



Munich Personal RePEc Archive

**Layers of evidence: discourse and  
typologies of faith-inspired community  
response to HIV/AIDS in Africa**

Olivier, Jill and Wodon, Quentin

World Bank

November 2012

Online at <https://mpra.ub.uni-muenchen.de/45380/>  
MPRA Paper No. 45380, posted 22 Mar 2013 02:17 UTC

# LAYERS OF EVIDENCE: DISCOURSES AND TYPOLOGIES OF FAITH-INSPIRED COMMUNITY RESPONSES TO HIV/AIDS IN AFRICA

*Jill Olivier and Quentin Wodon*  
University of Cape Town and The World Bank

*This paper has two objectives. The first is to provide a review of the discourses about the religious response to HIV/AIDS in Africa that have emerged from the recent literature, how these discourses has changed over time (from religiophobia to a cautious recognition of the comparative value of faith-inspired interventions), and the conflicting typologies of faith-inspired initiatives that they have inspired. Noting the limits of the existing typologies, the second objective is to suggest conceptually some of the ways in which typologies could be combined in order to be made more useful from an operational point of view.*

## INTRODUCTION

Engagement with communities has become a cornerstone of the international response to HIV/AIDS. There has not only been an instrumental recognition of the importance of communities in implementing of specific programs and policies, but also a recognition of the need to understand better the way in which local communities act and engage with their contextualized epidemic through local responses and initiatives. However, our knowledge of what community initiatives responding to HIV/AIDS look like, how they behave or what impact they have is still limited. Our tools and methods for understanding and supporting community initiatives remain inadequate in large part due to a limited evidential basis with which to work.

A particular question has arisen as to the nature, role and impact of *religious* communities and community initiatives.<sup>1</sup> There has been greatly increased advocacy for engagement with religious communities. Dialogue between religious leaders, religious institutions, multi-laterals and others working at a policy level has also increased over the last two decades. As a result, there is now an emerging literature addressing the ‘religious response to HIV/AIDS in Africa’ – some of which deals with community-level responses, albeit through a variety of lenses. Within both this literature, and the broader policy-level advocacy work, much has been said about the ‘comparative value’ of religious communities, initiatives and institutions – with arguments being made that religious communities have a particular or characteristic impact on HIV/AIDS (as well as health and development more broadly) and that the ‘faith sector’ contains untapped assets or potential which have not been properly leveraged in the pandemic response.

---

<sup>1</sup> We use ‘religion’, ‘religious entity’ and ‘initiative’ in this article as broad terms - recognizing the inadequacy and lack of precision of the terminology.

However, while the international policy environment may have moved towards a more interested attitude towards religious communities and initiatives (in sharp contrast to earlier periods when religious activities were seen as bringing mainly negative value), this increased attention and literature has not necessarily resulted in any significant policy or strategies for a particular kind of engagement with religious communities and initiatives that takes into account such special characteristics. Said differently, while there are many more policy documents and reports recognizing the importance of religious communities – there are few targeted operational strategies that can be acted upon. This lack of clarity is largely as a result of a failure of evidence, both due to significant knowledge gaps, and also as a result of clashing frames and typologies being applied to the assessment of religious community initiatives responding to HIV/AIDS.

In this context, this paper has two main objectives. The first is to provide a broad overview of these main perspectives or ‘discourses’ about the religious response to HIV/AIDS in Africa that have emerged out of the international research and policy environs: how these discourses have changed over time in the last three decades, and the typologies of faith-inspired community initiatives that they have inspired.<sup>2</sup> This provides us with a review of dominant perspectives visible in the literature which have driven policy and research action. Thereafter, noting the limits of the existing typologies used in the literature, we suggest in a conceptual and admittedly rather introductory fashion some of the ways in which these typologies could be combined and made more useful from an operational point of view – and for utilization at a policy level. In so doing, we make a few recommendations for a more properly integrated approach to assessing the religious community response and a return to some of the more basic forms of evidence-gathering that may have greater relevance for policy-level collaborative action and frameworks.

The paper is structured as follows. Section two reviews how attitudes towards the religious community response have changed over time. We identify three stages in this evolution, starting with the perception at the early stages of the HIV/AIDS pandemic that religion is at best irrelevant, or may even bring negative value to the HIV/AIDS response. Next comes a turn-around as of the mid to late 1990s in which much more enthusiasm is seen about the potential comparative advantages of religious health assets, but without actual evidence as to their performance. Finally, we review today’s somewhat more cautious mixed bag of opinions and calls for bridging the evidence gap. Next, in section three, we discuss some of the main typologies that have been used to frame the religious community response, in terms of the form of religious entities, their function, or their religiosity. Recognizing the well-acknowledged limits of existing typologies, we then explore in section four ways in which they could be combined to be more useful for policy makers.

---

<sup>2</sup> A broader analysis of this literature can be seen in Olivier (2010). Many examples provided in this article are taken from four religious community mapping studies implemented in eight sub-Saharan African countries by the African Religious Health Assets Programme (see ARHAP 2006, Haddad et al 2008, Schmid et al 2008, Thomas et al 2006).

## ATTITUDES TOWARDS THE RELIGIOUS COMMUNITY RESPONSE

In 1999, Garner wrote an article, asking the question “*religion in the AIDS crisis: irrelevance, adversary or ally?*” Although more than a decade has passed since he asked this question, it is still difficult to provide a concise answer. There has been a great flurry of debate as to what the *comparative value* (also described in the literature as ‘comparative advantage’ or ‘value-added’) of religious communities entails, and whether such initiatives and institutions have resulted in improved health and development - but little clarity on what strategic engagement with- or leverage of these might look like. It is helpful to start our discussion of this field by briefly considering some of the key phases the international research and policy environment has gone through – especially with regard to this question of the comparative value of HIV/AIDS-engaged religious communities and community initiatives. We do not systematically detail here the literature on the religious response to HIV/AIDS (of which there are several reviews newly available, see for example Haddad et al 2011), but rather provide a broadly chronological assessment of the dominant themes and attitudes towards religious community engagement as is visible in the HIV/AIDS literature and policy environment (Olivier 2010).

### **The early stage: Religion as irrelevant or of negative value**

In the first few years of the HIV/AIDS pandemic, international inquiry into the disease-complex was largely blind to religion and religious entities (REs) working in development and health. Under the influence of secularization and modernization, religious involvement in development had become invisible to the majority of scholars and international policy-makers who had become largely ‘religion-blind’.<sup>3</sup> Furthermore, modernization held (and holds) an inherent bias towards religion, where religions were seen as obstacles to progress (Melkote and Steeves 2001).

In the early stages of the pandemic, when the biomedical perspective dominated the inquiry (Weeks 1989, Plummer 1988) there was little mention made of religion or of REs. Of course, many REs were engaged in HIV/AIDS work and partnering with international organisations and governments from the very beginning stages.<sup>4</sup> But in terms of categorization, REs were generally assumed to be part of civil society, clustered as NGOs and community-based organizations (CBOs); or even more generally with non-state health service providers - with religion seen simply as one of many culturally relevant variables. Liebowitz (2002) suggests a number of factors which resulted in a belated consideration of the potential comparative advantages of religious engagement in the HIV/AIDS agenda including: the complex nature of the topic, the surrounding controversy, and the relatively modest impact of religious leaders in the developed world from where most of the research agendas are driven.

---

<sup>3</sup> The secularization thesis suggests, among other things, that as societies develop and modernize they will tend to follow the pattern that developed in Europe during the 20<sup>th</sup> century where religion has been increasingly relegated to the back seat and seemed to lose its influence in public life. Few religious scholars nowadays defend this view.

<sup>4</sup> Certainly there are many noted cases of a very early response by established health-engaged REs in Zambia, Lesotho, Kenya and Malawi for example (ARHAP 2006, Haddad et al 2008).

The first major appearance of religion in both the international and Africa-focused HIV/AIDS materials comes several years later, during what Weeks (1989) calls the phases of moral panic and crisis management, when HIV/AIDS began to be described as a 'gay plague' (in the USA and internationally), and the marginalisation of risk groups developed into a moral panic. Although Weeks is addressing the North American context, it is relevant that this phase of moral panic brought a specific discourse about religion into the international inquiry, and it is clear that this moral discourse was swiftly visible in materials addressing the African HIV/AIDS pandemic. Seidel (1993) describes the emergence of powerful medico-moral discourses, which she sees as being of primarily Christian intervention and frequently judgemental (such as those representing AIDS as God's punishment). These medico-moral discourses show a complex weaving of religious and biomedical 'truths' as people struggled to understand this devastating phenomenon, often to disastrous effects.

In reaction against these moral discourses, critical commentary arose that took a strongly adversarial position against religion, describing religion and REs as a barrier to effective HIV/AIDS intervention. Stories of religious leaders shunning PLWHA grew rapidly at this time, and the inquiring gaze towards religion and HIV/AIDS frequently becomes narrow-eyed with suspicion. As Green (2003) described, "*During the early years of the HIV/AIDS pandemic, many people who worked in HIV prevention believed religious leaders and organisations were intrinsically antagonistic to what they were trying to accomplish.*" UNAIDS took it a step further and named opposition from religious authorities as "*perhaps the greatest obstacle to AIDS prevention activities in many countries*" (Pisani 1999).

Significantly, in the 1990s, the main focus of the international inquiry shifted from a 'gay disease' to an 'African plague' (Treichler 1992), as HIV/AIDS turned into an administratively chronic disease in most Western countries, but continued to grow exponentially in African states as an epidemic disaster and disease of development (Fox 1992, Rosenberg 1992). Negative attitudes towards religion and REs were woven into such discourses of African AIDS, and narratives of stigmatising male African religious leaders began to flourish, although with little underlying evidence-base to assess the impact or scope of these kinds of behaviours.

'Religionophobia' in the form of doubt, suspicion and negative perceptions of religion and religious involvement in development and health continues to linger today (Cochrane 2008, Marshall 2009), and is evident in a number of areas of HIV/AIDS inquiry, tied to the emergence of religion into public life as a liability (particularly discourses about terrorism and religious fundamentalism), and continuing discourses of secularisation and modernisation. Concerns and frustrations also linger, for example, towards the detrimental effect of some religious leaders to HIV prevention strategies, the fear that religious organisations may use public funds for proselytizing or, "*concern that ideological considerations are replacing sound empirical evidence of effectiveness in delivering health services*" (Breger in Woldehanna et al 2005). All this fed into a dominant perspective of a negative or detrimental religious response to HIV/AIDS in Africa, a response that has been comparatively worse than the 'secular' response.

### **The turn-around: Cautious enthusiasm without systematic evidence**

Things started to turn around late in the twentieth century. While the HIV/AIDS pandemic hit its stride in Africa, contrary to the predictions of modernist and secular theories, religion began to re-emerge into public life on a number of startling fronts (Cochrane 2003, Derrida and Vattimo 1998).<sup>5</sup> Religious movements across the globe have been flourishing, for example, Pentecostal and charismatic varieties of Christianity in sub-Saharan Africa, a highly political Islam in North Africa, and religious revivals in Asia and the United States (Ellis and Ter Haar 2001). Religion has become increasingly important in the political sphere, where the 'resurgence of religion' has been treated both with welcome and alarm, context and perspective depending (Asad 2003).

Less public, but as influential has been the re-emergence of religion in research and scholarship. The most obvious example of this has been in the public critique (or failure) of the secularisation and modernism theses, which a range of commentators and scholars began noting had critical flaws, in particular the basic idea that development or modernisation equals secularisation. Berger, a key proponent of the secularisation thesis, bravely admits in 1999 that, "...the assumption that we live in a secularised world is false. The world today...is as furiously religious as it ever was, and in some places more so than ever. This means that a whole body of literature by historians and social scientists loosely labelled 'secularisation theory' is essentially mistaken. In my early work I contributed to this literature." This is not to say that religion has re-emerged into academia and scholarship in a blindly positivistic way; to the contrary, it has emerged into a deeply suspicious and antagonistic environment, but what is clear is that it cannot be ignored.

Tied to this broader reemergence of religion into public life and scholarship, researchers and policy makers began increasingly to turn their gaze towards the so-called 'faith sector' in relation to HIV/AIDS response. In Africa this interest came in a broader context of generally failing health systems and on the heels of what appeared to be unsuccessful attempts at health and development policy reform. HIV/AIDS itself further undermined confidence in existing development and public health strategies (Farmer 1999, Kim et al 2000). In 2000 World Health Organisation (WHO) Director General Brundtland stated that to confront the diseases of poverty, "*we must strengthen health systems. We must also go beyond the traditional health sector - working with people in their homes, their work places, their schools, their community halls and their places of worship.*"

The literature of the late 1990s and beyond shows two main reasons given for the renewed interest in REs: firstly, the recognition of the importance of religion to individual and community behaviour and decision-making, arguing for intervention strategies that are cognisant of that (Benn 2002) and secondly, the possibility of assets

---

<sup>5</sup> As noted by Ellis and Ter Haar (2001), "*Labelling it a 'revival' or 'resurgence' in some ways conveys the misleading impression of a trend that previously existed but that had gone underground, whereas in fact many of today's most visible religious movements have long been publicly active, but have only recently become subject to academic scrutiny.*"

held by religious communities that could be leveraged through partnership in a context of limited resources (Haddad et al 2008, Olivier et al 2006). The first reason was powered by the general failure of many HIV/AIDS interventions that were shown to be culturally inappropriate and the belated realisation that religion is important to the lives and decisions of the people most affected by HIV/AIDS. The second reason given for this renewed interest, that religious communities might hold assets for partnership, can be seen to have roots in broader trends in the HIV/AIDS agenda, to now treat HIV/AIDS as a disease of development and society, rather than a medical problem, and a pandemic primarily located in resource-poor settings characterised however by booming civil society sectors (Olivier 2010).

This generated a strong interest in partnership and multi-sectoral collaboration as visible in the development and health literature. Global health and development agencies (such as WHO, GFATM, World Bank, and UNICEF) began to “...turn to religious bodies who might offer what is otherwise lacking” (Cochrane 2006, see also Schmid et al 2008, Woldehanna et al 2005). The WHO stated in its 2004 World Health Report that: “Faith-based organisations have a crucial role to play in the widespread uptake of HIV/AIDS treatments...(they) could be brought into treatment scale-up in order to combine their comparative advantages.” It is from this period onwards that the theme really emerges that the ‘faith sector’ holds untapped resources not otherwise available in other sectors.

Alongside this renewed interest in REs from the international development and health communities, came a rapid realisation that due to historical neglect, there was a significant knowledge-gap on religion, the nature of REs, their response and (potential) impact on HIV/AIDS intervention. Indeed, the intersection of religion, health and development has become renowned for its substantial gaps in systematic information and basic data (Schmid et al 2008). However, seemingly disconnected from the struggle to develop better evidence on the role of REs, funding targeted at REs engaged in HIV/AIDS in Africa was increased significantly. As Christoph Benn of the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM) said in 2003, “for decades they were at best tolerated but not actively supported. Now there is almost a competition among big secular donors to fund the best programmes.” Another example is the US President’s Emergency Plan for AIDS Relief (PEPFAR) launched in 2002, which profiled religious organisations, acknowledged the concept of ‘spiritual care’ and entailed particular funding in relation to religious activities (PEPFAR 2009, Formicola et al 2003). Many of the other large multinational agencies similarly took the decision to target funds to religious organisations - described as a reliable and efficient means to impact on health crises and HIV/AIDS (Taylor 2005a, 2005b, 2007).

Increased funding for FBOs came several steps ahead of attempts to fill the knowledge gap, and actions were taken despite little supporting evidence for targeted engagement (Olivier et al 2006). Liebowitz (2004) concurs: “...increasing resources are being devoted to supporting FBOs in global campaigns...Yet remarkably little guidance is available for policy makers on exactly what the strengths of FBOs are, what best practices have allowed specific FBOs to achieve significant successes, and how FBOs can be integrated into broader campaigns for prevention and mitigation...” Said

differently, funding and action are mainly based on perceptions (such as those outlined above), and the individual experience of decision-makers, rather than on a body of evidence detailing the comparative value of REs. This is not to denigrate such decisions, but rather to point to lagging research and scholarship that could not at the time provide the underlying evidence to the scale and detail necessary for policy-level decision-making.

### **The latest phase: Mixed opinions and calls for evidence**

The acknowledgement of this knowledge gap (as well as broader effects of the HIV/AIDS research industry) has led to renewed inquiry at the intersection of religion, development and health, and has resulted in the emergence of a new body of literature addressing the religious response to HIV/AIDS in Africa. An analysis of this literature shows an array of directly conflicting conclusions about REs (Olivier 2010). Or as Dilger (2009) puts it, *“in recent years, relationships among religion, development, and globalisation have been discussed critically with regard to the potentially beneficial as well as detrimental opportunities that the work of faith-based organisations (FBOs) presents in relation to HIV/AIDS.”* However, a strong discursive device that can be seen in this literature is for the comparative strengths and weaknesses of REs engaged in HIV/AIDS to be listed, frequently in the opening paragraphs, but also usually unreferenced, and commonly prefaced by phrases such as ‘it is accepted that’.

Commonly listed strengths might be that REs have extensive infrastructure; reach and access; that they provide services in inaccessible areas; that they have access to dedicated volunteers and educated leadership; that they have unique credibility, trust and acceptance in communities; that they have well-developed networks extending from international to grassroots communities; that they provide a special kind of care; or that they have particular resilience and durability. For example Byamugisha (in WHO 2004) says: *“We have a unique presence and reach within communities. We have unique structures and programmes that are already in place. We are available. We are reliable. And we are sustainable. We were there long before AIDS came and we will still be there when AIDS goes away.”* In contrast are similar (but shorter) lists of potential weaknesses or liabilities, which make them comparatively poor partners for HIV/AIDS intervention. The weaknesses most commonly listed are limited resources, limited capacity, limited skills (in particular poor documentation), and such concerns as proselytizing tendencies. Again, such statements are usually unreferenced, difficult to track, and rarely tied to any apparent systematic evidence base. Furthermore, these conflicting statements about the comparative advantage or disadvantage of engaging with REs in HIV/AIDS response are likely to appear in the same text.

The real challenge is that based on this literature, *any* position or conclusion about REs and the religious response to HIV/AIDS can be defended. As Olivier (2010) notes, based on this body of recent literature, it is possible to substantiate almost *any* broad generalization about the religious response to HIV/AIDS. Given the lack of a systematic evidence base, generalisations and stereotyped representations are given more power. In her unpacking of what she calls an ‘epidemic of signification’, Treichler (1992) points out that while HIV/AIDS is a complex cultural phenomenon that produces diversity and



contradiction, dominant meanings also emerge - default meanings that can be expressed with little fear of being challenged. In the literature addressing the religious response to HIV/AIDS, the dominant meanings around the comparative advantage tend to be in direct opposition with equally powerful dominant meanings about comparative disadvantage, and researchers and policy-makers are left to negotiate these opposing views. After conducting a review of the literature on religion and HIV/AIDS, Haddad et al (2008) could only conclude that: *“there has been a recent boom of interest in the potential of religious entities in establishing effective HIV and AIDS interventions. This interest usually reflects a strongly positive attitude towards working with religious entities and simultaneously some cautionary note, based on perceptions of the potential negative effects of religious messages”* (in Taylor 2007). This is typical: data are uneven, diverse, and greatly lacking in specificity –rarely defined enough to know *which kinds* of REs are *more or less* suited to *which kinds* of HIV/AIDS programming.

The chronological way these three ‘stages’ of discourse towards the comparative value of the religious response to HIV/AIDS in Africa have been presented is possibly misleading - given that many of these themes linger today. However, it does appear that there has been some shift from early in the HIV/AIDS pandemic, when there appeared to be little targeted interest in how REs might add comparative value and a generally negative perception of REs; to a more enthusiastic discourse about the positive value REs; and finally to a conflicting body of uneven evidence that provides strong but equally conflicting assumptions about such comparative value.

Most recently, there have been signs of a new phase emerging in the international policy and research environment. At many of the recent meetings of international actors on religion and development, there was strong mention made of the need for ‘real evidence’ of the comparative value of religion and REs (CIFA 2010, TBFF 2009, WHO-CIFA 2009). The World Bank, for example, has undergone a transition in its relationship with REs, from a focus on dialogue with faith leaders to more policy-relevant empirical work with REs in the context of country-specific work. Statements have been made in international meetings alluding to a loss of patience for dialogue about the ‘peculiarities of FBOs’ and increasingly asking REs to show empirical evidence of their presence and the comparative value of their work. As noted in one recent meeting in Geneva, *“More effective and compelling mapping, including data on value-added by religious health assets, are needed to substantiate basic health services and demonstrate advantages and quality of care among all providers...How can we expect donors and governments to invest in ‘unknown’ or spurious services based on anecdotal evidence alone?”* (WHO-CIFA 2009).

### **Tensions that remain**

It is ironic (or perhaps just a reflection of increasing maturity) that despite a greatly increased body of literature on the religious response to HIV/AIDS in Africa, it appears to be *increasingly* difficult to make any generalized statements about the comparative value of REs, or specific conclusions that could be implemented at the policy level. It is clear that there is still a critical lack of *systematic* evidence on the presence, role and impact of religion and REs. Comparative and contextualized evaluations of specific

initiatives and institutions are urgently needed, as is the continued collection of base-line evidence through broad-scale tools such as national surveys.

One of the areas that remains most critically under-researched is that which could speak to the presence or impact of religious initiatives at a *community level*. Said differently, while the more ‘formal’ faith-inspired health and development institutions and organizations are slowly being recognized in a more comprehensive way, the community level is where less formal initiatives emerge and the impact on local populations remains critically under-researched, as noted by Schmid et al (2008) in their landscaping study of religious health assets in Africa. It is actually a paradox that it is on this precise level of the local community religious initiatives that we know the least, while it is also (it can be argued) here that the real comparative value of the ‘faith sector’ likely must lie – such as local trust, access, reach and acceptance, potentially impacting on both service provision and behavior change strategies (Olivier and Clifford 2011).

This paradox also reminds us that it is at the community level, that some of the most contentious issues for possibly religionophobic policy-makers are most visible. At the community level you are less likely to be engaging through international religious institutions that can appear almost identical to other non-governmental organizations, but rather through local religious leaders, local religious communities, or through ‘faith-forming entities’ such as congregations, churches and mosques – all with unapologetic religious characters, values and priorities.

Another reason for a continued lack of impact at a policy level, despite an increased literature – is that the collaborative arena in which this evidence gathering is being conducted is a highly charged and complex context. The issue of proving the comparative value of religion and REs in the response to HIV/AIDS has become a highly visible topic with different agendas influencing what gets researched and by whom. The idea of REs having a comparative value (which is the basis for fundamental issues such as calls for increased funding) is linked to both powerful advocacy groups pushing for the increased recognition of the previously invisible ‘faith sector’, and also to possibly religionophobic agendas.

The issue of just what ‘real evidence’ is in this context, or who should be gathering it, is therefore not without contestation. For example, there is a trend in the literature to speak of ‘secular analysis’ – such as Luker (2004) saying, “*although (churches) are major institutions...very little secular analysis of their contemporary social capacities and roles is available.*” Woldehanna et al (2005) also express some of the tensions, saying, “*...The increasing involvement of FBOs in delivering HIV/AIDS services and prevention activities warrants a balanced and impartial examination of their contributions to help optimise their future involvement and collaboration.*” The ideas expressed of ‘secular’ and ‘impartial’ research shows some of the tensions at play, and how the collection and analysis of evidence in this field of enquiry cannot be considered to be value-free (this not being about the methods of research, but about who is engaged in this work, and how findings are taken further). Many REs also have historical motivations for being protective of information about their activities and resources. The comparative

disadvantage often expressed – that REs ‘are poor at documentation’ – might, for some, be more about a historical lack of trust or alignment with national evaluation and informational systems (see Haddad et al 2008).

While there have been several calls for more ‘mapping’ research of REs, it should not be assumed that all REs would automatically see the benefits of being included on the international policy ‘map’ (Olivier 2010). Representation continues to be a critical issue, with REs expressing concern that the current system of networks which are supposed to represent the ‘faith sector’ at a national and international level are over-representative of certain formal and denominational groups, and under-representative of other religious groups, including (for example) the burgeoning Pentecostal groups in Africa who do not usually have clear denominational infrastructures or representation (Haddad et al 2008).

Advocating generally for the increased recognition of the presence and impact of the ‘faith sector’ can also have unintended consequences in this complex collaborative environment. For example, in the literature addressing the religious response to HIV/AIDS in Africa, as well as in the broader literature on religion and development, there is a strong theme which names RE as an ‘untapped resource’ that needs to be better utilized or leveraged. Such references have been made by many multilateral development agencies, including the World Bank. Literature emerging from religious groups similarly speaks of their ‘untapped resources’. One unintended consequence of such themes is that many religious leaders are increasingly expressing concerns that they feel ‘used’ by the instrumental way in which they are being drawn into government HIV/AIDS programs (Haddad et al 2008, Olivier 2010), or being utilized for a particular set of assets such as volunteers or specific programming, without concurrent recognition of the particular values or purpose that drives their work. Again, there is tension between those advocating for the faith sector to be more fully recognized, often using the unacknowledged provision of health services as a motivation - and the unintended result of an international community seeking to leverage these resources in secular-oriented policy environments.

Perhaps one of the reasons the growing body of literature on the religious response to HIV/AIDS in Africa has not resulted in significant policy-level action, is because of such tensions which hamper the gathering and utilization of evidence. Such issues cannot be overcome through simple strategies such as increased volume of research or increased M&E training for REs (only) - but is rather about collaborative cooperation around evidence gathering, trust, and how REs see themselves represented in the international information and policy arena. Said differently, the development of a systematic evidence-base on the religious response to HIV/AIDS is not possible without also negotiating this complex (historical) collaborative environment. Gaining access to baseline data as well as the actual *utilization* of completed research should not be taken for granted. However while such tensions and collaborative concerns can be negotiated – there is also another fundamental issue which inhibits policy engagement, that of clashing typologies and frameworks being applied to this evidential field. It is to this issue that we turn next.

## EXISTING TYPOLOGIES AND THEIR LIMITS

### Language and terms: confounding religious categories

Assessing community responses to health and HIV/AIDS is already complicated because communities themselves are complex and assessments are necessarily context-specific. In fact, it is not always useful to suggest what a ‘typical’ community response is or should be. As Rodriguez-Garcia et al (2011) put it: “*The richness of the community response may very well be in its multiple combinations and its variety - its uniqueness in the community’s cultural and geographic context.*” However, these authors continue by noting that at the same time, for policy-makers, some systematization and simplification is necessary in order to suggest broad tendencies, and come up with diagnostics of the strength and potential weaknesses of existing responses. It is also acknowledged that religion and the myriad ways in which religion manifests itself in local communities often require qualitative and textured forms of description and research. However, in the same way, it is still necessary to *also* strive towards some level of systematization and quantification if religion and REs are to be acted on at a policy level.

The assessment and gathering of systematic evidence of religious community response to HIV/AIDS may be *particularly* hazardous, given the historic neglect of the research field followed by a rapid resurgence of interest. As a result of this interest a variety of lenses have been rapidly applied to religious communities and institutions, with rarely any two studies using the same typology, classification system or unit of analysis - and many taking transverse slices across traditionally separate fields of inquiry (for example, by investigating the ‘faith sector’ including all entities from congregations to mission hospitals, with no equivalent comparative made of these combinations in the ‘secular sector’). With no clearly defined field, diverse lenses and units of measurement have been applied to the ‘religious response’ - resulting in diverse and uneven evidence. The intersection of religion, health and development has long been hampered by differences in language (of discipline and culture rather than linguistic). As Benn notes (2009), “*Sometimes the biggest challenge for forging collaboration around this theme between public health experts, representatives of international organizations, and the faith community is the lack of a common language and terminology, which often leads to misunderstandings and frustrations.*” The most obvious example of this communication gap is the exceptional lack of clarity and consensus on the basic ‘unit’ – say, the ‘faith-based organization’ – to be assessed.

Scholars have argued for some time that there is simply no such thing as a ‘typical NGO’ (Martens 2002) – and a lively discussion has ensued around classification systems. However, this is completely eclipsed by the vigour of the debate over what a ‘faith-based organisation’ should most appropriately be named – which continues to rage on both scholarly and the international policy fronts, seemingly without any consensus. Beyond the academic realm, global health and development institutions, governments and REs themselves have all weighed in through attempts to reshape and redefine what REs are, and what they should most appropriately be compared with. A recent example of lack of consensus can be seen in UNAIDS’ Strategic Framework for Partnership with Faith-based Organizations (UNAIDS 2009), which reports on the results of an 18-month

consultation process during which terminology was discussed extensively with UNAIDS partners. Although the document does describe a particular terminological framework, it then concludes that: *“Each UNAIDS Cosponsor may have reasons for its own specific terminology and engagement. For ease of reference in this framework, the term ‘faith-based organization’ will generally cover the various categories listed above, except where indicated otherwise.”* This demonstrates both the continued lack of consensus among collaborative partners – as well as the difficulties of finding appropriate nomenclature. This is not only a debate about terms, but also about substance.

The scholarly debate over the ‘FBO’ (Bradley 2009, Berger 2003, Clarke 2006, Sider and Unruh 2004), appears to have had little impact on the parallel policy or operational environments, where few meetings are held where the terminological issue is not (re)addressed (Olivier 2011). For example, a typical statement showing some of the concerns can be seen in a symposium report from the Center for International and Regional Studies (2008): *“...the group focused initially on exploring the significance that should be given to the terms and concepts of ‘faith’, ‘faith-based’, and ‘faith-inspired’, and the significance of describing organisations or communities as Muslim or Islamic, or non-denominational or secular...[and was admonished] to pay special attention to vocabulary and especially terms that may be imbued with western framing and historical legacies...The crux of the issue lies less in how an individual or an organisation defines their ‘faith’ motivations than on how others interpret and assess its significance. The topic is strewn with pitfalls, and virtually all terms and categories are slippery and problematic.”*

One of the main challenges is that terms such as ‘FBO’ or similar terms<sup>6</sup> are now being used interchangeably to indicate any range of meanings – indeed, any entity with a partially religious character. For example, showing some of the range, a World Council of Churches document (Lux and Greenaway 2006) states: *“The term FBO is used here to describe a broad range of organisations influenced by faith. FBOs include: religious and religion-based organisations and networks; communities belonging to places of religious worship; specialised religious institutions and religious social service agencies; and registered and unregistered non-profit institutions that have a religious character or mission. They might be small, grassroots organisations with simple structures and limited personnel or large, global institutions with highly sophisticated bureaucracies, wide networks, substantial financial resources, and significant human capacity. In some cases they are led by clergy...in other cases laypersons...”*

Terms such as ‘FBO’ can be used broadly in this way, and also specifically for a range of different sub-categorizations. A landscaping literature review of religious health provision in sub-Saharan Africa (Schmid et al 2008) noted over three hundred terms

---

<sup>6</sup> There are currently several terms used to broadly describe an entity with a religious or faith dimension, and that distinguishes them from secular entities. The most commonly used term is ‘faith-based organization’ (FBO), but alternatives include ‘faith-inspired organization’ (FIO), and ‘faith-based initiative’ (FBI), as well as many other terms (see Olivier 2011a). There are also a plethora of abbreviations for secular or broader categories, including civil society organization (CSO), community-based organization (CBO), non-governmental organization (NGO), religious non-governmental organization (RNGO), and even community support group (CSG).

being used to describe REs engaged in health care in Africa. A review of the literature addressing the religious response to HIV/AIDS in Africa indicates similar variety – and six common meanings given to ‘FBO’ (none discrete): 1) faith-forming entities (whose primary function is the formation of faith or worship), 2) religious leaders, 3) Religious nongovernmental organizations, 4) community-based religious initiatives, 5) networks, and 6) health facilities. At this time, there is no consensus on the terminology and definition of REs involved in development and HIV/AIDS, in Africa or internationally – and the trend has arisen where authors redefine the terms in each individual piece of literature; utilize different terms in different outputs from the same empirical research; or even change terms mid-document without explanation (Olivier 2011).

Mapping work on the religious response to HIV and AIDS at a community level has forced researchers to confront these inconsistencies and the inadequacies of our current frames of assessment. In the rest of this section, we illustrate just a few of the main confounding difficulties with some of the most common classification approaches.<sup>7</sup>

### **Classification by form**

One challenge for typologies of the response to HIV/AIDS is the identification of ‘form’. In many development contexts, at a local level, REs are rarely constituted in the form suggested by terms such as ‘institution’ or ‘organization’ and just as frequently appear as fluid formations of individuals, initiatives or responses (ARHAP 2006, Thomas et al 2006). Even the classification of entities whose primary purpose is the formation of faith is problematic: since even terms such as ‘church’ or ‘congregation’ are not without difficulties, given that the formality suggested by such terms is undermined when faced with informal religious ‘congregations’. The concept of ‘congregation’ is indeed much more fluid in multi-religious settings than in most Western contexts. In African settings, for example, communities may simultaneously negotiate and utilize different religious community resources – as evidenced by plural health-seeking behaviors where individuals commonly utilize multiple ‘healing’ strategies such as faith-healing and traditional-healing alongside biomedical care in response to HIV/AIDS (ARHAP 2006).

There is also some tension with REs being ascribed to different sectors. As Melkote and Steeves (2001) say, the objects of development are often “*inserted into implicit (and explicit) typologies which define a-priori what they are...Third World countries became pliable objects to be manipulated by the development experts.*” This is particularly apparent in the HIV/AIDS context in Africa – where some REs are defined as part of the development response (as religious NGOs, RNGOs, part of the civil society sector, collaborating and being supported through Multisectoral AIDS Councils); and others are defined as part of the medical response (as health facilities, part of non-state service provision, collaborating and being supported through Ministries of Health) (Haddad et al 2008). What is challenging is that there is only a limited logic to these classifications, and

---

<sup>7</sup> See also Rodriguez-Garcia et al (2011) who use the following criteria for identifying community-based HIV/AIDS responses: (1) the types of organizations and structures implementing the response, (2) the types of activities or services implemented and the beneficiaries of these, (3) the actors involved in and driving community responses, (4) the contextual factors that influence community responses, (5) the extent of community involvement in the response, and (6) the extent to which community responses involve wider partnerships and collaboration.

more confounding outliers than neatly compliant entities. For example, Christian Health Association members typically get named and counted both as part of civil society response to HIV/AIDS (RNGOs engaged in development) and part of the health system providing a medical response to HIV/AIDS (ARHAP 2006, Schmid et al 2008). Being classified as a health facility or a RNGO has consequences for critical issues such as representation and access to government and external resources.

Mapping studies have uncovered the presence of a significant number of REs working against HIV/AIDS not previously recognized by national and international health institutions – in particular a mass of smaller community-based religious initiatives often not recognizable as NGOs or health-facilities, more difficult to measure and understand, and varying considerably in different contexts (ARHAP 2006, Haddad et al 2008, Schmid et al 2008). This is a significant hidden group of initiatives, differently described as informal, unorganized, non-mainstream, non-facility-based, or community-based (Foster 2004, Schmid et al 2008). One reason for their continued invisibility could be because they fit less comfortably with current nomenclature and classification systems. For example, a women's group working out of a congregation without the knowledge of their religious leader, or a neighborhood initiative using bicycles to transport AIDS patients to the local hospital each week for treatment – are less easily mapped than CBOs, NGOs and health facilities. We know significantly more about the forms of religious community initiatives which we are comfortable in seeing – such as RNGOs or health facilities with a recognizable form and facility. These are the initiatives which have so far received the greatest research focus, and which clearly receive the most support, which in turn results in the establishment of more initiatives of these kinds (for example, a boom of RNGOs has been noted since around 2000 in many African countries such as Zambia, Malawi, Kenya or Uganda – ARHAP 2006, Haddad et al 2008). There remain huge challenges to our research strategies and tools to be able to adequately map and support informal initiatives without (even inadvertently) destroying them or reshaping them by imposing rigid frameworks on them.

### **Classification by function**

Attempts have also been made to classify REs by their geographic location, size, scope, reach or primary activity (Berger 2003). There are of course contextual similarities and patterns to be found. For example, there are hints at regional patterns that differ between Anglophone, Francophone and Lusophone countries. Many francophone West African countries demonstrate a particular range of civil society institutions and initiatives which includes fewer religious health facilities or RNGOs, and community level response more frequently channeled through religious congregations (such as mosques) and religious schools. In comparison, Southern African countries with similar colonial and historical contexts, such as Zambia, Malawi or Kenya demonstrate an abundance of RNGO and health facility-type initiatives (Schmid et al 2008).

Still, classifications by function show strain when faced with the reality of complex community contexts. For example, regional categorizations are problematized by the diverse transnational and transregional ties among REs with their unique connections for collaboration, resources, funding or ownership (Schmid et al 2008). REs often work



across national boundaries, collaborating in complex regional and transnational networks that fit poorly into national scale assessments (Haddad et al 2008). Representation (e.g. local, regional, international) is another category that does not fit comfortably - as there are many REs that are simultaneously represented as part of a local program, a regional denomination, and an international network. Or vice versa, international REs that simultaneously act in a local community as an intermediary (channeling funding to other local initiatives) *and* operate their own local programs (therefore sometimes perceived as competition by the same local initiatives) – making it difficult to map these initiatives in any simplistic way (ARHAP 2006).

Mapping studies have also suggested that religious initiatives are often fluid in nature, adapting to the needs around them and shifting focus, making it particularly difficult to categorize their type or activities over time (Olivier et al 2006, Schmid et al 2008). That is, while many religious community initiatives are shown to have been in place for a long time, they are also often extremely adaptive to need and available resources – changing character faster than they can be mapped (ARHAP 2006). Many, if not most, HIV/AIDS-engaged REs in sub-Saharan Africa have demonstrated broad, holistic portfolios that simultaneously range across a number of primary activities; some such activities might very well be religious, while others are more recognizable with a development or public health lens. For example, there are Muslim communities financially supporting a government hospital; or traditional healers (who might also be Christian pastors) running ART and referring patients to government hospitals (ARHAP 2006, Schmid et al 2008). Religious communities also tend to have a particular language in which they describe and evaluate their care and support activities, which often might extend beyond what is typically defined as ‘care’ – in particular the framing of ‘spiritual care’ as a core part of care and support (Olivier and Clifford 2010).

### **Classification by ‘religiosity’**

Perhaps the most problematic classification approach is the basic binary division between religious and secular – which is especially troublesome given that the terminology (and literature) described above rests on the assumption that religious initiatives can (and should) be separated from their secular comparatives. There are several available models which classify an organization by its level of ‘religiosity’. For example, the World Council of Churches has differentiated between ‘faith-related organizations’, ‘faith-background organizations’, ‘faith-centered organizations’ and ‘faith-saturated organizations’ (Doupe 2005, see also Sider and Unrah 2004). Some studies have sought to show how religious organizations can be classified on such a scale, or how the activities in which an organization engages may affect how it fares on such a scale. For example, work in the US context has suggested that HIV/AIDS-engaged organizations might lose their religiosity as they become more dependent on ‘secular’ funding (Chambre 2001). However, while measures of ‘religiosity’ may appear relevant in communities with more fixed congregational structures, such as American congregational studies, they become more problematic in development settings, and when engaging with local communities (Olivier 2010).



The underlying problem, is that the Cartesian division between ‘religious’ and ‘secular’ cannot be assumed in many African contexts where religion is embedded in everyday life, and also integral to the character of many secular-classified organizations. An institution which a researcher or policy-maker might assume to be secular may insist that they are religious. Just as an illustration, at a workshop on mapping religious health assets in Kampala, a member of the Infectious Disease Institute (attached to the university) insisted that “...*we are a faith-based organization...all organizations in Uganda are faith-based*” (ARHAP 2007). Conversely, the Aga Khan Development Network, a large and power Islamic hospital system and development agency, states emphatically that it is *not* a religious institution. There are also community level initiatives whose religious identity is undefined – that is, describing themselves as deeply religious, but not affiliated to any particular religious group - for example community support groups that are providing HIV/AIDS care in Lesotho but are not tied to any structure or organization and receive little or no external support (ARHAP 2006, Liebowitz 2002, Schmid et al 2008).

Some studies have attempted to assess FBOs by ownership, for example by which denomination, faith tradition, or coordinating network the entity might belong to. This is also hazardous. For example, in many countries, faith-inspired health facilities have been designated as district hospitals (that is, as part of the public system), and vice versa, for example, Kilembe Mines Hospital in Tanzania is owned by a parastatal body but is *managed* by the Catholic Diocese of Kasese (Schmid et al 2008). It is in fact common for health programs and facilities to be owned or operated by more than one network or body. While it might seem easy to identify a local ‘congregation’ – very often it is the offshoot activities that are of most interest (especially in relation to measuring HIV/AIDS response), and mapping studies have shown that it cannot be assumed that the religious leader is aware of such off-shoot initiatives (and are possibly more likely to be involved if there is funding - see Agadjanian and Sen 2007).

Classification is nowhere a value-free activity, and institutions and initiatives often adjust descriptions of their type and activities according to how they perceive it would be most useful to be understood in a particular situation or context. Classification has clear implications such as access to resources, representation and collaboration (for example with government). At one time it might be useful to be labeled an ‘FBO’ to open certain funding doors (such as PEPFAR), and at other times less so, for fear of “*potentially negative connotations associated with religious references as well as legal obstacles that arise when applying for public funding*” (Berger 2003).

We do not mean here that the religious-secular classification should be ignored or that we should return to a state of categorical religion-blindness (even were that possible). However, one of the implications of these examples emerging from community mapping studies is a warning that in the process of gathering systematic evidence of this previously neglected field, we might have become too caught up dialoguing about the comparative value of ‘FBOs’, and have invested less energy in gathering evidence on how religion and religious values might work as a motivational force or have an impact on behavior in and through institutions and initiatives not currently classified as ‘religious’. In a research study in Zambia and Lesotho, local communities identified the

exemplar community initiatives working in HIV/AIDS as those who both demonstrated (the expected) solid programmatic, operational, and associative characteristics; and then infused these with ‘intangible’ religious factors such as a particular kind of compassionate care or hope (ARHAP 2006). This implies that to understand local community initiatives in Africa, it is often necessary to go beyond standard evaluation measures when we compare REs to their ‘secular’ counterparts, to also consider creative ways for evaluating and better understanding ‘the religious’ elements and values in initiatives across the board. As ARHAP (2006) argued, “...*engagement with REs must not be with an eye to ‘convert’ them to exemplary NGOs and diminish the very intangible dimension that distinguishes their contribution to health...The opportunity is not to turn public structures into religious ones or to turn religious structures into public ones, but to gain the benefits of the alignment of their respective strengths for the community.*”<sup>8</sup>

Finally, REs do not function in a secular vacuum, and it is important that religious response be evaluated as part-of local community, rather than apart-from. This is emphasized by a local mapping exercise in Zambia and Lesotho, where in every site, local health seekers emphasized how religious initiatives always operate in partnership with a range of ‘partner initiatives and institutions’ (ARHAP 2006). The real challenge is therefore how to gather systematic evidence that is inclusive of religion and religious initiatives, but in doing so does not cut these off from the comparative context of the communities in which they are located.

### **Summing up: Generalization is dangerous**

All this talk of typologies and classifications may seem a bit too much like a descriptive word game – particularly frustrating for those dealing with the everyday challenges of working in resource-constrained environments. However, these ‘words’ are the building blocks upon which international and national policy relevant dialogue are built. The battles over naming REs appear to be less about finding the best terminology, and more as a result of ill-fitting and chafing evidential frameworks – highlighting the fragility of our knowledge systems and methods of inquiry. We provide here no ready answers - and certainly no suggestions for new terminologies - but it is worth noting that the continued debates over finding a broad generic term for REs or a sustained set of subcategories has been unhelpful and may have exacerbated the lack of systematic evidence and policy engagement. This is less a concern about reaching a mass consensus on terminology, and more about serious assessment of the basic units of analysis and the frameworks being applied. Only then can a more systematic (and comparative) evidence-base be established, for more relevant and strategic policy engagement.

---

<sup>8</sup> The African Religious Health Assets Programme (ARHAP) has suggested the ‘religious health asset’ (RHA) framework and language, which seeks to circumvent some of these classification issues. An RHA is described as a (tangible or intangible) asset located in or held by a religious entity that can be leveraged for the purposes of development or public health. The approach goes beyond the more easily identifiable tangible assets, e.g. buildings and equipment, to include what have been described as ‘intangible’ health determinants. These include aspects of health behaviour modification programmes and the beliefs, values and commitment of health workers. The focus on intangible assets makes possible an assessment of the contribution of FBOs not merely as alternative health service providers (see Schmid et al 2008).

As a result of the transverse slicing of the field, where an interest in the ‘faith sector’ is not rooted in any single field, interest or particular set of indicators – terms such as ‘FBO’ have generally lost any specific meaning or definition, and this makes any comparison of data between studies of the religious response to HIV/AIDS in Africa difficult, if not impossible (Olivier 2010 and 2011, Schmid et al 2008). As a result, there is also little consensus on which parts of the ‘faith sector’ are best targeted for specific strategies, which areas require more support, or where comparative strengths and weaknesses might be evidenced. It should be clear by now that generalizations about the generic ‘faith sector’ or the generic ‘FBO’ might be a powerful advocacy tool, but has limited value as an evidential or analytical measure. How necessary is it really to prove that *all* REs are comparatively more networked? Or that *all* REs are weak in the area of documentation? The huge variety and contextual variation within the ‘faith sector’ makes any generalized statement about the comparative value of REs immediately suspect and open to critique.

### **TOWARDS OPERATIONAL TYPOLOGIES: AN ILLUSTRATION**

It should be clear from the two previous sections that the assessment of the religious community response to HIV/AIDS appears through a diverse and at times opposing array of lenses. This lack of consensus is probably one of the reasons why existing frameworks and typologies have had so far a limited ability to inform policy-level engagement, especially that relating to operational action. They also have not helped as much as was hoped in providing a more systematic understanding of the response itself. Given that the HIV/AIDS thematic is an area around which some policy actions still remain controversial, at least for some, disagreements in perceptions and points of view are likely to remain for some time. But this does not mean that progress cannot be accomplished.

Consider the case of methodological approaches. There is still tension in getting the right balance between qualitative, context-rich information which can describe different formations of community response, and systematic quantitative assessments which require standardization of data and language. But there seems to be more consensus today that both forms of empirical evidence are needed – especially in evaluation of HIV/AIDS response. What is then missing is the toolset that could more adequately integrate multiple (and diverse) data streams or dimensions for systematic analysis of complex community contexts. Such integrative methods are required to answer specific questions such as which population is best served by religious initiatives, or what impact individual religious leaders may be having on behaviour change for HIV/AIDS response. Acknowledging the challenges and inherent complexity of religious community responses, the gathering of baseline data focusing on integrating data streams and frameworks could help move the policy discussion further.

In this last section, our objective is very limited. We hope to suggest with a simple conceptual illustration how the combination and visualization of various data sources or typologies could indeed be useful in providing more operationally-oriented typologies. It is of course much easier to review and point to the limits of existing typologies, as we did

in the previous section, than to provide new ideas that help overcome some of those limits. We are conscious of the fact that what we are suggesting in this section remains embryonic, but the idea is to try to show how some of what has been discussed in the literature can be harnessed in more user friendly ways so that the information can be actually used by policy makers faced with difficult trade-offs. Essentially, what we suggest is to combine various dimensions or typologies in such a way that they may highlight what exists on the ground, and what is missing to help households cope with HIV/AIDS. This is done using matrix-based visualizations, as is often done in management practice. We provide only one example here, but many alternatives could be proposed as well.

In the review of the literature in the previous section, two of the distinctions that were made when describing the role of REs were first the classification by form, pointing especially to the range existing REs from purely informal to purely formal organizations (i.e., who is providing services and benefits), and second the classification by function, which relates to the types of services that are being provided (i.e., what services or benefits are being provided in various areas, including prevention and care, and by whom). Both classifications are important for policy. Ultimately, policy focuses on the types of services to be provided. In addition, because policy requires institutional instruments and accountability frameworks for implementation, forms – whether REs and other providers are formal or informal - also matters. But what we would like to suggest is that the combination of these two types of classifications may provide more insights for policy makers than each of the two classifications taken on its own.

One more important methodological point must be made regarding the scope and nature of the application of typologies aiming to inform policy. We are considering the context of a secular state that does not have any aims pertaining to religion per se. This means that any new typology or combination of new typologies could consider the ‘comparative value’ of REs, but only in its secular aspects. For example, it could be that faith itself is the key behind the success of a particular intervention, and that this intervention in turn strengthens the faith of those exposed to it – which is perhaps in large part why REs implemented the intervention in the first place. But a secular state would probably (in most cases) fund only the ‘secular’ component of the intervention, and judge its outcome only in secular terms.<sup>9</sup> In addition, a secular government aiming to support and coordinate the overall response to HIV/AIDS should clearly map all of the activities that may contribute to specific objectives in this area, and not only those managed by REs. That is, in seeking a comprehensive and systematic understanding of community responses to HIV/AIDS, it is necessary to be inclusive of a wide range of forms of community initiatives in order to account for both formal organizational response as well as informal community initiatives which might not have any organizational (or physical) structure and be significantly more fluid in nature, and it is also necessary to include both secular organizations and REs, as well as whomever falls in between (under the religiosity typology).

---

<sup>9</sup> This is admittedly quickly said, and the issue of what a secular state should and should not do in interacting with religion is much more complex, but we wish not to delve in this here.

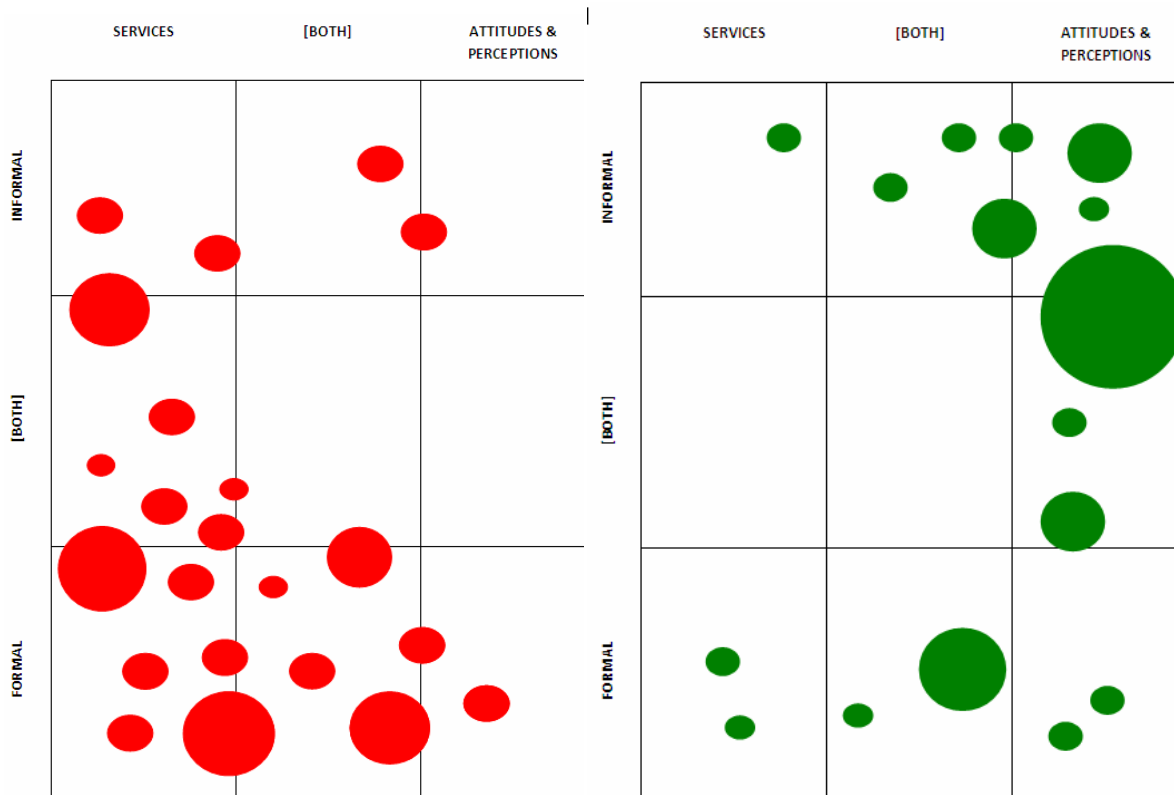
Consider then as an illustration of policy-oriented typology the matrix in Figure 1, which combines the classifications by form and by function. Community initiatives – whether religious or not – are placed on the vertical axis on the basis of their form: whether they are *formal, informal, or a combination* of both or some intermediary nature. We say then an intervention is formal if it is implemented by an organization with some form of institutional infrastructure and status. This might be a facility, legal registration, bank account, management committee, defined responsibilities, paid staff, strategic plans, or benefit from external support (e.g. CBOs, NGOs, or health facilities). We define as informal the myriad varieties of initiatives and responses that usually do not conform to these criteria and thus typically would not have a facility, organizational infrastructure, or even necessarily a name, often relying on voluntary effort, and operating without external support. By emphasizing the level of formalization we circumvent some of the problematic labels, and rather focus evidence gathering on what capacity and resources are available, and in what form. This does not imply that one form has greater value than another, but rather that for strategic purposes, it is critical that policy makers know, for example, whether the interventions are being enacted by a faith-inspired university hospital, or an initiative being run out of a local congregation. As many studies have shown, the local and community informal responses are frequently more powerful at a local level. But lack of formality also often makes it more difficult for Ministries or local authorities to support such initiatives. One of the lingering questions, therefore, is how to ‘formalize’ (at least partially) such initiatives without destroying the very fabric of the communities that helped them flourish, or the flexible and supportive nature of their initiative.

A second critical differentiation, especially in the area of HIV/AIDS, relates to the kinds of activities in which REs and other organizations are primarily engaged, or the function they serve. As argued above, the literature addressing the religious response to HIV/AIDS demonstrates two main concerns for the comparative value of religious community initiatives – on the one hand, service provision, and on the other, the potential for faith communities to influence individual or community behaviors and attitudes, particularly in relationship to HIV/AIDS. It should thus be helpful for those working at an implementation or policy level to know which REs and other initiatives are more geared towards service provision (such as a home-based care group, or the extensive non-state service provision provided by the Christian Health Associations), and which have more potential in areas of community engagement and impact on behavior and attitudes (such as an individual religious leader or a small group of women from a congregation influencing sexual behavior). Again, this can be expressed as a range – given that many programs are engaged in both types of work, and again, no value judgment should be made as to whether service delivery is more important than work related to behaviors and attitudes.

Different community activities (religious or not) could be mapped onto such a matrix. Each activity would be represented by a circle whose size could be proportional, say, to the number of people reached, or depending on the use of the typology, to the cost of the activity or even the likely impact of an activity on specific targets related to HIV/AIDS if

that information is available. Different colors could be used to represent activities benefiting from government support, as compared to activities that do not benefit from such support, or urban-rural service allocations, or a distinction between faith-inspired and secular interventions. Based on the qualitative research done to-date, we would expect that in some community contexts, the matrix might look very different from what is going on in another community, and this can be helpful in assessing which types of policy/program interventions need to be supported more, or created.

**Figure 1: Illustrative Typology of Community Responses to HIV/AIDS**



Source: Authors.

Note: The matrices illustrate conceptually how two different community contexts might look, and are not representative of any particular country or local context.

For example, one could expect that in many Francophone Africa, faith-inspired networks of formal service providers (such as the Christian Health Associations) tend to be less developed and have smaller memberships, while in Anglophone Africa, these networks often account for 30 percent to 40 percent of hospital facilities. We would also expect more formal NGOs to be present at the local level in a typical Anglophone African country than in a Francophone one. But there may be fewer differences in the role of informal networks and interventions between the two types of countries (we simply do not yet know). But the more general conclusion is that this type of visualization may help in assessing whether more support is needed for service delivery as opposed to interventions aiming to change behaviors and attitudes, and whether the type of support

provided needs to be adapted to take into account the more or less formal nature of the organizations or groups implementing the interventions.

This visualization is admittedly very simple, but such methods can be used as a starting point, provided the evidence is indeed gathered, which should not be too difficult at least at the local level (national inventories are much more complex to assemble given the need to carry out extensive mapping work first). Such visualizations can help identify weaknesses, strengths, gaps and potential areas of overlaps in various areas of the community response, and more generally in re-orienting resources in order to achieve higher overall impact. Importantly, such visualizations seek to blend several different types of data, and can also be useful in making more apparent the inadequacy of assessments which focus only on particular aspects of the religious and other community responses and are not inclusive of the range of other supportive activities in which the REs (and other initiatives) may be engaged. Further work is of course needed to test empirically whether mixed typologies such as the illustration suggested here indeed work, but this is the type of work that seems required today in order to make analysis of the community response more operationally relevant, while still acknowledging the inherent complexity of this response.

## CONCLUSION

The comparative value of religious entities or responses to HIV/AIDS as they emerge from communities of faith is still difficult to prove based on the current evidence at hand. Broad advocacy statements of comparative advantage (or disadvantage) of the ‘faith sector’ or the generic ‘FBO’ should be avoided where possible. Such broad-scale assumptions may do more damage than good as they tend to get immediate pushback from international and ‘secular’ audiences when they are positive – and conversely, broad statements of comparative disadvantage get immediate pushback from religious groups and institutions who do not feel they are adequately understood or assessed fairly. Instead of such broad statements, focusing on specific and targeted comparative assessments at the local level – that is, close assessment of comparative strengths and weaknesses, can help design better and more targeted interventions.

It is however important that in the research agenda on the religious response to HIV/AIDS, we do not shy away from complexity. Religion, religious institutions and community initiatives are by nature diverse and complex. And indeed, ‘simple’ solution to the HIV/AIDS pandemic has been challenged. Peter Piot said as he opened the Mexico AIDS Conference in 2008, *“Let’s never forget that the epidemic could still bring us new surprises – as it has done so many times already. If we are to get ahead of this epidemic, it is time to come to terms with complexity...”* In some cases, it may even be the complexity (or richness) of a contextually-specific local response that provides added value. The challenge is therefore to work towards multidisciplinary methods of describing and assessing such complexity in a way that is not only conscious of the intricate collaborative environment in which interventions and evidence-gathering take place, but also does not weaken the initiatives we are seeking to support through ill-fitting classification or policy-level paralysis. While improving typologies in this area

will remain messy and imperfect work, it appears to be worth the continued effort – and although discussions of evidence, typologies and classifications might seem technical or even abstract, at their heart is a basic understanding that there is potential and opportunity here for positive change.

## REFERENCES

African Health Assets Programme (ARHAP). 2006. *Appreciating Assets: The Contribution of Religion to universal access in Africa*, Cape Town: African Religious Health Assets Programme.

\_\_\_\_\_. 2007. PIRHANA Workshop Report: Uganda, Kampala. Cape Town: African Religious Health Assets Programme.

Agadjanian, V., and S. Sen. 2007. “Promises and Challenges of Faith-Based AIDS Care and Support in Mozambique.” *American Journal of Public Health* 97 (2):362-366.

Asad, T. 2003. *Formations of the Secular: Christianity, Islam, Modernity*. Stanford: Stanford University Press.

Benn, C. 2002. “The Future Role of Church Related Hospitals and Health Services in Developing Countries.” Edited by DIFAEM, Tubingen: German Institute for Medical Mission.

\_\_\_\_\_. 2003. “Why Religious Health Assets Matter.” In *ARHAP: Assets and Agency Colloquium*, Pietermaritzburg: ARHAP.

\_\_\_\_\_. 2009. “The Continued Paradigm Shift in Global Health and the Role of the Faith Community.” In *ARHAP Conference: When Religion and Health Align - Mobilizing Religious Health Assets for Transformation*. Cape Town: African Religious Health Assets Programme.

Berger, P. L. 1999. “The Desecularization of the World: A Global Overview.” In P. L. Berger, *The Desecularization of the World: Resurgent Religion and World Politics*. Washington, DC: Ethics and Public Policy Centre.

Bradley, T. 2009. “A Call for Clarification and Critical Analysis of the Work of Faith-Based Development Organizations (FBDOS).” *Progress in Development Studies* 2:101-14.

Brundtland, G. H. 2000. “Massive Effort Advocacy Meeting.” *Winterhur*, 03 October 2000.



Center for Interfaith Action on Global Poverty (CIFA). 2010. *Many Faiths, Common Action: Increasing the Impact of the Faith Sector on Health and Development - A Strategic Framework for Action*. Washington, DC.

Center for International and Regional Studies (CIRS). 2008. *Symposium: Global Development and Faith-Inspired Organizations in the Muslim World*. Doha: CIRS and Berkley Center for Religion, Peace and World Affairs.

Chambré, S. M. 2001. "The Changing Nature of 'Faith' in Faith-Based Organisations: Secularisation and Ecumenicism in Four AIDS Organisations in New York City." *Social Service Review* September: 435-455.

Clarke, G. 2006. "Faith Matters: Faith-Based Organizations, Civil Society and International Development." *Journal of International Development* 18: 835-848.

Cochrane, J. R. 2008. "Fire from Above, Fire From Below: Health, Justice and the Persistence of the Sacred." *Theoria* 116: 67-96.

\_\_\_\_\_. 2006. "Religion, Public Health and a Church for the 21st Century." *International Review of Mission* 95, no. 376-377: 59-72.

\_\_\_\_\_. 2006. "Understanding Religious Health Assets for Public Health Systems." Paper Presented at the DIFAM Consultation on Religion and Health, Tübingen, Germany, February.

\_\_\_\_\_. 2003. "Religion as Social Capital in the Context of Health: Mapping the Field." In *ARHAP: Assets and Agency Colloquium*, Pietermaritzburg: African Religious Health Assets Programme.

Derrida, J., and G. Vattimo. 1998. *Religion: Cultural Memory in the Present*. Cambridge: Polity Press.

Dilger, H. J. 2009. "Doing Better? Religion, the Virtue-Ethics of Development, and the Fragmentation of Health Politics in Tanzania." *Africa Today* 56 (1): 89-108.

Doupe, A. 2005. "Partnerships Between Churches and People Living with HIV/AIDS Organizations." Geneva, Switzerland: World Council of Churches.

Ellis, S., and G. TerHaar. 2001. *Worlds of Power: Religious Thought and Political Practice in Africa*. Johannesburg: Witwatersrand University Press.

Farmer, P. 1999. *Infections and Inequalities: The Modern Plagues*. Berkeley, LA: University of California Press.

Formicola, J. R., M. Segers, and P. Weber. 2003. *Faith-Based Initiatives and the Bush Administration: The Good, the Bad and the Ugly*. Lanham: Rowman and Littlefield.

Foster, G. 2004. "Study of the Response by Faith-Based Organizations to Orphans and Vulnerable Children." New York: World Conference of Religions for Peace and United Nations Children Fund.

Fox, D. M. 1992. "The Politics of HIV Infection: 1989-1990 as Years of Change." In E. Fee and D.M. Fox, eds, *AIDS: The Making of a Chronic Disease*. Berkeley: University of California Press: 125-143.

Garner, R. C. 1999. "Religion in the AIDS Crisis: Irrelevance, Adversary or Ally?" *AIDS Analysis Africa* 10: 6-7.

Green, E. C. 2003. "Faith-Based Organizations: Contributions to HIV Prevention." Washington DC: US Agency for International Development and The Synergy Project, TvT Associates, Harvard Center for Population and Development Studies.

Haddad, B., J. Olivier, and S. De Gruchy. 2008. "The Potential and Perils of Partnership: Christian Religious Entities and Collaborative Stakeholders Responding to HIV and AIDS in Kenya, Malawi and the DRC." Study Commissioned by Tearfund and UNAIDS. Cape Town: Africa Religious Health Assets Programme.

Kim, J. Y, J. V. Millen, A. Irwin, and J. Gershman, eds. 2000. *Dying for Growth: Global Inequality and the Health of the Poor*. Monroe: Common Courage Press.

Liebowitz, J. 2004. "Faith-Based Organizations and HIV/AIDS in Uganda and KwaZulu-Natal." Health Economics and HIV/AIDS Research Division, University of KwaZulu Natal.

\_\_\_\_\_. 2002. "The Impact of Faith-Based Organizations on HIV/AIDS Prevention and Mitigation in Africa." Health Economics and HIV/AIDS Research Division, University of KwaZulu Natal.

Luker, V. 2004. "Civil Society, Social Capital and the Churches: HIV/AIDS in Papua New Guinea." In *Techreport*, State Society and Governance in Melanesia Project (RSPAS), ANU.

Lux, S., and K. Greenaway. 2006. "Scaling up Effective Partnerships: A Guide to Working with Faith-Based Organisations in the Response to HIV and AIDS." Church World Service, Ecumenical Advocacy Alliance, Norwegian Church Aid, UNAIDS, World Conference of Religions for Peace.

Marshall, K. 2009. "Confronting Religionophobia." *Washington Post*, August 10, 2009.

Martens, K. 2002. "Mission impossible? Defining Nongovernmental Organizations." *Voluntas* 13(4): 271-285.

Melkote, S. R., and H. L. Steeves. 2001. *Communication for Development in the Third World: Theory and Practice for Empowerment*. London: Sage.

Olivier, J. 2011. "An FB-oh?: Mapping the Etymology of the Religious Entity Engaged in Health." In B. Schmid, Cochrane, J. R. and T. Cutts, eds *When Religion and Health Align: Mobilizing Religious Health Assets for Transformation*. Pietermaritzburg: Cluster Publications.

\_\_\_\_\_. 2010. "In Search of Common Ground for Interdisciplinary Collaboration and Communication: Mapping the Cultural Politics of Religion and HIV/AIDS in sub-Saharan Africa." PhD Dissertation. University of Cape Town.

Olivier, J., and P. Clifford. 2011. "Religious Community Care and Support in the Context of HIV and AIDS: Outlining the Contours." In B. Haddad, editor, *Religion and HIV/AIDS: Charting the Terrain*. Pietermaritzburg: Cluster Publications.

Olivier, J., J. R. Cochrane, and B. Schmid. 2006. "ARHAP Literature Review: Working in a Bounded Field of Unknowing." Cape Town: African Religious Health Assets Programme.

Piot P. 2008. "Don't Give up the Fight!" In *XVIIth International AIDS Conference*, Mexico City, Mexico: UNAIDS.

Pisani E. 1999. "Acting Early to Prevent AIDS: The Case of Senegal." In *Best Practice Collection*. Geneva: Joint United Nations Programme for HIV/AIDS.

Plummer K. 1988. "Organizing AIDS." In P. Aggleton and H. Homans, eds, *Social Aspects of AIDS*. London: The Falmer Press.

President's Emergency Plan for AIDS Relief (PEPFAR). 2009. "Working with Community-Based and Faith-Based Organisations." Washington, USA.

Rodriguez-Garcia, R., R. Bonnel, N. N'Jie, J. Olivier, F. Pascual, and Q. Wodon. 2011. *Analyzing Community Responses to HIV and AIDS: Operational Framework and Typology*. Policy Research Working Paper 5532, World Bank, Washington, DC.

Rosenberg, C. E. 1992. *Explaining Epidemics: And Other Studies in the History of Medicine*. Cambridge: Cambridge University Press.

Schmid, B., E. Thomas, J. Olivier, and J. R Cochrane. 2008. "The Contribution of Religious Entities to Health in sub-Saharan Africa." Cape Town: African Religious Health Assets Programme.

Seidel, G. 1993. "The Competing Discourses of HIV/AIDS in sub-Saharan Africa: Discourses of Rights and Empowerment vs Discourses of Control and Exclusion." *Social Science & Medicine* 36: 175-194.

Sider, R., and H. R. Unruh. 2004. "Typology of Religious Characteristics of Social Service and Educational Organizations and Programs." *Nonprofit and Voluntary Sector Quarterly* 33: 109-134.

Taylor, N. 2005a. "Many Clouds, Little Rain?" The Global Fund and Local Faith-Based Responses to HIV and AIDS. Teddington: Tearfund.

\_\_\_\_\_. 2005b. "The Warriors and the Faithful: The World Bank MAP and Local Faith-Based Initiatives in the Fight Against HIV and AIDS." Teddington: Tearfund.

\_\_\_\_\_. 2006. "Working Together? Challenges and Opportunities for International Development Agencies and the Church in the Response to AIDS in Africa." Teddington: Tearfund.

\_\_\_\_\_. 2007. "DFID, Faith and AIDS: A Review for the Update of Taking Action." London: UK Consortium on AIDS and International Development.

TBFF. 2009. "Faith and Malaria: Towards an Integrated Solution." In *Faith and Malaria*, Yale University: Tony Blair Faith Foundation, Yale University and Center for Interfaith Action on Global Poverty.

Thomas, E., B. Schmid, M. Gwele, R. Ngubo, and J. R. Cochrane. 2006. "Let us Embrace: The Role and Significance of an Integrated Faith-Based Initiative for HIV and AIDS." Cape Town: African Religious Health Assets Programme.

Treichler, P. 1992. "AIDS and HIV Infection in the Third World: A First World Chronicle." In E. Fee, and D.M. Fox, eds, *AIDS: The Making of a Chronic Disease*. Berkeley: University of California Press.

United Nations Programme on HIV/AIDS (UNAIDS). 2009. *Partnership with Faith-Based Organizations: UNAIDS Strategic Framework*. Geneva.

Weeks, J. 1989. "AIDS: The Intellectual Agenda." In P. Aggleton, G. Hart and P. Davies, eds, *AIDS: Social Representations, Social Practices*, New York: The Falmer Press.

World Health Organization (WHO). 2004. "The World Health Report 2004: Changing History, Community Participation in Public Health." Geneva.

WHO-CIFA. 2009. "NGO Mapping Standards Describing Religious Health Assets." Chateau de Bossey Conference Center - Geneva, Switzerland, 10-12 November 2009.

Woldehanna, S., K. Ringheim, C. Murphy, et al. 2005. "Faith in Action: Examining the Role of Faith-Based Organizations in Addressing HIV/AIDS - A Multi Country Key Informant Survey. Washington, DC: Global Health Council.