their entire childhood. A mother's capacity for child care – the time and energy she can devote to her children, the conditions in the home, her material resources, her skills and knowledge – continues to govern a child's passage from childhood to maturity socially, physically and emotionally. Whether or not an HIV-infected mother transmits the virus to one or more of her children, her early death from AIDS will have a profound impact on all of them. If she is the key provider of food, clothing and household utilities for all her children, a mother's death has profound social and economic consequences for her orphans and for her husband, if he survives.*[44]

HIV-related programmes to strengthen the capacities of families in low prevalence and/or concentrated epidemic settings are generally delivered in the context of broader programmes, especially within poverty reduction strategies, that address the needs of orphans and other children who are vulnerable to having their basic rights not met. This approach recognizes that all children are entitled to their basic rights regardless of the cause of vulnerability and reduces the risk of stigmatization associated with HIV.

Key actions identified by UNICEF to strengthen the capacities of families are:

- Improve household economic capacity
- Provide psychosocial support to affected children and caregivers
- Strengthen and support child care capacities
- Support succession planning
- Prolong the lives of parents
- Strengthen young people's life skills[45]

5.3.1 Rationale for FBO Involvement

Family is a key point of reference in all major religions. Religions provide the ideological support for families, as well as social structures in which families interact with the wider community and the rituals and ceremonies in which key family events are enacted (e.g. christenings, weddings, funerals).

HIV raises fundamental questions for people about the purpose and meaning of life. These questions are at the heart of religious teachings. FBOs are uniquely placed to provide comfort and support for those struggling with the impact of HIV in their lives.

"Care and support activities are regarded as the 'traditional strength' of FBOs, particularly Christian groups that were among the first to openly treat and embrace individuals with AIDS. Even in settings where AIDS is not dealt with openly, many religious communities still have a 'logic that can encourage acceptance of and care for people with AIDS'."[46]

Faith-based workers are also a key source of advice and support on practical matters for most families. This advice ranges from day-to-day practical matters (e.g. management of household material resources) to organization of significant family events (e.g. christenings, marriages).

Because of the extensive reach of FBOs into local communities, they can provide the institutional framework needed to deliver the services required to strengthen the capacities of families.

5.3.2 Existing Policies and Programmes

Strengthening the capacities of families is a feature of FBO activity throughout the East Asia and Pacific region. Activity is being implemented across the range of key interventions prioritized by UNICEF.

Care and support for people affected by HIV appears to be the most common form of assistance provided by FBOs. While most often characterized by the provision of comfort and counselling for individuals, it also includes organizational support for people living with HIV to form peer support groups, addressing stigma targeted at families affected by HIV and material assistance to individuals and families. Examples of FBO initiatives in the region to strengthen families are described below.

BOX 5. ANGLICAN CHURCH PAPUA NEW GUINEA (ACPNG) PROGRAMMES TO STRENGTHEN FAMILIES

The rural dioceses of the ACPNG are now gaining the experience and skills to coordinate complex HIV & AIDS programmes. The Training of Peer Education Trainers (TOPET) has built the capacity of three rural dioceses (New Guinea Islands [NGI], Aipo Rongo and Popondota) to have their own PE trainers organizing and carrying out the PE training in their local communities. This HIV awareness programme relies on people at the village level to continue discussing issues relating to HIV & AIDS, in the hope that HIV transmission will slow down and the stigma associated with being HIV positive or having AIDS will decrease.

Many people living in the PNG remote areas have no access to basic medical care. ACPNG continues to work in partnership with the government health services to offer comprehensive home-based care training to people living with HIV & AIDS (PLWHA). This allows families to perform home-based care duties, including nursing support for PLHWA.

A key element to this project is to work with the clergy and their wives in the knowledge that these people play a key role in their communities in influencing sexual behaviour and destigmatizing the disease.

BOX 6. CHBAR AMPOV PAGODA, CAMBODIA

"Buddhist monks play an important role to decrease stigma and discrimination against families living with HIV & AIDS," said the head of UNICEF Cambodia's HIV & AIDS Section, Haritiana Rakotomamonjy. "Monks provide spiritual and psychological support to families and children affected by HIV & AIDS. They also help mobilize community support to make sure that those children are able to come to their monthly medical visit."

On one recent weekday afternoon, the Venerable Ong Sary and two fellow monks from the Chbar Ampov Pagoda near Phnom Penh visited the home of Sim, a 43-year-old mother of four who is living with HIV and lost her husband to AIDS three years ago. The young monks were welcomed warmly by Sim's family and neighbours. Along with spiritual guidance, it was an opportunity for the monks to advise the family about HIV treatment and prevention and the importance of proper nutrition.

Sim said she appreciated the monks' help, particularly the rice they brought and the advice they offered her children. Fortunately, her teenage children are all HIV-negative, but having already lost one parent to AIDS they are among Cambodia's growing number of orphans.[47]

FRIENDS FOR LIFE FOUNDATION, THAILAND

Phra Phongthep, or the Friends for Life Foundation, began by providing hospice services. Soon, however, it realized the disadvantages – i.e. large numbers of people not relying on their own or family resources, high operating costs, etc. – so it changed its approach to that of a respite centre. Under the new structure, symptomatic people requesting support were invited to stay at the centre while receiving treatment on the condition that an accompanying family member would stay at the centre and be educated on HIV & AIDS and caring for positive people. Once they had recovered from the opportunistic disease that brought them there, patients were invited to return home and care for themselves, with support from their family. In this way, the community was educated on HIV & AIDS, and self-care, home-based care and community-based care were promoted. The centre, which once never had an empty bed, began to cater to a smaller number of people. The only long-term residents were those who really did not have families or someone to support them.

5.3.3 Review of Evidence

There is extensive evidence that orphans and children living in families affected by poverty, illness and a range of other factors are more vulnerable than unaffected children to exploitation and abuse and not having their basic needs adequately met. The extent to which HIV adds a further layer of vulnerability, however, is not clear and may depend on specific circumstances. The data is still being collected and analyzed in this region: for example, UNICEF has been conducting national assessments of children affected by HIV in China, Lao PDR, Indonesia and Malaysia.

5.4 Ensuring Access to Essential Services

Sections 3 and 4 of this paper outline UNICEF's priorities in ensuring access to essential services. Those services relate to:

- Prevention of mother-to-child transmission
- Provision of HIV paediatric treatment
- Prevention of infection among adolescents and young people
- Protection and support for children affected by HIV & AIDS and other orphans and vulnerable children (issues include education, basic health services, birth registration)
- Material, psychosocial support and life skills education for children affected by HIV and other vulnerable children without family support

HIV-specific services as well as broader public health services (e.g. access to safe water and sanitation) impact the above priorities. However, HIV vulnerability and the quality of care and support for children directly affected by HIV as well as other vulnerable children are determined by a range of factors other than health.

Education provides an opportunity for children to develop the knowledge, awareness and skills that can reduce the risk of HIV infection. Equally important, schools can provide children with a safe, structured environment, the emotional support and supervision of adults, and the opportunity to learn how to interact with other children and develop social networks.[48]

Birth registration is often essential as a means of accessing services such as education and health in many countries.

Judicial protection and placement services for children without family care need to be provided if children affected by HIV and vulnerable children are to be protected from exploitation.

A comprehensive programme framework is required to ensure access to essential services. The scope of an effective programme ranges from policy and legislation to local planning and action. It includes systems for planning and ensuring resources reach communities, processes to ensure the capacity of government and other service providers is being developed, and research, monitoring and evaluation systems to ensure ongoing quality improvement. Partnership between service providers and across sectors is an essential feature of ensuring access to essential services.

Accessibility Factors

Geographic accessibility, availability, affordability and acceptability are basic criteria that determine access to essential services.

Geographic accessibility

Where services are located can have a major impact on accessibility. Some services (e.g. specialized paediatric treatment) require a high level of technical infrastructure (e.g. highly specialized staff, laboratory services etc.) and can therefore only be provided in a limited number of locations. Provision of transport, accommodation and other support can reduce barriers to geographic access.

Availability

Some countries in the region have highly developed public health infrastructure with medical services primarily available through government programmes. There are many countries, however, where public health infrastructure is weak and services are not widely available.

Affordability

Affordability relates not only to costs incurred in medical service provision (e.g. pharmaceuticals, diagnostic procedures, medical and nursing staff) and other services such as education, but also access. The high cost of providing some services (e.g. specialist HIV medical staff) may require frequent travel that is beyond the affordability of some patients. Assistance with travel and accommodation are practical measures that FBOs are often well-placed to provide.

Acceptability

The acceptability of essential heath services is based on people's health literacy. "Health Literacy is the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions."[49] This not only requires that the knowledge provided is relevant to people's level of education and in forms that are accessible (e.g. verbal, written, graphic etc.) but also takes into account norms, values, beliefs and attitudes that may be barriers.

5.4.1 Rationale for FBO involvement

The extent to which accessibility criteria are met by existing service infrastructure varies between countries and within countries. Consequently, the role of FBOs in providing access to essential services should be based on their potential contribution and relative strength compared to other providers based on national and local contexts.

Some countries in the region have highly developed public health services systems with medical services primarily available through government programmes. In those countries with well-developed health service systems, policies, procedures and systems for FBO service delivery are usually (and probably ideally should be) well linked with overall government programmes. In those countries where public services are limited and FBOs have established highly developed health programmes internationally, are already key service providers within countries and have strong local linkages, they can play a significant role.

Programmes required for preventing infection among adolescents and young people and protection and support for children affected by HIV and other vulnerable children do not generally require the same complexity of health service infrastructure as the provision of medical services. FBOs, because of the breadth of their geographic coverage and capacity to draw on a large volunteer resource base, have specific strengths to contribute in facilitating availability.

The high cost of providing some services (e.g. specialist HIV medical staff) may require frequent travel that is beyond the affordability of some patients. Assistance with travel and accommodation are practical measures that FBOs are often well placed to provide.

FBOs in most communities play a key role in determining norms, values, beliefs and attitudes. As such, they are uniquely placed to contribute to the acceptability of essential services.

Perhaps the most problematic area in relation to the role of FBOs in ensuring access to essential services is that of prevention. Despite the continuing high rates of HIV and sexually transmitted disease transmission in many parts of the world, the complexity of prevention is often underestimated to include only simple behavioural choices. In reality, effective prevention programmes need to address a range of cultural and social dimensions as well as take into account bio/medical interventions (e.g. the biological vulnerability and infectivity of HIV related to issues such as concurrent STIs, reduced viral load associated with ART, etc.).

The promotion and provision of condoms has been a major point of controversy in the role of FBOs in prevention. However, most FBOs have moved past the point of outright opposition. In Uganda (one of the few countries where HIV transmission rates have declined), FBOs agreed not to undermine government efforts to promote condoms.[50]

Many FBOs support the use of condoms between serodiscordant couples. Yayasan Dana Islamic Centre, popularly known as IMMIM (Indonesia Mosque Association Mushallah Muttahidah), is a coordinating agency for Islamic preachers based in Makassar, provincial capital of South Sulawesi. Teachings convey the message that while illicit sexual relations (*zina*) "is a religious sin, particularly for those already married … *zina* without protection (i.e. without the use of condoms) [is] an even greater sin because it allows a deadly virus to be transmitted."[51]

In Africa many church leaders now support condom promotion. Kevin Dowling, a Catholic bishop in South Africa, has said about condom use that: "Simplistic attitudes blind us to the realities of life for millions of poor people. In this terrible pandemic, should we focus all our efforts on proclaiming an ethic of sexuality or also on the ethic of preserving and saving life?"[52]

5.4.2 Existing Policies and Programmes

"In some countries, as much as 40 per cent of health care services are provided by faith-based groups. In many rural areas throughout the world, the first clinic or hospital was opened by faith-based groups (often Christian missionaries), and even today it might still be the only formal health facility for the region. In the case of HIV specifically, the Vatican estimates that Catholic institutions worldwide provide 25 per cent of the total care given to people living with HIV and AIDS."[53]

Within the East Asia and Pacific region the number of countries in which FBOs are major providers of medical services is limited. Papua New Guinea, which has a severely limited public health service infrastructure, is one such country. The Catholic Church is perhaps the FBO which has the most extensive involvement in provision of medical services across the region.

FBOs are involved in a range of activities supporting access to essential services.

Examples are provided in the table below.

BOX 7. FBO INVOLVEMENT IN ACCESS TO ESSENTIAL SERVICES IN EAST ASIA AND PACIFIC

ORGANISATION	DESCRIPTION
YWCA (PNG): **Sex Worker Programme**	■ Literacy and income generating skills training to increase employment options ■ HIV counselling and testing
Buddhism for Development (Cambodia)	■ Provision of education facilities ■ Opportunities for children to go to and continue their schooling until the end of High School ■ Introduction of small scale savings and credit schemes and income generation projects ■ Providing advice, information, and assistance for small businesses
Partners in Compassion (Cambodia)	Home care, transport, food provision
Buddhism and Society Development Association (Cambodia)	■ Education for impoverished street children and orphans focused on life issues, violence prevention and social/Buddhist morality ■ Vocational training
Champassak Province Buddhist Association	Production of IEC/BCC HIV prevention film
Interfaith Network on HIV & AIDS in Thailand/Norwegian Church AID: **Caring, Sharing and Healing Centres**	Temples, mosques and churches provide an organizational base for: ■ Home care teams ■ Supervised ARV dosing ■ Income generation projects and other programmes
Hope World Wide (Indonesia)	■ Computer vocational training for youth ■ Education, nutrition and health service for vulnerable street children ■ Scholarships for basic education
Anglicare (PNG): **StopAIDS**	■ VCT centres ■ Peer Education Programmes ■ ARV treatment ■ Social Marketing (HIV prevention) ■ Condom distribution
Salvation Army (PNG): **Ela Beach Drop-in Centre**	■ Overnight accommodation (for clients with medical appointments etc.) ■ Meals ■ Counselling ■ Clinic referrals ■ Skills training ■ Support for orphans
National Catholic AIDS Office (PNG): **Diocese Programme**	Programme to provide in all dioceses: ■ Care centres ■ VCT for couples and pregnant women ■ Promotion of PMTCT ■ Scaling up ART ■ Activities to assist orphans and vulnerable children
World Vision (PNG): **Sex Worker Programme**	■ Periodic Presumptive Treatment (STI) programme ■ Condom distribution ■ Development of IEC material

BOX 7. FBO INVOLVEMENT IN ACCESS TO ESSENTIAL SERVICES IN EAST ASIA AND PACIFIC (continued)

ORGANISATION	DESCRIPTION
Catholic Health services (PNG)	■ VCT centres ■ PMCT programmes
United Church PNG/ Uniting Church Australia: **Personal Viability Programme**	■ To teach people how to make the most of local land and resources such as timber, fish and minerals ■ To assist people in finding employment and establishing small businesses
Hien Quang Pagoda (Viet Nam)	■ Professional counselling ■ Home-based care ■ Health examination and referral services for free medical treatment (OI and ARV), including CD-4 count and TB test ■ Social and spiritual support ■ Religious and memorial services for deceased persons ■ Home visits or group meetings ■ Herbal garden for herbal medicine ■ Emergency support, including provision of care package to needy families
World Vision (Malaysia): **Rain concert**	Korean superstar Rain, when performing in Malaysia during his recent world tour, worked with World Vision in promoting HIV awareness and support for children affected by HIV.
Yayasan Dana Islamic Centre (Indonesia): **Islamic teacher training**	HIV education training programme for Islamic teachers

5.4.3 Review of Evidence

There is strong evidence that FBOs play a significant role in extending the availability of essential services. This is particularly the case in relation to clinical services in countries with poor or underdeveloped public health infrastructures. In many countries, FBOs are major providers of services for OVC and play a significant role in facilitating their access to the services of other providers.

While in many countries FBOs are implementing prevention programmes, there is little rigorous evidence regarding their effectiveness.

6 The Way Forward

Section 6 of this document outlines some of the key issues to be discussed in strengthening partnerships between FBOs and government, non-government and international agencies in responding to HIV and addressing the needs of children affected by HIV and other vulnerable children in the East Asia and Pacific region.

6.1 Policy, Programming and Service Delivery

The overall aim of strengthening partnerships is to assist FBOs in utilizing their strengths in responding to HIV and addressing the needs of children affected by HIV and other vulnerable children in the East Asia and Pacific region. The broad strategic areas of work to achieve this aim are:

- Building a supportive environment
- Mobilizing and supporting a community-based response
- Strengthening the capacities of families
- Ensuring access to essential services

UNICEF's priorities on HIV were outlined in sections 3 and 4 of this document. They are to:

- Prevent mother-to-child transmission of HIV
- Provide paediatric treatment
- Prevent infection among adolescents and young people
- Protect and support children affected by HIV & AIDS[54]

Specific priorities are determined at a country and local community level, based on patterns of infection, local institutional arrangements and cultural and social factors.

Across each of the broad strategic areas of work, activities need to be identified that:

- Develop new (where necessary) and strengthen existing policies and organizational frameworks to enhance the work of FBOs and strengthen partnerships with other agencies
- Increase the capacity of FBOs and their organizational and individual members
- Enhance the availability of strategic information on which FBOs base activity

6.2 Partnership, Roles and Responsibilities

Partnership is at the core of UNICEF's work on HIV & AIDS. As a co-sponsor of UNAIDS, UNICEF is committed to the Three Ones principle as a framework for building partnership. The Three Ones are:

- One agreed HIV & AIDS action framework
- One national HIV & AIDS coordinating framework
- One agreed country-level monitoring and evaluation system

The Three Ones principle was adopted against a background of proliferating international initiatives on HIV. It aims to reduce duplication and increase effectiveness of HIV & AIDS funding and planning. The response of FBOs to HIV needs to be aligned with national HIV & AIDS action frameworks and support country level monitoring and evaluation systems.

6.3 Capacity Development

There are a range of functions that are currently being operationalized by FBOs and could be enhanced. To maximize their effectiveness, they require a strategic approach to capacity development. Capacity in this context refers both to the organizational requirements for programme implementation (e.g. funding, planning and management systems), as well as the capacity of individuals to implement programme activities.

A detailed assessment of organizational capacity development needs should occur in the context of strategic planning.

A systematic approach needs to be adopted for the capacity development of individuals. This involves:

- Identifying the human resource needs in each strategic area of work
- Defining the competencies required
- Identifying gaps in capacity
- Assessing current training provided against competencies defined and the ability to address gaps in capacity
- Identifying other opportunities to address gaps
- Prioritizing needs identified and organizing training provision to address those needs

As identified above, the extent to which existing training meets the needs required has to be considered. In so far as FBOs may be involved in highly technical areas of service delivery (e.g. medical services), training generally would occur through established institutional processes. In regard to services such as VCT, decisions regarding capacity development need to be made on the basis of local circumstances.

Where specific groups are to be trained (e.g. religious leaders), it may be advantageous to deliver training to these groups under the auspices of their respective FBOs.

6.4 Monitoring/Evaluation and Strategic Information

Monitoring and Evaluation serves two main purposes. Those are:

- Accountability and transparency
- Providing information for programme decision-making

Accountability and transparency are basic requirements of effective programme management. Programmes must be accountable to key stakeholders (e.g. funding providers, target populations). Therefore information must be collected demonstrating that funds are allocated and activity implemented as agreed to. If this is to be achieved, information must be transparent (i.e. unambiguous, objective and readily accessible). Monitoring systems which involve the collection of routine information regarding expenditure and activity and meet the criteria of transparency ensure accountability. Monitoring systems provide most of the information required to evaluate the process of programme implementation.

Evaluation includes, but is not limited to, monitoring. Evaluation aims to provide information regarding:

- Process (How was the programme implemented?)
- Impact (Did the programme have the effect that was intended e.g. how many people/ communities were reached?)
- Outcome (Did the programme have the effect that was intended e.g. did involving local leaders in HIV create a more supportive environment?)

Evaluation is only useful if the assumptions underlying programme planning are explicit, there is a logical link between process, impact and outcome, and objectives are quantifiable.

In general, programme evaluation will include routine processes for measuring process and impact. The BLI has been making great efforts to incorporate its monitoring and evaluation framework into its activities and has developed regional assessment tools including questionnaires, focus group guides and other evaluation instruments that can be used across countries participating in that programme. This allows variation to be identified between countries regarding process, impact and outcome. This provides a very useful tool for quality improvement because it facilitates investigation of what factors might have contributed to implementation being more effective in one location than another. Also, the data collected provides baseline measures for identifying changes over time.

It is often difficult to attribute outcomes (as described above) to a particular programme. For example, creating a supportive environment may require addressing a range of factors over which religious leaders have only some influence. This reinforces the need to work in partnership with other organizations (including the alignment of planning and cooperation in implementation), as well as aligning evaluation with that of other initiatives. This underlies the Three Ones principle referred to in section 6.2.

Strategic information includes monitoring and evaluation. It also includes other information that will not only help to inform evaluation but also is necessary for programme planning. Examples of strategic information include:

- Epidemiological surveillance (this allows patterns of infection to be identified and programme priorities established)
- Behavioural monitoring (patterns of risk practices can be identified)
- Vulnerability mapping (contexts and locations that create heightened vulnerability can be incorporated into planning)
- Qualitative social research (more detailed understandings of vulnerability and risk can be investigated, allowing interventions to be better targeted)
- Service utilization data (can help identify effectiveness and efficiency of programmes)

7 Next steps

The UNICEF East Asia and Pacific Regional Office is holding an interfaith consultation meeting in January 2008. The meeting is part of a process to assist FBOs in responding to HIV and addressing the needs of children affected by HIV and other vulnerable children in the East Asia and Pacific region. Discussions held at the meeting will identify strategies to achieve that goal.

The meeting has been structured to engage FBOs around themes that reflect the strategic approach of UNICEF and can build on the particular attributes of FBOs. In adopting this approach, the aim is to develop strategies that are sufficiently flexible to facilitate and strengthen the role of FBOs, given the enormous variation between countries (e.g. existing involvement of FBOs, stage of the HIV epidemic, etc.).

Content: The meeting is largely structured around the themes of:

- Building a supportive environment
- Community-based responses
- Access to essential services
- Strengthening the capacities of families

These themes reflect UNICEF's approach to building effective prevention, care and support programmes. They also recognize common features of effective programmes, irrespective of specific country dynamics.

Methodologies: Although best practices and evidence related to FBO's HIV activities will be presented, group discussions that incorporate participants' own country experiences will be a major part of the meeting. Participants are encouraged to bring information and communication materials from their own countries. There will be an exhibition space at the meeting as well as opportunities for discussion in plenaries and workshops.

Meeting Outcomes: A report of proceedings of the meeting will be distributed soon after its conclusion. The UNICEF East Asia and Pacific Regional Office will identify opportunities to address priorities identified at the meeting.

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