

**HIV/AIDS Prevention Policy Processes in
Faith-Based Non-Governmental Organizations
in Tanzania**

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Abstract

Many faith-based organizations (FBOs) are providing valuable care and support to people living with and affected by HIV/AIDS. The overall response of FBOs, however, has been controversial, particularly in regards to HIV/AIDS prevention and FBO's rejection of condom use and promotion. This response has negatively influenced national HIV/AIDS prevention response efforts.

The aim of this thesis is to explore the factors influencing the HIV/AIDS prevention policy process within faith-based non-governmental organizations (NGOs) of different faiths, and in particular how faith is reflected in and interacts with this process. These processes were examined within three faith-based NGOs in Dar es Salaam, Tanzania – a Catholic, Anglican and Muslim organization. The research used an exploratory, qualitative case-study approach. It employed a health policy analysis framework, examining the context, actor, and process factors and how they interact to form content in terms of policy and practice within each organization.

Three key factors were found to influence faith-based NGOs' HIV/AIDS prevention policy process in terms of both policy development and implementation: 1) the faith structure in which the organizations are a part, 2) the presence or absence of organizational policy, and 3) the professional nature of the organizations and its actors. The interaction between these factors, and how actors negotiate between them, was found to shape an organization's HIV/AIDS prevention policy process.

By understanding the factors and processes that influence faith-based NGOs' HIV/AIDS prevention policy process, and how this conflicts with the national policy response, more appropriate policies can be developed and implemented within faith-based NGOs. Furthermore, the government may be better able to identify how best to intervene and/or work with faith-based NGOs in order to meet their HIV/AIDS prevention targets, and achieve a more uniform and evidence-based approach to HIV/AIDS prevention.

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Abbreviations

- AIDS - Acquired Immune Deficiency Syndrome
- AMREF – African Medical Research Foundation
- ARHAP – African Religious Health Assets Program
- ART – Anti-Retroviral Treatment
- BAK-AIDS – BAKWATA National HIV/AIDS Program
- BAKWATA – Baraza Kuu La Waislamu Tanzania (The National Muslim Council of Tanzania)
- BRELA – Business Registrations and Licensing Agency
- CBO – Community Based Organization
- CCT – Christian Council of Tanzania
- CMAC - Council Multicultural AIDS Committee
- COMATAA - Community Mapping and Theatre against HIV/AIDS
- COSTECH – Commission for Science and Technology
- CSO – Civil Society Organization
- CSSC – Christian Social Services Commission
- CSW – Commercial Sex Worker
- FBO – Faith-Based Organization
- HBC – Home-Based Care
- HIV – Human Immunodeficiency Virus
- HIV/AIDS – Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
- HSHP – Health Sector HIV and AIDS Strategic Plan
- IEC – Information, Education, and Communication
- IMF – International Monetary Fund
- LIHS – Leeds Institute of Health Sciences
- MCDGC - Ministry of Community Development, Gender and Children
- MFHLE - Muslim Family Health Life Education
- MoH – Ministry of Health
- MoHSW – Ministry of Health and Social Welfare
- MSM – Men who have sex with men
- MTP – Medium Term Plan
- NACP – National AIDS Control Programme
- NBS – National Bureau of Statistics
- NGO – Non-Governmental Organization

NIMR – National Institute for Medical Research
NMSF – National Multi-Sectoral Strategic Framework on HIV and AIDS
OVC – Orphans and Vulnerable Children
PASADA – Pastoral Activities and Services for People with AIDS
PLWHA – People Living with HIV/AIDS
PMTCT – Prevention of mother-to-child transmission
RFE – Rapid Funding Envelope
RITA – Registration, Insolvency, and Trusteeship Agency
STD – Sexually Transmitted Diseases
STI – Sexually Transmitted Infection
STP – Short Term Plan
TACAIDS – Tanzania Commission for AIDS
TB – Tuberculosis
TEC – Tanzania Episcopal Conference
THMIS - Tanzania HIV/AIDS and Malaria Indicator Survey
UMFAA – United Muslim Fighters Against AIDS
UNAIDS - Joint United Nations Programme on HIV/AIDS
UNICEF – United Nations Children's Fund
URT – United Republic of Tanzania
URT-PMO – United Republic of Tanzania Prime Minister's Office
USAID – United States Agency for International Development
VCT – Voluntary Counselling and Testing
WHO – World Health Organization

Chapter 1 – Introduction to Thesis

1.1 Introduction to Thesis

The aim of this study is to gather new evidence and gain further theoretical understanding of the factors influencing the HIV/AIDS prevention policy processes within faith-based organizations¹ (FBOs), by examining the policy process of three faith-based non-governmental organizations (NGOs) of different faiths in Tanzania. This introductory chapter outlines the background and rationale of the study by identifying the gap in current literature, presents the study's objectives and research questions, and provides an outline of the thesis.

1.2 Background and Rationale

Until recently, the separation of church and state has been an underlying feature, and often condition, of development for many low to middle income countries (Ellis & ter Haar, 2004b). The assumption within the literature was that as countries became increasingly developed, the public role of religion would decline and religion would be consigned to a matter of private belief (Ellis & ter Haar, 2004a). However, this “secularization thesis” – the view that there would be a worldwide decline in religion as development produced more secularized states – has been proven incorrect; instead religion and religious networks have gained increasing prominence particularly in low to middle income countries (Olivier, et al., 2006). According to the African Religious Health Assets Programme² (ARHAP 2006), religion is vibrant in Africa – “Christianity in the South and Islam in the North and West are the major mainstream religions in Africa and most Africans would label themselves as one or the other” (*ibid.*, 9). At the same time, African traditional religions remain prominent and are often practiced simultaneously with Christianity and Islam (*ibid.*). The role of religion in development, therefore, has received an increasing amount of attention; and within this, the role of religion in health.

Religion impacts on health in many ways, such as by reducing risk behaviours associated with sexually transmitted diseases and by acting as a source of hope and encouragement when people fall ill. I am interested in the role of religious organizations, or faith-based

¹ The term “faith-based organization” has been used to encompass “any religion, religious communities, religious institutions, faiths and denominations” (Parker & Birdsall, 2005: 11), and often includes both “places of worship and their members as well as any organization affiliated with or controlled by these houses of worship” (Liebowitz, 2002: 2). See section 2.3.1 for further discussion on FBOs.

² The African Religious Health Assets Programme is “an international research collaboration working on the interface of religion and public health, with a focus on Africa” (ARHAP, 2011). Since data collection its name has been changed to the International Religious Health Assets Programme.

organizations (FBOs) in health and health service provision. FBOs, for example, are often praised for being long time providers of health care facilities and services, and in particular for establishing programs for HIV prevention and mitigation, such as providing care and support for people living with HIV/AIDS (PLWHAs) and orphan support (ARHAP, 2006; Liebowitz, 2002; Olivier, et al., 2006; Parker & Birdsall, 2005). At the same time, however, some FBOs are criticized for their approach to sexual and reproductive health issues, such as resistance to condom use and abortion, and refusal to provide services for non-married men and women (Liebowitz, 2002; Olivier, et al., 2006). There are conflicting views on the role of FBOs in health and health service provision but it is important to recognize the potential impact FBOs might have, whether positive or negative; this is especially important as FBOs are becoming increasingly significant players (*ibid.*).

It is currently estimated that 30-70%³ of all health care provision and education in Africa is provided by FBOs (Olivier, et al., 2006). There is currently an array of research attempting to understand better the exact role of FBOs in health and health service provision and attempts to record and map such provision have been undertaken (ARHAP, 2011; Olivier, et al., 2006). Due to the scale and impact of the HIV/AIDS epidemic and due to FBOs' involvement, such research has particularly drawn attention to the role of FBOs in HIV/AIDS prevention and mitigation (Liebowitz, 2002; Tiendrebeogo & Buyckx, 2004a). According to Olivier et al. (2006), since 2000 the faith-based response to HIV/AIDS has proliferated at an astounding rate, making FBOs significant players in the response to HIV/AIDS. In response to this there have been calls for further research in order to understand better the response of FBOs to HIV/AIDS (ARHAP, 2006; Liebowitz, 2002; Olivier, et al., 2006; Tiendrebeogo & Buyckx, 2004a).

As suggested above, FBOs' overall response to HIV/AIDS has not been without controversy. Within the literature, FBOs' positive contribution to HIV/AIDS is often recognized in relation to HIV/AIDS care and support (Liebowitz, 2002; Olivier, et al., 2006). At the same time, however, their response to HIV/AIDS has also been criticized for undermining overall response efforts (Casale, et al., 2010; Dilger, 2009; Dilger, et al., 2010; Liebowitz, 2002; Tiendrebeogo & Buyckx, 2004a). Such criticisms have predominately surrounded FBOs' role in HIV/AIDS prevention (Casale, et al., 2010; Tiendrebeogo, et al., 2004b). According to Casale *et al.* (2010), FBOs' involvement in HIV prevention has been limited compared to their involvement in HIV/AIDS-

³ The exact percentage of health service provided by FBOs is unknown and differs between countries. Olivier et al. (2006) for example recognize that there is frequently contradictory and confusing evidence regarding FBOs' health service provision. What is evident, however, is that there is convincing evidence of the scale in which FBOs are involved in health service provision in Africa.

related care, and arguably less effective. This may be due to the theological challenges inherent in issues surrounding sexual behaviour, particularly around condom use and promotion and sex outside marriage, each of which are part of HIV prevention (*ibid.*). FBOs' approaches to HIV/AIDS prevention in particular are criticized for being unrealistic, unjust, and dangerous, contributing to inequity and HIV-related stigma (Campbell, et al., 2005; Casale, et al., 2010; Denis, 2009). At the same time, however, many authors have argued for FBOs' involvement in HIV/AIDS prevention due to such things as their moral authority over issues closely connected to HIV/AIDS and their ability to reach large groups of people through existing networks (Liebowitz, 2002; Parker & Birdsall, 2005).

The significance of FBOs in HIV/AIDS response efforts and the magnitude of HIV/AIDS in sub-Saharan Africa has meant that government decision-makers need to engage with FBOs in order to ensure that appropriate and effective programmes and interventions are put in place (ARHAP, 2006). The benefits of the government and public sector engaging with FBOs at the national and local levels have been well documented and there has been an increasing drive to create partnerships with such organizations (Green, 2001; Liebowitz, 2002; Lux & Greenaway, 2006). However, there is still a lack of understanding about what FBOs are and how they operate, particularly in regards to the theological component of FBOs which drives their HIV/AIDS response (*ibid.*). This is especially the case regarding the role of religion at the operational and institutional level of FBOs – for example at the level of decision and policymaking – where an organization's HIV/AIDS response is developed. According to the African Religious Health Assets Program (ARHAP) (2011), for example:

[w]hat is largely missing from most studies [...] is the dimension of religion that is "internal" to faith based communities or organizations, an element that explains their motivations, commitments, attitudes, actions and relational or associational strengths on the basis of their own self-understanding and world-views.

ARHAP believes that the religious-specific aspects of FBOs – the non-visible “volitional, motivational and mobilizing capacities that are rooted in affective and symbolic dimensions of religious faith, belief and behaviour” – are what makes FBOs different from other health organizations and structures (quoted in Thomas, et al., 2006: 12). They argue that it is this difference that puts FBOs in a unique and strategic position to positively influence the HIV/AIDS epidemic, while at the same time recognizing the potential negative influence that these ideological differences can have, such as those described above.

From the above it is clear that FBOs are important actors within overall HIV/AIDS response efforts; however, currently there is a lack of understanding regarding FBOs' HIV/AIDS responses, particularly in the area of HIV/AIDS prevention. To date, there are no known studies exploring FBOs' HIV/AIDS policy processes, and in particular the role of faith within this process. I believe that in order to engage adequately with such organizations and effectively include them in national HIV/AIDS response efforts, there needs to be an understanding of the factors that shape FBOs' HIV/AIDS prevention policy processes, and in particular how faith is reflected in, and interacts with, this process, which will influence FBOs' overall HIV/AIDS prevention response. By doing so I hope that this research will contribute to a greater understanding of how faith is conceptualized and utilized by FBOs in the fight against HIV/AIDS, in order to understand better the effect of the faith-based response on national HIV/AIDS prevention efforts, and improve the overall role of FBOs in the fight against HIV/AIDS.

1.3 Focus of the Study

This thesis explores the factors influencing the HIV/AIDS prevention policy process within faith-based NGOs. The broad aim of this study is to gain a better understanding of the faith-based HIV/AIDS response. This will be accomplished through its more specific aim – to gather new evidence on, and gain further theoretical understanding of, the factors influencing the HIV/AIDS prevention policy process, and in particular how faith is reflected in, and interacts with, this process within faith-based NGOs of different faiths in Tanzania. As will be discussed in Chapter 2, faith-based NGOs are a sub-set of FBOs and were chosen for this study due to their long tradition of providing relief and social services in many economically disadvantaged areas of the world, particularly in the area of HIV/AIDS.

1.3.1 Research Objectives and Questions

The study aim is achieved by addressing the following research objectives and corresponding research questions. The research objectives and questions were developed according to the conceptual framework presented in Chapter 2. The research objectives, and corresponding questions, are presented in Table 1.

Table 1 – Research Objectives and Questions

Research Objectives	Research Questions
<p>1. Identify and assess what factors influence the HIV/AIDS prevention policy process of faith-based NGOs, in relation to process, context, actors, and content.</p>	<p>1.1 What key contextual factors influence the HIV/AIDS policy process of each faith-based NGO?</p> <p>1.2 What key process factors influence the HIV/AIDS policy process of each faith-based NGO?</p> <p>1.3 What actors and actor-related factors influence the HIV/AIDS policy process of each faith-based NGO?</p> <p>1.4 What is the HIV/AIDS prevention policy content, in terms of policy and practice, in each faith-based NGO?</p>
<p>2. Identify and assess the role of faith within the HIV/AIDS prevention policy process of faith-based NGOs.</p>	<p>2.1 Where in the HIV/AIDS prevention policy process does faith have a role (i.e. process, context, actors, content)?</p> <p>2.2 What role does faith play within the HIV/AIDS prevention policy process of faith-based NGOs?</p> <p>2.3 What factors influence the role of faith with the HIV/AIDS prevention policy process?</p>
<p>3. Identify how the key process, context, actor, and faith factors inter-relate to form the HIV/AIDS prevention policy content, in terms of policy and practice, within each faith-based NGO.</p>	<p>3.1 What is the inter-relationship between key process, context, actor, and faith factors in relation to faith-based NGOs' HIV/AIDS prevention policy content in terms of policy and practice?</p>

These questions were examined within three faith-based NGOs in Dar es Salaam, Tanzania – a Catholic, Anglican and Muslim organization. The research used a prominent health policy analysis framework, examining how faith interacts with key context, actor, and process factors to influence the HIV/AIDS prevention policy content within each organization. An exploratory, qualitative case-study approach was used to collect and analyse the data. The research methodology and theories underlying the research are explored in subsequent chapters.

1.4 Thesis Overview

This chapter outlined the background and rationale to the study and presented the study's objectives and corresponding research questions. Chapter 2 situates the study within academic literature and explores the main theoretical perspectives informing the study. It concludes with a discussion of the conceptual framework used to inform the research objectives and questions, which informed data collection and analysis. Chapter 3 provides a detailed description of the research methodology used to address the overall research aim, objectives, and questions. Chapter 4 situates the study within the Tanzanian context by exploring relevant contextual information, including the country's national HIV/AIDS response and the role of non-state private sector organizations within this response, in addition to FBOs' HIV/AIDS response in Tanzania. Chapters 5-7 present the study's findings in relation to the three case studies, exploring the key factors influencing the HIV/AIDS prevention policy process within the Catholic, Anglican, and Muslim organizations. Chapter 8 concludes the thesis with a summary of the key findings and a comparison of the factors influencing the HIV/AIDS prevention policy process within the three case studies, which are discussed in relation to the literature. It also outlines the study's main contributions to knowledge, which includes a revised conceptual framework based on the study's findings. Chapter 8 concludes with a discussion of the implications of the findings for research, policy, and practice.

Chapter 2 – Reviewing the Literature: HIV/AIDS, FBOs, and the Policy Process

2.1 Introduction

As stated in Chapter 1, this research aims to explore HIV/AIDS prevention policy processes within faith-based NGOs, with particular attention to the role of faith within this process. In order to understand such processes in their broader context, and situate faith-based NGOs within wider response efforts, we need to examine the literature with regards to HIV/AIDS and HIV/AIDS prevention, the overall faith-based response to HIV/AIDS, and policy processes in general. This chapter therefore begins with a discussion of the HIV/AIDS context, including its main drivers, the key historical influences on international and national responses to HIV/AIDS, and dominant HIV/AIDS prevention paradigms. The next section explores the faith-based response to HIV/AIDS in relation to the wider HIV/AIDS context. The chapter concludes with a discussion of the theoretical perspectives informing the study's conceptual framework, data collection, and data analysis, including dominant policy perspectives and theories of faith utilization. The study's conceptual framework is presented at the end of the chapter.

The search for relevant literature was a continuous process, and was carried out at various stages throughout the PhD. In addition to keeping up to date with relevant literature throughout the study, two thorough searches were conducted, one in 2007-2008 to help develop and frame the study within the current literature, and one in 2011 to locate any new and relevant literature, particularly in reference to the study's findings. The literature searches were conducted using keyword searches on multiple databases and the University of Leeds library catalogue, cited reference searching, and tracing of citations. A list of databases and keywords used to search for literature is presented in appendix A.

2.2 The HIV/AIDS Epidemic

According to UNAIDS, there were an estimated 33.3 million people living with HIV at the end of 2009 (UNAIDS, 2010). Sub-Saharan Africa bears the brunt of this burden, with 22.5 million people living with HIV – 68% of the global total – and 72% (1.3 million) of all deaths attributable to the epidemic (*ibid.*). Although the total number of people living with HIV/AIDS (PLWHA) continues to rise (an estimated 27% since 1999), due mainly to the reduction in AIDS-related deaths as a result of the uptake of anti-retroviral therapy (ART), the number of new

infections has been declining since the late 1990s (*ibid.*). In 2009 the number of new infections was estimated to be 2.6 million, down from 3.1 million in 1999 (a 19% reduction). The majority of new infections, however, continue to occur in sub-Saharan Africa, where an estimated 1.8 million people were infected in 2009 (*ibid.*). According to UNAIDS, this trend is the result of the natural course of HIV epidemics and the impact of overall HIV prevention efforts (*ibid.*). Although Southern Africa remains the hardest hit area in the world, with HIV prevalence rates of 15-28%, the HIV prevalence in Tanzania remains high at 5.7%, with regional prevalence ranging from 1.5-15.7% (TACAIDS, et al., 2008). The nature of the epidemic in Tanzania is discussed in greater detail in Chapter 4.

2.2.1 Key Historical Influences on National HIV/AIDS Responses

While it is important to look at the national response, it must first be situated within the wider international and national context, which includes, for example, the international donor community, state, and civil society responses over the last three decades. The purpose of this section is to provide a brief overview of the key historical influences on national HIV/AIDS responses. HIV/AIDS response efforts involve three inter-relating areas: prevention, care and support of people infected and affected by HIV/AIDS, and treatment of PLWHA. According to Patterson, most “African states, international donors, and NGOs, have focused on prevention”, whereas care and support and treatment programmes have lagged due to “high levels of poverty and underdeveloped health-care services” (2005: 6-7). Underdeveloped health services remain a significant problem in most parts of Africa, including Tanzania. Harman argues that states’ underdeveloped health care systems were the result of “the International Monetary Fund (IMF) and World Bank structural adjustment policies of the 1980s and early 1990s, which opened provision to the market and thus reduced state intervention in basic services, exacerbated poverty, and reduced budgetary spending on health” (2009: 354). This ultimately reduced the role of the state in health provision and undermined governments’ capacity to deal with the HIV/AIDS epidemic (*ibid.*). According to Boesten, the underdeveloped health care system, created by the “neoliberal economic restructuring championed by international financial institutions”, coupled with states’ lack of legitimacy and sometimes delayed response to the epidemic, produced a health care provision gap (2011: 782). The international nongovernmental community, or civil society organizations (CSOs), stepped in to fill this gap (Boesten, 2011; Patterson, 2005).

Within the literature, CSOs refer to a broad range of organizations, such as: international and national NGOs; faith-based organizations (FBOs), umbrella organizations, and community-based organizations (CBOs), as well as others. Since the mid-1990s the number of CSOs working on HIV/AIDS has proliferated, coinciding with the large inflows of international HIV/AIDS funding which was seen after 2000 (Hartwig, 2001; Kelly & Birdsall, 2010; Web, 2004). As a result of these inflows, not only were hundreds of new CSOs, including FBOs, NGOs, and CBOs, formed, but existing organizations shifted their focus to HIV/AIDS-related work (Kelly & Birdsall, 2010). Kelly & Birdsall (*ibid.*) argue that the timing of the growth in CSOs was driven by the need for HIV/AIDS responses at the community-level, in addition to increased HIV/AIDS funding opportunities for CSOs encouraged by the World Bank and other organizations – creating what Boesten (2011) refers to as an “AIDS industry”. The rise in CSOs has been criticized for creating weak and ineffective organizations, due to, for example, a lack of resources, leadership and connections (Patterson, 2005). Despite these criticisms, however, CSOs are also recognized for the good and often essential work they are doing in relation to HIV/AIDS (Benotsch, et al., 2004; Boesten, 2011; Kelly, et al., 2006; Patterson, 2005; Web, 2004). The factors discussed above, such as World Bank and other donor policies, and the proliferation of CSOs throughout the 1990s and 2000s have influenced Tanzania’s national HIV/AIDS response, which is discussed in Chapter 4.

2.2.2 Drivers of the HIV/AIDS Epidemic

The nature of the epidemic in sub-Saharan Africa is different from the nature of the epidemic in more affluent industrialized countries. In industrialized countries, for example, the epidemic is mainly localized to high risk groups, such as commercial sex workers, men who have sex with men, and drug users. In sub-Saharan Africa the epidemic is more generalized, affecting all members of the population, and the primary modes of transmission are heterosexual intercourse and mother-to-child transmission during pregnancy and lactation (*ibid.*). Moreover, there is great geographical and regional variation throughout sub-Saharan Africa, ranging from below 1% prevalence in Zanzibar to 25.9% prevalence in Swaziland (UNAIDS, 2010). In order to implement effective prevention strategies, it is important to understand the causes of the epidemic (Stillwaggon, 2005). The purpose of this and the following section is to introduce the drivers of the HIV/AIDS epidemic and their corresponding prevention strategies, in order to gain a better understanding of the HIV/AIDS epidemic and where the role of faith-based organizations fit within overall response efforts.

Within the AIDS literature, a broad array of medical, social, economic, behavioural, and cultural factors have been identified in facilitating the spread of HIV (Patterson, 2005; Poku & Whiteside, 2004; Stillwaggon, 2000, 2005; Whiteside, 2005). Although the reasons for the geographical and regional variation within Africa are not fully known, dominant drivers have been identified (Poku & Whiteside, 2004). These drivers can be separated into three broad categories: biological factors, behavioural factors, and structural factors, the last of which contains its own dominant drivers, such as poverty, gender, culture, and stigma. Each category will be discussed in greater detail below. The importance placed on these individual drivers greatly influences which prevention strategies and programmes are implemented at the international, national, and local levels (Stillwaggon, 2005). The corresponding prevention approaches to each dominant driver are discussed in section 2.2.3.

According to Poku and Whiteside (2004), there are three major biological factors which facilitate the spread of HIV. The first biological factor is the existence of undiagnosed and untreated sexually transmitted diseases (STDs) (*ibid.*). Research has provided evidence, for example, that “sexually transmitted infections in HIV-uninfected men and women increases their susceptibility to HIV infection” (Padian, et al., 2008: 588). Second, the low rate of male circumcision has been found to have some influence on the spread of HIV (Poku & Whiteside, 2004). Evidence suggests, for example, that “circumcised men [are] half as likely to be infected with HIV as uncircumcised men” (*ibid.*: xix). Lastly, the third biological factor is the physiological vulnerability of women (*ibid.*). Women are two to four times more likely to be infected during unprotected vaginal intercourse than men due to a larger area of exposed mucosa and the high concentration of the HIV virus in infected semen (Poku & Whiteside, 2004; Turmen, 2003). As will be discussed in greater detail below, particular prevention strategies have been designed in recognition of these factors.

In addition to biological factors, there are particular behavioural factors that have been identified as facilitating the spread of HIV. Behavioural factors are individual-level behaviours that can increase a person’s risk of acquiring HIV. Such factors are often discussed in reference to the structural factors below, as broader structural factors will affect actions at both the household and individual level (Whiteside, 2002). As HIV is transmitted predominately through heterosexual sex in sub-Saharan Africa, behavioural factors are often discussed in relation to a person’s sexual behaviour, and include: having multiple sexual partners or concurrent relationships, practicing polygamy, and not using barrier methods such as a

condom during sexual intercourse (Coates, et al., 2008; Poku & Whiteside, 2004). Similar to biological factors, specific prevention strategies and programmes have been implemented in response to behavioural factors. According to Stillwaggon, much of the African HIV/AIDS literature has tended to focus on behavioural factors when explaining HIV/AIDS prevalence, perpetuating “Western stereotypes of African sexuality” (2000: 989). Stillwaggon, for example, observes that in “much of the popular and professional discourse, there is a presumption – generally unstated – that populations with high rates of HIV must have higher rates of early initiation of sex, multi-partnered sex, and commercial sex than countries with low rates of HIV” (2005: 16-17). Differences in HIV prevalence, however, cannot be adequately explained by differences in sexual behaviour (*ibid.*). As a result, many academics have recognized the importance of structural factors in facilitating the spread of HIV (Boesten & Poku, 2009; Gupta, et al., 2008; Parker, et al., 2000; Patterson, 2005; Poku & Whiteside, 2004; Stillwaggon, 2000; Sumartojo, 2000).

Structural factors are larger macro-level factors that facilitate the spread of HIV/AIDS. Structural factors include: poverty, gender relations, culture, labour migration, malnutrition, parasites, poor access to curative care for STDs, and HIV/AIDS-related stigma (Gupta, et al., 2008; Stillwaggon, 2005). Although there is no space to discuss all the recognized drivers here, the following section explores four dominant drivers that have been identified in the literature, and that are particularly relevant in the Tanzanian context and the research that follows. These include: poverty, gender, culture, and stigma. For analytical purposes the factors are discussed separately, however, it must be recognized that each factor interacts with the others to create a complex contextual environment which can facilitate HIV infection. Barnett and Whiteside label these contexts “risk environments”, or social and economic environments “in which infectious disease can expand and develop rapidly into an epidemic” (2006:78).

HIV/AIDS has been linked to poverty and inequality (Patterson, 2005; Poku & Whiteside, 2004; Stillwaggon, 2005; Whiteside, 2002). According to Patterson (2005), for example, over 95% of PLWHA globally live in the developing world, with over two-thirds of PLWHA living in sub-Saharan Africa. Although the relationship between poverty and HIV/AIDS is not simple, poverty has been shown to create environments that place people at risk of acquiring HIV/AIDS, particularly women and girls (Poku & Whiteside, 2004). HIV prevalence, for example, is associated with malnutrition, low calorie intake, migration, labour mobility, lack of access to affordable health care, and lack of access to information – all of which are associated

with poverty (Hamblin & Reid, 1991; Poku & Whiteside, 2004; Stillwaggon, 2005; Turmen, 2003). According to Whiteside (2002), not only does poverty cause the spread of HIV/AIDS, HIV/AIDS causes poverty. The cycle between HIV/AIDS and poverty means HIV/AIDS deepens poverty and increases inequalities by undermining “efforts at poverty reduction, income and asset distribution, productivity and economic growth” (*ibid.*: 325). According to Whiteside, effective HIV prevention therefore requires long-term poverty reduction strategies (*ibid.*).

HIV/AIDS infection has also been linked to gender relations and gender inequality (Baylies, 2000; Boesten & Poku, 2009; Hamblin & Reid, 1991; Siplon, 2005; Turmen, 2003). According to UNAIDS (2010), just over half of all PLWHA are women and girls. In addition, 80% of all HIV positive women live in sub-Saharan Africa, while young women aged 15-24 are up to eight times more likely to be HIV positive than men. Not only are women more biologically susceptible to HIV infection than men, as noted above, but women’s social and economic status, in addition to gendered cultural practices, which will be discussed below, facilitate their risk of HIV infection (Turmen, 2003). The lower economic status of women, for example, can cause women and girls to have relationships with older men, participate in commercial sex work, and enter into marriages where they have little power to negotiate for safe sexual practices, particularly when they suspect their husband of having extra-marital affairs (Siplon, 2005; Turmen, 2003). Other aspects that are associated with gender which can increase a woman’s susceptibility to HIV include: violence against women, discriminatory customary and formal statutory law, discriminatory government policy, poverty, migration, and stigma and discrimination (*ibid.*). For many, effective HIV/AIDS prevention therefore includes strategies to address gender relations and inequality.

Culture has also been linked to HIV/AIDS infection in terms of both cultural expectations of both men and women and cultural practices (Poku & Whiteside, 2004; Siplon, 2005; Turmen, 2003). Cultural practices that have been associated with the spread of HIV include: polygamy (when a man marries more than one wife), sexual cleansing (the sexual purification of a person, usually a woman, after the death of their spouse through sexual intercourse), widow inheritance (the inheritance of a widow by a male family member of her husband), circumcision carried out using the same knife, dry sex (using herbs to dry out a woman’s vagina before sexual intercourse), beliefs in witchcraft (which are regarded as an obstacle for understanding the nature of HIV/AIDS), and the use of traditional medicine and doctors (Gausset, 2001). In relation to HIV/AIDS, cultural expectations often relate to male and female norms regarding sexual behaviour. According to Gausset (2001), as a result of the association

of cultural practices with the spread of HIV, many authors have called for the elimination of such practices within HIV/AIDS prevention. Gausset (*ibid.*) argues, however, that it is not the practices themselves that should be eliminated but the unsafe way that they are sometimes carried out, so as to not disrupt local traditions and identities. Other authors have been much more critical of harmful cultural practices, especially those which are seen to perpetuate unequal gender relations (Siplon, 2005). Gausset (2001) refers to this as a 'double discourse' on HIV/AIDS prevention, one which campaigns to stop dangerous cultural practices, and one which campaigns to make these practices safer. How one views the role of culture in facilitating the spread of HIV will therefore influence the particular HIV/AIDS prevention strategies that are advocated.

In addition to the above structural factors, stigma has been regarded as a key driver of the epidemic (Campbell, et al., 2006; Campbell, et al., 2007; Mbonu, et al., 2009; Ogden & Nyblade, 2005). According to Mbonu et al., HIV/AIDS stigma "negatively affects seeking HIV testing, seeking care after diagnosis, [and the] quality of care given to HIV patients", as well as the perception and treatment of PLWHA by communities and families (2009: 1). Within the literature stigma is often associated with the practices and discourses of religious institutions. In two separate studies, for example, the complex interplay between HIV/AIDS, sex, sin, and immorality was seen as a key determinant in HIV/AIDS-related stigma (Campbell, et al., 2005; Ogden & Nyblade, 2005). In their study, Ogden & Nyblade found the "assumptions made about the moral integrity of people living with AIDS were a central cause of stigma" across four countries – Tanzania, Zambia, Ethiopia, and Vietnam (2005: 20). In the three African countries studied, respondents assumed that PLWHA, for example, had become infected through sex – in particular through inappropriate, immoral, and disorderly behaviour (*ibid.*). The authors found that the relationship between HIV/AIDS, sex, sin, and immorality was often related to religious belief and moral dogmas (*ibid.*).

Similarly, in their study in South Africa, Campbell et al. (2005) found that the main contributor to these beliefs was the Church. According to Campbell et al. (2006), by teaching that sex should only be conducted within a faithful marriage and that sex outside marriage is a sin, the Church perpetuates HIV-related stigma by associating HIV/AIDS infection with sin. At the same time, many authors have linked stigmatization with power and control, and women in particular are regarded as bearing the brunt of HIV/AIDS-related stigma (Campbell, et al., 2007; Mbonu, et al., 2009; Ogden & Nyblade, 2005). According to Campbell et al. (2007), the Church,

in addition to traditional leadership systems, is seen to uphold male power over women, sometimes undermining HIV prevention efforts. Within the literature, churches and other religious organizations have been documented as playing both supportive and detrimental roles in relation to HIV/AIDS-related stigma, which will be discussed in greater detail below in reference to FBOs' role within HIV/AIDS prevention and mitigation (Liebowitz, 2002; Mbonu, et al., 2009; Parker & Birdsall, 2005). Breaking the relationship between HIV/AIDS, sin, and immorality and reducing HIV/AIDS-related stigma, are therefore regarded as important HIV/AIDS prevention efforts. The HIV/AIDS prevention strategies that have been developed in response to these key drivers are discussed below.

2.2.3 HIV/AIDS Prevention Paradigms

The previous section discussed the drivers of the HIV/AIDS epidemic. Many authors have acknowledged the need for HIV/AIDS prevention strategies to be developed according to the causes, or drivers, of the epidemic (Gupta, et al., 2008; Merson, et al., 2008; Stillwaggon, 2005). Different understandings of the causes of the epidemic, and their related evidence, have led to different HIV/AIDS prevention approaches. Merson et al., argue that these competing understandings “have sometimes undermined rather than contributed to an effective prevention response” (2008: 475). Competing understandings are often grouped into one of three paradigms: behavioural, biomedical, or structural, which are related to the drivers discussed in the previous section (Coates, et al., 2008; Gupta, et al., 2008; Padian, et al., 2008). Each paradigm emphasises particular prevention strategies over others. In order to understand where faith-based prevention efforts fit within overall response efforts, it is important to understand the different prevention strategies that can be employed. Each prevention paradigm, and its corresponding prevention interventions, is discussed below.

The behavioural paradigm is related to the behavioural drivers discussed in the previous section. It has dominated HIV/AIDS prevention policy and strategies in low to middle income countries for the last twenty-five years, due to being encouraged and actively promoted by the international community, including international donors such as the World Bank and U.S Agency for International Development (USAID) (Jones, 2004; Stillwaggon, 2005). Behavioural strategies attempt to influence individual attitudes, knowledge, and behaviour, and are directed towards behavioural factors, such as sexual behaviour and intravenous drug use. These strategies attempt to, for example, “delay onset of first intercourse, decrease the number of sexual partners, increase the number of sexual acts that are protected, provide

counselling and testing for HIV, encourage adherence to biomedical strategies preventing HIV transmission, decrease sharing of needles and syringes, and decrease substance use” (Coates, et al., 2008: 670). Behavioural strategies are targeted at people who are HIV negative, to prevent them from becoming infected with HIV, and people who are HIV/AIDS positive, to prevent them from infecting others or becoming re-infected with a different strain of the virus (*ibid.*). In addition to the international community’s HIV/AIDS prevention response, the behavioural paradigm has also dominated the faith-based HIV/AIDS prevention response.

Stillwaggon (2005) argues that HIV/AIDS prevention has predominately focused on sexual behaviour for a number of reasons. First, the primary mode of HIV transmission is heterosexual intercourse; second, in North America and Europe behavioural-modification programs have been quite successful in reducing HIV infections; and third, an emphasis on behaviour appears to offer a quick solution to the epidemic – the distribution of condoms and HIV/AIDS education were seen as the quickest strategies to stop the spread of HIV. The behavioural paradigm has dominated the faith-based HIV prevention response due to the association of HIV/AIDS with sex and immorality, as will be discussed below. The assumption of such approaches is that differences in HIV prevalence between populations can be effectively determined by behavioural modification (*ibid.*). This has meant that HIV/AIDS has been predominately viewed as an individual’s responsibility – in order to effectively prevent oneself from acquiring HIV/AIDS one must change one’s behaviour. According to Stillwaggon (*ibid.*), however, the epidemiology of HIV/AIDS in Africa compared to the West is not the same, and differences in HIV/AIDS prevalence cannot be effectively attributed to behaviour. Such approaches, for example, ignore the underlying structural drivers and/or causes of the epidemic (Gupta, et al., 2008; Stillwaggon, 2005). Critics of the behavioural paradigm argue that, despite the dominance of behaviour prevention strategies, HIV/AIDS incidence and prevalence rates continue to remain high (Gupta, et al., 2008; Stillwaggon, 2005).

Alternatively, biomedical interventions advocate for medical interventions to address biomedical drivers. These include: the use of barrier methods such as male condoms and diaphragms, the control of other sexually transmitted infections through screening and medication, the use of antimicrobial products such as gels and creams, encouraging male circumcision, and the search for an anti-HIV vaccine (which has not yet proven to be successful) (Mayer, et al., 2010; Padian, et al., 2008). Biomedical interventions also include increasing the availability and use of anti-retroviral treatment (ART) in order to reduce the viral

load of PLWHA and lessen the chances of passing on the infection. The promotion and use of ARTs in particular has been occurring for a long time within the West; however, the high cost of ARTs, coupled with donor preference for behavioural interventions, has meant they have only relatively recently been promoted within sub-Saharan Africa (compared to behavioural strategies for example) (Jones, 2004). This has meant that ARTs have not been reaching those most in need, affecting overall prevention rates.

The structural paradigm focuses on the wider drivers and/or causes of the HIV/AIDS epidemic (Stillwaggon, 2005). According to Gupta et al, structural approaches “seek to change social, economic, political, or environmental factors determining HIV risk and vulnerability” (2008: 764). These approaches are different from behavioural approaches because they are targeted at the population level as opposed to the individual level and address factors that affect individual behaviour, instead of targeting the behaviour itself (Gupta, et al., 2008). They are often regarded as long-term initiatives, and include such things as: the development and implementation of national policy, legal amendments to address discriminatory practices, and microcredit programmes aimed at addressing women’s economic dependency (*ibid.*). According to Stillwaggon (2005), HIV/AIDS is the result of complex and inter-related factors, such as poverty, gender relations, poor access to health care, and malnutrition that exist in poor countries. However, the structural drivers that promote HIV transmission have been overlooked due to the “expense of any prevention programme, the complexities of dealing with host governments with differing political agendas, and the seeming enormity of resolving the more fundamental causes of AIDS” (*ibid.*: 990). This has meant that overall prevention efforts have emphasized behavioural strategies – namely the promotion of condoms and reduction in sexual partners. According to Stillwaggon (*ibid.*), however, although condom use has the potential to save lives and should be included in programmes that support safe sex, they are useless if, for example, a woman does not have the power within a relationship to insist on their use (see also: Boesten & Poku, 2009). Advocates of the structural paradigm argue that if HIV/AIDS is to be effectively addressed in the long-term, more emphasis must be placed on structural interventions, such as, for example, changing sexual power relationships (Boesten & Poku, 2009; Gupta, et al., 2008; Stillwaggon, 2005).

The faith-based response to HIV/AIDS prevention is discussed in more detail below. As stated above, similar to international response efforts, the behavioural paradigm has dominated the faith-based response to HIV/AIDS prevention. Common discourse among many FBOs, for

example, is that HIV/AIDS infection is the result of individual risky behaviour (Denis, 2009). Unlike other behavioural responses, however, the faith-based response places more emphasis on the lack of ethics or morality, often accusing PLWHA of sexual misconduct (*ibid.*). This moralization of the epidemic contributes to HIV-related stigma, particularly gender-related stigma (Campbell, et al., 2007). Although the HIV prevention response within the three organizations included in this study did not always fit with dominant faith discourses, their approaches were dominated by behavioural strategies. The following section explores the faith-based response to HIV/AIDS and HIV/AIDS prevention.

2.3 Faith-Based Organizations and HIV/AIDS

As discussed in Chapter 1, the role of FBOs' in HIV/AIDS prevention and mitigation is increasingly being recognized (Casale, et al., 2010; Dilger, et al., 2010; Tiendrebeogo & Buyckx, 2004a). Responses to FBOs' role in HIV/AIDS prevention and mitigation, particularly in relation to HIV/AIDS prevention have been mixed. In order to locate the case studies' HIV prevention response within wider faith-based response efforts, the following discusses the literature in relation to FBOs' overall HIV/AIDS response. It begins with a definition of FBOs, and faith-based NGOs as a subset of FBOs, followed by FBOs' overall role in HIV/AIDS, concluding with a discussion about FBOs' approach to HIV/AIDS prevention.

2.3.1 Defining Faith-Based Organizations

In the literature, the term "faith-based organization" (FBO) has been used to encompass "any religion, religious communities, religious institutions, faiths and denominations" (Parker & Birdsall, 2005: 11), and often includes both "places of worship and their members as well as any organization affiliated with or controlled by these houses of worship" (Liebowitz, 2002: 2). The terms religious and faith-based organization can refer to a variety of organizations. Clarke (2006: 840), for example, defines five main types of FBOs:

1. **Faith-based representative organizations or apex bodies:** rule on doctrinal matters, govern the faithful and represent them through engagement with state and other actors;
2. **Faith-based charitable or development organizations:** mobilize the faithful in support of the poor and other social groups; fund or manage programmes which tackle poverty and social exclusion;

3. **Faith-based socio-political organizations:** interpret and deploy faith as a political construct, organize and mobilize social groups on the basis of faith identities but in pursuit of broader political objectives. Alternatively, they promote faith as a socio-cultural construct, as a means of uniting disparate social groups on the basis of faith-based cultural identities;
4. **Faith-based missionary organizations:** spread key faith messages beyond the faithful by actively promoting the faith and seeking converts to it. They support and engage with other faith communities on the basis of key faith principles;
5. **Faith-based illegal or terrorist organizations:** engage in illegal practices on the basis of faith beliefs or engage in armed struggle or violent acts justified on grounds of faith.

Churches or mosques would fit into the first category, while faith-based NGOs, the target of this study, would fit into the second category. Many religious and faith-based organizations will self-identify as such, and, as a result, will be motivated and/or governed by a particular religious belief. However, how much a FBO bases its identity on its religion will vary, as will how much it is motivated and/or governed by its religious beliefs. Using the above definition, it is obvious that not all FBOs will be involved in HIV/AIDS prevention and mitigation. A FBO's response to HIV/AIDS, therefore, will be dependent on the type of organization it is, as well as how it identifies itself with, and how much it is motivated by, its religion and religious beliefs, in addition to other factors. The role of faith within FBOs is discussed in greater detail in section 2.4.3.

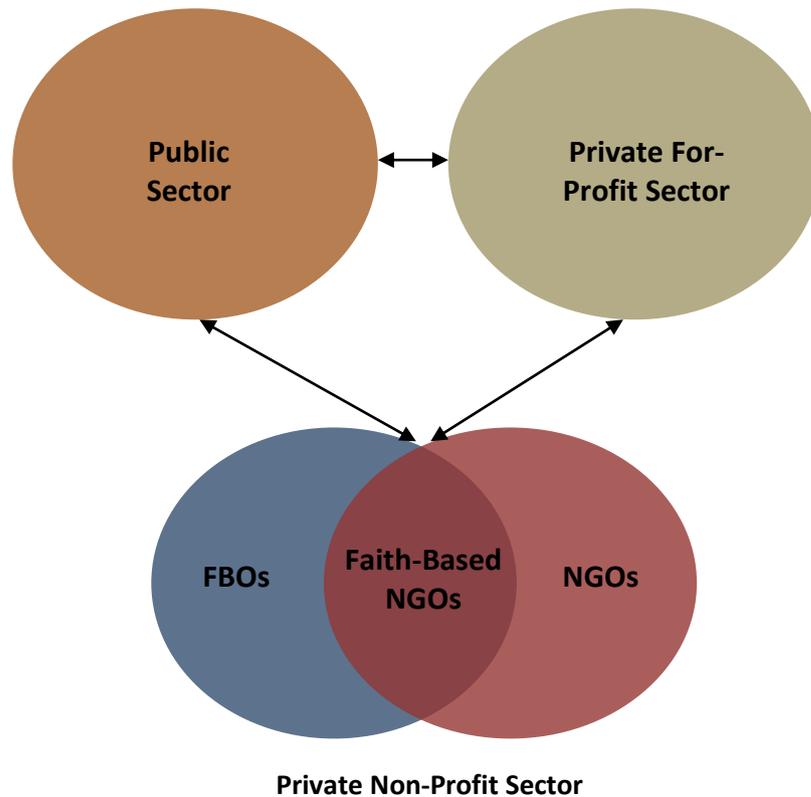
2.3.2 Faith-Based Non-Governmental Organizations

Non-governmental organizations (NGOs) are formal organizations within the private sector with humanitarian aims and objectives, which are non-profit making and independent from the government (Green & Matthias, 1997). The private sector is separate from the public sector, and includes both for-profit and non-profit organizations. The public sector includes all organizations which are controlled and financed through government (*ibid.*). According to Green and Matthias (1997), NGOs have three main characteristics: they are a formal organization; have non-profit social or humanitarian objectives; and, have decision-making processes that are independent from government. These characteristics, however, are not

always straightforward. While NGOs' decision-making processes can be considered independent from government, for example, government is likely to have an influence on decision-making at a variety of levels (*ibid.*). In fact, Green and Matthias argue that it is necessary that "governments *do* provide a policy framework within which NGOs operate and to which they contribute" (*ibid.*: 28). The critical issue is therefore not that NGOs are independent of influence from government, but that they have the "constitutional freedom to make decisions which may or may not take account of the government views", such as appointing a Board of Directors (*ibid.*: 29). Secondary features of NGOs include: the involvement of volunteers, their small organizational size, and their funding base, which can stem from a variety of sources and have implications for the sustainability of the organization's activities (*ibid.*). According to Green and Matthias, a significant shift in NGOs has been a move away from "organizations that are volunteer-driven to organizations that are heavily dependent on trained and salaried staff" (*ibid.*: 20). The effects of this has been the creation of tensions in some organizations between volunteers and staff within the decision-making process, a loyalty among staff to their professional objectives, as opposed to emotional objectives, and an overall increase in confidence and legitimacy of NGOs and their staff (*ibid.*).

Much of the current literature on NGOs, however, deals with secular organizations, resulting in faith-based NGOs being an under-researched sub-section (see: Benotsch, et al., 2004; Ferrari, 2011; Kelly, et al., 2006). Berger defines faith-based NGOs as "formal organizations whose identity and mission are self-consciously derived from the teachings of one or more religious or spiritual traditions [...] which operate on a non-profit [...] basis to promote and realize collectively articulated ideas about the public good" (2003: 16), a definition which combines both Green and Matthias' definition of NGOs above, and Clarke's definition of charitable or development FBOs discussed in the previous section. Figure 1 shows where faith-based NGOs fit in relation FBOs, NGOs, and the public and private for-profit sectors. As not all FBOs are involved in health provision, it relates to only those organizations that are involved in health and health provision.

Figure 1 – Organizations Involved in Health and Health Provision



As the above diagram suggests, faith-based NGOs are a subset of non-governmental organizations in general, which in many countries play a critical role in HIV/AIDS prevention and mitigation. Although there are many organizational similarities between secular NGOs and faith-based NGOs, such as those discussed above, faith-based NGOs differ from their secular counterparts due to their religious motivations and objectives. As faith-based NGOs have had a long tradition of providing relief and social services in many economically disadvantaged areas of the world, particularly in the area of HIV/AIDS, it is therefore important that their HIV/AIDS response is better understood (Berger, 2003).

While faith-based NGOs are separate from larger representative organizations, such as churches or mosques, they can be subsidiary to such organizations. In such cases they may have to follow the main doctrinal matters or directives set out by these organizations. In discussing Christian faith-based HIV/AIDS NGOs, Denis (2009) describes faith-based NGOs as informal or formal organizations that are a component of the Church, initiated by the churches themselves or some of their members to fight against HIV/AIDS. According to Denis, such organizations are “the visible face of the Church’s response to HIV/AIDS”; however, they

cannot claim to represent the Church (*ibid.*: 69). At the same time, members of local congregations can be at odds with such organizations in terms of their behaviour and attitudes, as such organizations may advocate the use of condoms in contradiction to Church directives or criticize the stigmatizing behaviour or attitudes of local congregations (*ibid.*). Christian faith-based NGOs, therefore, while being a subsidy to a larger church body, maintain a level of independence.

Less information exists regarding Muslim faith-based NGOs and HIV/AIDS within the literature, most likely due to their lack of involvement in HIV/AIDS compared to Christian NGOs, as will be discussed in Chapter 4 in relation to Tanzania. However, they do differ from Christian NGOs in that they are often not components of larger organizations. At the same time, an organization may be a part of or created by members of a mosque, and seek to follow Islamic mandates issued by Islamic leaders. Compared to Christian faith-based NGOs, less restrictions or consequences appear to be placed on actors within these organizations if their actions are at odds with wider religious mandates, due to lack of clear leadership delineations and authority structures. This study is exploring the HIV/AIDS policy processes within mainline Christian and Muslim faith-based NGOs. While other types of faith-based NGOs, such as Pentecostal NGOs, exist, as they are not the focus of the study they are not discussed here. In order to situate the faith-based response to HIV prevention within the overall faith-based response to HIV/AIDS, the following section discusses the overall faith-based response to HIV/AIDS.

2.3.3 The Faith-Based Response to HIV/AIDS

As described above, faith-based NGOs are a subset of the wider category of 'FBO'. Most literature on FBOs' responses to HIV/AIDS discusses FBOs as a broad category, usually referring to faith-based representative or development organizations described above, as they are the most likely to be involved in HIV/AIDS work. As a result, this section explores the overall faith-based response to HIV/AIDS, of which faith-based NGOs are important actors. As stated in Chapter 1, it is estimated that 30-70 percent of all health care provision and education in Africa is provided by FBOs (Olivier, et al., 2006). Due to the scale of the HIV/AIDS epidemic, much of this health care provision is around HIV/AIDS prevention and mitigation. According to Olivier et al. (2006), since 2000 the faith-based response to HIV/AIDS has proliferated at an astounding rate, making FBOs significant players in the response to HIV/AIDS.

Currently Christian FBOs are the most active (among FBOs) in HIV/AIDS prevention and mitigation in Africa (Tiendrebeogo & Buyckx, 2004a). Christian FBOs include: Catholic, Protestant (including Lutheran and Anglican), Orthodox, and Charismatic, such as Pentecostal, organizations. Denis (2009) argues that when analyzing the Christian response to HIV/AIDS it is important to distinguish between different types of churches, as each will respond differently to the epidemic. Christian FBOs have a long tradition of providing healthcare in Africa, particularly Christian missionary FBOs which have played an important role in the development and provision of healthcare over the last century (Green, et al., 2002). Other FBOs stem from other religions such as: Islam, Judaism, Indian religions such as Hinduism, Buddhism, and Sikhism, and African traditional religions. Balogun argues that for a long time Islamic bodies and scholars in particular “distanced themselves from Christian groups and bodies engaged in open religious struggles and HIV/AIDS campaigns in Africa” (2011: 460). More recently, however, Muslim FBOs are being recognized as becoming increasingly active with regards to HIV/AIDS prevention and mitigation (Tiendrebeogo & Buyckx, 2004a). As will be discussed in Chapter 3, this study is exploring the role of faith and other factors in the HIV/AIDS prevention policy process within Christian and Muslims faith-based NGOs.

FBOs’ overall response to HIV/AIDS has not been without controversy. On the one hand, many authors have recognized FBOs’ positive contribution to HIV/AIDS, particularly in the area of HIV/AIDS care and support, including orphan support, clinical care, home-based care, spiritual and pastoral support, counselling, and food and material support to PLWHA and their caregivers (ARHAP, 2006; Olivier, et al., 2006; Parker & Birdsall, 2005). FBOs in particular have been recognized as potential agents for preventing and mitigating the HIV/AIDS epidemic due to, for example: the respect and trust they enjoy from the communities in which they operate; their moral authority within society as a whole; their nature as value-based institutions with direct ‘jurisdiction’ over issues of personal behaviour, morality, family life, and belief; their regular involvement with members and followers, including direct contact with people at key life events (birth, coming of age, marriage, death); and their position as a source of strength, support, and hope for people who are ill or in need (Parker & Birdsall, 2005: 13). Liebowitz claims that countries like Uganda and Senegal, which have “involved religious leaders directly in their campaign to publicize, prevent and minimize the impact of HIV”, have been able to successfully reduce HIV prevalence as a result of the above (2002: 10). Many authors have therefore called for better engagement with FBOs in the fight against HIV/AIDS (Liebowitz, 2002; Olivier, et al., 2006; Parker & Birdsall, 2005).

At the same time, however, FBOs' response to HIV/AIDS has also been criticized for undermining overall response efforts (Casale, et al., 2010; Dilger, 2009; Dilger, et al., 2010; Liebowitz, 2002; Tiendrebeogo & Buyckx, 2004a). Parker and Birdsall claim for example, that FBOs have been faulted for their delayed response, their "failure to acknowledge the scope and implications of rising HIV infection rates, and [...their] moralistic, judgemental and socially conservative stances towards HIV/AIDS which have contributed to silence and secrecy" (2005: 12). FBOs have been criticized, in particular, for: their resistance to condom use; their reduction of HIV infection to issues of individual morality and sin, resulting in HIV-related stigma, particularly gender-related stigma; their failure to engage openly with topics fundamental to HIV/AIDS prevention, including human sexuality, women's empowerment and gender relations; and, for their denial that HIV/AIDS is a problem within one's own faith (Liebowitz, 2002; Moszynski, 2008; Parker & Birdsall, 2005). From the above it is clear that support for the involvement of FBOs involvement in relation to HIV/AIDS is varied. The following section explores the faith-based response to HIV/AIDS prevention, the main focus of this study.

2.3.4 FBOs' HIV/AIDS Prevention Response

According to Casale *et al.* (2010), FBOs' involvement in HIV prevention has been more limited compared to HIV/AIDS-related care, and arguably less effective. One explanation for these limitations is the set of theological challenges inherent in issues surrounding sexual behaviour, particularly around condom use and promotion and sex outside marriage, each of which is inherent to HIV prevention (*ibid.*). Most FBOs' HIV/AIDS prevention messages emphasize abstinence and faithfulness over condom use. In their study about FBOs' involvement in HIV-related activities in Malawi, Rankin et al. found that in the five organizations studied (three mainstream Christian groups, one indigenous Pentecostal group, and one Muslim group) there was a consistent HIV prevention message which promoted "absolute insistence of premarital abstinence and marital fidelity" (2008: 599). Within these organizations condoms were universally condemned as a prevention strategy, and abstinence and fidelity were seen as the only means of reducing the spread of HIV (*ibid.*). Both Christian and Muslim leaders within the organizations feared that acceptance of condoms would undermine their message of abstinence and promote infidelity by encouraging sinful behaviour (*ibid.*). Although the above study found similar approaches between Christian and Muslim FBOs to HIV/AIDS prevention,

differences between Christian and Muslim approaches exist. The following section explores the Christian and Islamic responses to HIV/AIDS prevention.

2.3.5 Christian Responses to HIV/AIDS Prevention

According to Tiendrebeogo & Buyckx, "Christianity is defined as a religion of love: Divine love for human kind, reflected in mutual love of human beings", celebrated through the gift of sexual intimacy between a couple (2004a: 26). While "modern attitudes towards sexual pleasure tend to detach it from procreation and a lasting mutual commitment, [Christian] churches emphasize the importance of marriage in which responsibility, faithfulness and exclusive intimacy are considered essential" (*ibid.*: 26). As a result, many Christian FBOs ban the use of condoms, emphasizing instead abstinence and fidelity. Tiendrebeogo & Buyckx (*ibid.*) argue that the role of Christian FBOs in HIV/AIDS prevention has been characterised by the deadlock over condom use. The Catholic Church first took a strong position against condom use in 1965 when Pope Paul VI referred to family planning issues, stating that sexual contact (reserved for marriage) "should not be barred from transmitting life by condoms" (*ibid.*).

Since the advent of HIV/AIDS, however, Christian Churches' – both Catholic and Protestant – position on condom use has in some cases changed. Although it is still perceived as a moral issue, there is recognition that sexual contact can in some cases transmit a deadly virus rather than life. According to Tiendrebeogo & Buyckx, in such cases some churches see the commandment "Thou shall not kill" prevail, particularly with regards to discordant couples, where one partner is HIV positive and one is HIV negative, viewing condoms as the "lesser evil" (*ibid.*). As recently as 2009, however, on a visit to Africa Pope Benedict XVI was quoted as saying that HIV/AIDS was "a tragedy that cannot be overcome by money alone, that cannot be overcome through the distribution of condoms, which can even increase the problem", a stance which has since been criticized for threatening public health policies and gains in HIV/AIDS prevention (BBC News, 2009). In 2010, however, Pope Benedict XVI was quoted saying that condoms could reduce the risk of HIV/AIDS infection in exceptional circumstances, such as with male prostitutes, at the same time advocating that condoms were not the proper way to combat HIV infection (BBC News, 2010). This change in position appears to be in accordance with the idea of condoms being the "lesser evil". Although only time will tell whether this is evidence of a softening of the Catholic Church's hard line on HIV/AIDS and

condom use, many have seen it as a positive step towards recognizing “that responsible sexual behaviour and the use of condoms have important roles in HIV prevention” (*ibid.*).

2.3.5.1 Islamic Responses to HIV/AIDS Prevention

According to Tiendrebeogo & Buyckx (2004a), Islam-based sexual health and HIV/AIDS prevention strategies are based on a few key Islamic principles and teachings. Firstly, Islam forbids promiscuity. According to the Prophet Mohammed, “[if] fornication and all kinds of sinful sexual intercourse become rampant and openly practised without inhibition in any group or nation, Allah will punish them with new epidemics and new diseases” (*ibid.*: 33). Accordingly, HIV/AIDS within Islam is often thought to be God’s retribution for promiscuity, homosexual activity, and extra-marital sexual relationships. Many Muslims therefore believe that the only way to stop the spread of HIV/AIDS is to radically change sexual behaviour, abandoning immoral sexual practices (*ibid.*). Furthermore, within Islam adultery, prostitution, and anal intercourse are prohibited, all of which are seen to perpetuate HIV infection. In the context of HIV/AIDS, condoms are permitted as a form of family planning, and the intake of alcohol and drugs is prohibited as it is seen to dissolve moral restraints (*ibid.*). All Islamic principles and teachings stem from the Quran and other religious texts, or fatwas (religious decrees issued by Islamic scholars).

With regards to the Islamic response to HIV/AIDS, Balogun (2011) argues that Islam regulates most aspects of an adherent’s life, including approaches to health and wellbeing, making it a way of life. According to Balogun (*ibid.*), dominant Islamic discourse regards condom promotion as encouraging unlawful sexual intercourse, and is therefore unacceptable. Islamic adherents see sexual abstinence outside marriage and fidelity within marriage as the only solution to stop the spread of HIV (*ibid.*). Islamic teaching also provides direction regarding other modes of transmission, including transmission through blood and blood products (for example, blood transfusion, transplants, cultural practices, which include skin cutting, and intravenous drug use) (*ibid.*). In addition, Balogun (*ibid.*) argues that Islam prohibits the use of intoxicating substances, and cultural practices such as female genital mutilation, blood rituals, and tattooing (*ibid.*).

Similarly, in their study about the role of Islam in addressing HIV/AIDS in a town in Kenya, Maulana et al. (2009) found that Islamic teachings only permitted sex within marriage, with sex outside of marriage being considered immoral. Immoral practices were referred to as

zinaa, which applied to both adultery (where one or both people are married to someone else), and fornication (where neither person is married). In their study, respondents described *zinaa* as leading to HIV/AIDS, while some respondents viewed HIV as a punishment from God (*ibid.*). As a result, condom promotion to unmarried couples was not viewed as an option as it was seen to promote *zinaa*. At the same time, however, respondents in their study approved of the promotion of condoms within marriage for both family planning and discordant couples, as it was viewed as the ‘lesser to two evils’ and a way to preserve public interest, an approach which has been reported in other studies (*ibid.*).

2.3.5.2 Criticisms of FBOs’ HIV/AIDS response

FBOs’ dominant approach to HIV/AIDS prevention – their value-laden behavioural messages which include the promotion of abstinence and fidelity while rejecting condom use and promotion – has been criticized by many (Browning, 2009; Casale, et al., 2010; Denis, 2009). Such approaches have been criticized for their reduction of HIV infection to issues of individual morality and sin, their reinforcement of stigma of PLWHA, especially women, and their dismissal of wider structural determinants of HIV/AIDS. Denis (2009) argues that Christian FBOs’ HIV/AIDS prevention responses both individualize and moralize HIV/AIDS. FBOs individualize HIV/AIDS by reinforcing the belief that HIV/AIDS is the result of individual risky behaviours, ignoring structural determinants of the epidemic (*ibid.*). Religious institutions moralize the epidemic through their dominant discourse which associates HIV/AIDS with sin and immorality (*ibid.*).

Many religious leaders attribute HIV infection to a lack of adherence to sexual norms such as abstinence and fidelity, finding an HIV infected person guilty of sexual misconduct (*ibid.*). It is argued that this moralization of the epidemic has undermined overall HIV/AIDS response efforts, particularly by reinforcing the stigmatization of people living with HIV/AIDS (Campbell, et al., 2005; Maulana, et al., 2009; Parker & Birdsall, 2005). This criticism has been particularly directed at FBO’s role in perpetuating gender-related HIV/AIDS stigma. FBOs are criticized for sanctioning unequal relationships between men and women, postulating a strong link between moral order and individuals’ sexuality (Campbell, et al., 2005). Women in particular are often blamed when there is a loss of morality. In their study Campbell et al. found, for example, that many of their respondents believed “the epidemic was caused by women who were too weak or immoral to refuse sexual intercourse outside of monogamous marriage” (2007: 410). Such positions direct HIV-related stigma to women, reproducing “wider patterns of social

disadvantage” (*ibid.*). At the same time, however, many religious institutions and theologians have attempted to develop a “theology of AIDS”, which attempts to address these issues, and efforts to respond to the HIV/AIDS epidemic in a less stigmatizing way can be found among both Christian and Muslim FBOs (Balogun, 2011; Denis, 2009).

From the above it is clear that the faith-based response to HIV/AIDS and HIV/AIDS prevention is not homogenous. The faith-based response differs across different types of FBOs, and across FBOs of different faiths, influenced by a number of inter-relating and sometimes conflicting factors, not least of which include issues surrounding “religious doctrines, ethics, morality and the official positions of religious hierarchies” (Tiendrebeogo & Buyckx, 2004a: 8). It is therefore important to try to understand better the different faith-based responses to HIV/AIDS and how they are translated into practices which will influence overall prevention efforts. As described above, faith-based NGOs are active players within overall HIV/AIDS response efforts; however, currently there is a lack of understanding of how faith-based NGOs respond to HIV prevention. In order to understand the overall faith-based response to HIV/AIDS, we must first understand the multiple inter-relating and sometimes conflicting factors that influence individual FBOs’ HIV/AIDS prevention response efforts. In order to aid in this understanding, this study is exploring the HIV/AIDS prevention policy processes within three faith-based NGOs of different persuasion. The following section discusses the theoretical perspectives that have informed this exploration, which include relevant policy perspectives and faith utilization theories. These perspectives helped to inform the conceptual framework, which is presented at the end of the chapter.

2.4 Theoretical Perspectives Informing the Study

This study is exploring the factors influencing the HIV/AIDS prevention policy process of faith-based NGOs, which will influence faith-based NGOs’ overall prevention response. FBOs’ responses to HIV/AIDS prevention was described above. In order to reach an understanding of an organization’s HIV/AIDS prevention policy process, there must first be an understanding of what is meant by policy and the policy process. The following section therefore provides a definition of policy, and describes the health policy analysis framework that was applied within the study. As faith is seen as an important component within faith-based NGOs’ policy processes, this is followed by a discussion of faith utilization theories, with particular attention to the use of faith within the policy process.

2.4.1 Defining Policy

Policy is made at many levels – within local or central government, multi-national organizations, or local organizations (Buse, et al., 2005). While ‘public policy’ refers to government policy, ‘policy’ can refer to policy at all levels or within all sectors. Policies, for example, are made in private (both non-profit and for-profit) and public sector institutions. In the private sector, multi-national organizations or similar bodies may develop policies for their subsidiary organizations, at the same time allowing them to set their own policies at the service level (*ibid.*). Likewise, large church structures, such as the Catholic and Anglican Church, often set policies for their subsidiary organizations working on the ground, while allowing these organizations to develop their own organizational policies regarding the day to day running of the organization. In the case of the Catholic Church, for example, these policies may be set by the Vatican in Italy, or by the church structures within the country where an organization works.

Many authors have struggled to define ‘policy’ (Hill, 2005; Jenkins, 1997). Buse et al. define policy as a “statement of goals, objectives and means that create the framework for activity”, often taking “the form of explicit written documents” but may also be implicit or unwritten (2005: 4). Baggott defines policy as a position taken by an organization or person in authority in the form of “a statement, a decision, a document, or a programme of action” (2007: 2). Barker (1996) asks whether a policy is of any significance if it has yet to be (or will never be) implemented. She argues that a policy might only exist when an action has been taken to implement it; and it is only then when it acquires any real significance (*ibid.*). Walt (1994) offers a series of suggestions in which to understand what is meant by “policy” that seem to encompass the above considerations. For Walt (*ibid.*), policy includes a decision to act on a particular problem, but also includes subsequent decisions concerning its implementation and enforcement. Policy involves more than just a statement of intent; it should involve what governments or organizations actually do (*ibid.*).

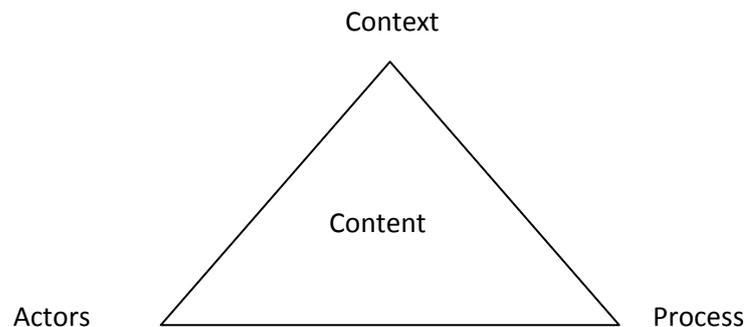
Within this study, policy content refers to organizational policy within the private non-profit sector, and refers to any policy that has to do with HIV/AIDS prevention. Policy content is defined as both “formal and informal, explicit and implicit, represented [...] or written documents, as well as reported intentions, promises and practices” (WHO, 2007: 23), as well as actors’ intentions and decisions not to act on a particular issue. Hence, this definition includes both the written and unwritten policy, as well as practice at the implementation level.

Policies can be expressed in a variety of different ways, which can include, for example: visions, objectives, decisions, strategies, targets, plans, guidelines, and directives. In relation to the above definition of policy, the following section explores the health policy analysis framework applied within the study.

2.4.2 Health Policy Analysis Framework

There are many factors that influence how policy is made. Walt and Gilson's (1994) framework, known as the 'health policy triangle', divides influencing factors into four categories – process, context, actors, and content, focusing on the interaction between these factors. This health policy triangle is useful as it provides a broader explanatory framework in which to begin to explore the role of faith in relation to other factors within the policy process. In Walt and Gilson's original framework 'actors' was in the centre of the triangle, here it has been replaced by 'content'. This is done because I believe that content is the end-product of the interaction between context, process, and actors and the triangle has been modified to reflect this. A modified version of Walt and Gilson's health policy triangle is presented below in Figure 2.

Figure 2 – Health Policy Triangle



Source: Adapted from Walt and Gilson (1994)

The health policy triangle is not intended to be a complex all-encompassing approach to health policy analysis. According to Buse et al., it is "a highly simplified approach to a complex set of inter-relationships" (Buse, et al., 2005: 9; Walt & Gilson, 1994). Although for analytical purposes the four factors are considered separately, in reality one factor cannot be considered without the others. In order to gain a better understanding of what influences the policy process, each element of the health policy triangle will be examined. Although originally

designed to analyse national policymaking processes, Walt & Gilson's framework is used here as a tool to analyse institutional policy formation, as the same factors appear to influence both national policy processes and organizational policy processes (often referred to as decision-making processes within organizational theory) (Jones, 2001; Walt & Gilson, 1994). I therefore hypothesized that Walt and Gilson's framework could be extrapolated to the institutional level. As will be discussed below, the policy process is often separated into individual stages. Walt and Gilson's policy triangle is often used to explore and describe the entire policy process – from agenda setting to policy evaluation (Walt & Gilson, 1994). However, the triangle can also be used to explore the factors influencing each individual stage of the policy process. Due to the nature of the organizations and their policy processes within the study, the process, context, actor, and content factors influencing policy implementation in particular were found to be most influential within the organizations' HIV/AIDS prevention policy process. Theories of policy implementation are discussed in greater detail below.

2.4.2.1 Process

There are certain processes that underpin policy development and implementation (Baggott, 2007; Buse, et al., 2005; Hill, 1997; Jenkins, 1997). According to Buse et al., process "refers to the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated" (2005: 13). Jenkins (1997) argues that when analysing policy, a conceptual understanding of this process is fundamental. Problems are identified, issues are raised, decisions are made, and policies emerge. Figuring out how these supposedly fragmentary events are linked is an attempt to understand what the policy process is (*ibid.*). Many authors recognize that these processes are complex and messy. The most common approach to understanding the policy process has been to break it down into a series of functional and distinct stages, or sub-processes, and analyse each stage individually (Baggott, 2007; Jenkins-Smith & Sabatier, 1993; Porter & Hicks, 1998). Within the literature there are four steps that are commonly acknowledged in the policy process (Porter & Hicks, 1998). These include:

- (1) **Problem Identification and Issue Recognition:** how issues get onto, or do not get onto, the agenda (agenda-setting);
- (2) **Policy Formation:** who is involved in the formation of policies, how policies are developed and decided upon, and how they are communicated;

- (3) **Policy Implementation:** the execution and operation of policies; and,
- (4) **Policy Evaluation:** exploration of what happens after the policy is implemented, identification of a policy's outcomes and impact (intended and unintended consequences) (Buse, et al., 2005; Porter & Hicks, 1998).

These stages are often viewed as a 'policy cycle', as opposed to a straight line, where the evaluation stage overlaps with the problem identification stage as policies are changed, terminated, or new ones are introduced (Porter & Hicks, 1998). Many authors recognize that this approach, referred to as the "stages model", is not necessarily an actual representation of what happens, but instead a theoretical device which provides a "useful conceptual disaggregation of the complex and varied policy process into manageable segments" (Buse, et al., 2005: 2; Jenkins-Smith & Sabatier, 1993).

Buse et al. (2005) point to a few caveats that are important to acknowledge in this simple, but useful framework. Most importantly, by ordering the stages in a sequential fashion, it appears that the policy process is linear – proceeding smoothly from one stage to the next. The process, however, is seldom so clear or ordered. Problem recognition may occur at the implementation stage or a policy may be formulated, but for many reasons, never implemented (Buse, et al., 2005). At the same time, different outside processes may influence and have an effect upon different stages of the policy process – for example an actor may be very influential in getting a problem recognized and on to the agenda but may have no role in the implementation of the policy that is formulated, or a contextual factor may affect whether a policy is actually implemented or not.

The processes that occur at the national and organizational levels will differ. At the organizational level, for example, the policy formation stage can occur both inside and outside of the organization, depending on the policy issue. Organizations may be required to follow government, donor, or in the case of faith-based NGOs, church policies that have been developed outside of the organization. At the same time, actors within the organization will be developing organizational policy in relation to service-related or other issues. Where the policy is made can therefore have an effect on the overall policy process, particularly at the implementation stage. As noted above, within this study policy refers to both written and

unwritten policy and organizational practice. As some policy at the organizational level will be directed top-down, the implementation stage of the policy process therefore becomes very important. As a result, implementation theories are discussed in greater detail below. Within low to middle income countries, the evaluation stage of the policy process is often omitted due to lack of capacity. When it does occur it is often the requirement of individual donors or funding bodies and relates mainly to programme targets. As policy formation can occur both inside and outside of an organization, and organizations may be required to follow multiple policies that were developed outside the organization, each individual stage of the policy process is not analysed separately. Instead, the factors influencing the overall policy process will be explored in relation to context, actor, and process and how these relate to form content as defined above. Individual stages will be explored more in depth where factors are seen to influence a specific stage of the policy process.

Policy Implementation Theories

The stages model presented above, although recognized as not an accurate representation of the overall policy process, remains an important device for drawing attention to activities within the policy process (Buse, et al., 2005). Policy implementation is particularly important within the overall policy process, as it is common to find discrepancies between written policy and policy practice – or in other words “a ‘gap’ between what was planned and what occurred as a result of a policy” (*ibid.*: 121). In fact, many policies that are implemented fail to meet the objectives of policymakers. Buse et al. (2005) point to case studies where international donor policies imposed on poor countries have less than positive results. A common example of this is the set of structural adjustment policies introduced in the 1980s by the World Bank within many low to middle income countries (Baum, 2008). There are two common theoretical models of policy implementation: top-down approaches and bottom-up approaches.

Top-down approaches to policy implementation regard the policy process as a linear process with clear distinctions between the different stages (Buse, et al., 2005; Pressman & Wildavsky, 1984; Sabatier & Mazmanian, 1979; Walt, 1994). Policies are set at the national or organization level and then communicated to subordinate levels, whose role is to put policy into practice (*ibid.*). This approach theorizes that certain conditions must be met in order to achieve effective policy implementation, and reduce the gap between policy and practice (*ibid.*). It is argued that if these conditions were met, policy should be implemented as policymakers intended (Buse, et al., 2005; Sabatier & Mazmanian, 1979). Sabatier and

Mazmanian (Buse, et al., 2005: 123; Sabatier & Mazmanian, 1979) devised a list of six necessary conditions that should be met, which include:

1. Clear and logically consistent objectives;
2. Adequate causal theory (i.e. a valid theory as to how particular actions would lead to the desired outcomes);
3. An implementation process structured to enhance compliance by implementers (i.e. appropriate incentives and sanctions to influence subordinates in the required way);
4. Committed, skilful, implementing officials;
5. Support from interest groups and legislature; and,
6. No changes in socio-economic conditions that undermine political support or the causal theory underlying the policy.

Proponents of the top-down approach argue that the use of such criteria would help policy analysts to explain why a policy is implemented effectively or not and put mechanisms in place to ensure that a policy is implemented effectively where appropriate (*ibid.*). Critics of this approach argue, however, that policy implementation is much more complex than the top-down approach suggests and advocate instead for a bottom-up approach to policy implementation.

In contrast to top-down approaches to policy implementation, bottom-up approaches recognize the role of implementers as important actors within the overall process, “not merely as managers of policy percolated downwards, but as active participants in an extremely complex process that informs policy upwards too” (Walt, 1994: 155). According to Walt, implementers may change a policy at implementation, sometimes re-defining the objectives of a policy “because they are closer to the problem and the local situation” than policymakers (*ibid.*: 155). Lipsky’s (1980) study on the behaviour of what he termed ‘street-level bureaucrats’ was one of the most influential in relation to the development of bottom-up approaches and in understanding causes of policy implementation more fully (Buse, et al., 2005). According to Lipsky (*ibid.*), street-level bureaucrats included front-line staff administering programmes and benefits, teachers, social workers, local government officials, and doctors and nurses. Lipsky found that actors working in hierarchical rule-bound environments still retained a degree of discretion in their relations with clients, and actors such as teachers, doctors, and social workers had high levels of discretion which allowed them

to navigate central policy directives and reshape policy according to the professionals' own needs. According to Buse et al. (2005: 125),

Lipsky's work helped re-conceptualize the implementation process, particularly in the delivery of health and social services which is dependent on the actions of large numbers of professional staff, as a much more interactive, political process characterized by largely inescapable negotiation and conflict between interests and levels within policy systems.

As a result of Lipsky's work, much more attention has been paid to the role of actors in the implementation process, particularly with regards to their strategies, goals, and activities (*ibid.*). Buse et al. (*ibid.*) argue that Lipsky's work is still relevant to this day, and many studies since have explained the gap between policy development and policy practice as a result of implementers' actions, beliefs, and implementation strategies.

2.4.2.2 Context

Policymaking does not take place in a vacuum. Instead a complex contextual environment affects how policy is made and who makes it at all levels (local, national, and global) (Collins, et al., 1999; WHO, 2007). According to Buse et al. (2005), context refers to systemic factors (both internal and external) which may have an effect on policy – for example, political, economic, and social factors. Buse et al. argue that “understanding how health policies change, or do not, means being able to analyse the context in which they are made, and trying to assess how far any, or some, of these sorts of factors may influence policy outcomes” (*ibid.*: 12). There is a multitude of factors that may affect policy – factors which are unique and complex in both time and setting (*ibid.*). While there are many ways to categorize and conceptualize such factors, a useful way is provided by Leichter (1979, quoted in Buse, et al., 2005: 11). Leichter orders the contextual factors into four categories:

- (1) **Situational Factors:** impermanent, transient, less repetitive, distinctive conditions, such as war, drought, or political instability, which may have an effect on policy (e.g. an earthquake that leads to a change in hospital building regulations).
- (2) **Structural Factors:** less transient, relatively unchanging elements such as economic structure, the political system, demographic features, or technological advances (e.g. lack of government capacity to provide health care, facilitating international and/or local organizations' involvement within healthcare provision in the country).

- (3) **Cultural Factors:** such as values and beliefs on issues surrounding gender, religion, family planning, or ethnic minorities (e.g. sexual abstinence is promoted above contraceptive delivery or access to abortion due to religious beliefs; social differences (class, ethnicity) may affect who has a role in the policy process or who is able to influence how and what policy is made).
- (4) **International or Exogenous Factors:** such as the role and influence of international agreements and treaties, or the role and influence of international donor policies on organizations.

Understanding the context in which policies are made is therefore important if we are to understand policy outcomes. Faith-based NGOs, for example, can be influenced by international, national, and local contextual factors, such as larger religious structures, international donor frameworks, and/or national government HIV/AIDS policy. In order to understand the policy process at the organizational level, we must understand what contextual factors influence this process, and how that influence plays out within an organization.

2.4.2.3 Actors

According to Buse et al., 'actor' is the "[s]hort-hand term used to denote individuals, organizations or even the state, and their actions that affect policy" (2005: 4). It includes the notion of 'stakeholder', which is often used synonymously with 'actor' and refers to "[a]n individual or group with a substantive interest in an issue, including those with some role in making a decision or its execution" (*ibid.*: 175). Because Walt & Gilson's framework is used here to analyse policy formation at an institutional level, actors are conceptualized much more narrowly than in the original framework. In the original framework actors are based at the international, national, and local levels and include both government and non-government actors. Here, actors are those that may be influential to a faith-based NGO's policy process. These include actors within the organization itself, its service users, and/or actors outside the organization with direct influence over the policy process. Actors within the organization include employees and/or volunteers. Service users are members of the community that utilize the organization's services. Actors outside the organization can include those that are a part of larger religious bodies, such as prominent religious leaders, in addition to government or donor actors. There are also important actor-related factors that can affect an actor's influence within an organization's policy process. These include their relative power,

legitimacy, or whether they hold a leadership position. Each is explored in greater detail below.

Power, Legitimacy, & Leadership

An actor's power or legitimacy and whether they hold a leadership position within an organization can influence their role, as well as their individual influence, within the policy process. According to Buse et al., within the policy process power "is generally understood to mean the ability to achieve a desired outcome – to 'do' something" (2005: 21). In a relational sense it refers to having 'power over' others – getting someone to do something that they may have not done otherwise (*ibid.*). On both an individual and organizational level, power may be characterized by a combination of personality, individual wealth, authority, or an actor's level of access to knowledge (*ibid.*). An individual's power, however, "is strongly tied up with the organization and structures (including networks) within which the individual [...] works and lives" (*ibid.*:10). Such structures can be based on larger societal influences, including socio-economic, cultural, and gender-related structures. Power therefore refers to whether or not an actor has the ability to make (or not to make) decisions and whether they are then able to project those decisions onto others, influencing and shaping others' behaviours and/or preferences.

A group's or individual's power and legitimacy are intertwined. How much power a group or individual has is dependent upon whether they, and consequently their involvement in the policy process, is considered 'legitimate' – and whether they are considered 'legitimate' is often dependent upon how much power they have. The World Health Organization (WHO) (2007) identifies several possible bases from which an organization, and by extension an individual, may seek to assert their legitimacy. According to WHO (*ibid.*), organizations and individuals can claim the following bases of legitimacy:

- (1) **Moral:** groups or individuals can claim legitimacy on the basis of values and ethical imperatives that motivate their involvement;
- (2) **Technical:** groups or individuals that hold unique professional expertise and experience in the relevant policy field may legitimately have an impact on policy since their professional opinions may be crucial for policy success;

- (3) **Political:** groups or individuals may derive their legitimacy from successfully mobilizing public support for their cause through various forms of political activism; and,
- (4) **Representative:** groups or individuals can gain legitimacy by representing mandates given by a specific community to influence policy-making on their behalf (*ibid.*).

An actor's power and legitimacy within an organization will also be related to the leadership or authority structures within the organization, and whether or not an actor holds a level of authority within the organization (Buse, et al., 2005; Jones, 2001). Jones defines authority as "the power to hold people accountable for their actions and to make decisions concerning the use of organizational resources" (2001: 37). According to Jones (*ibid.*), organizations are differentiated into individual organizational roles, which results in clear authority structures within the organization, creating an organizational hierarchy based on managerial roles. Buse et al. (2005) discuss the relationship between power and leadership at the national level, stating that most of the power to make policy lies with top leadership positions. At an organizational level this can be related to top managerial and leadership positions within the organization. An actor's power, legitimacy, and position within the organization will therefore affect their overall influence within the policy process.

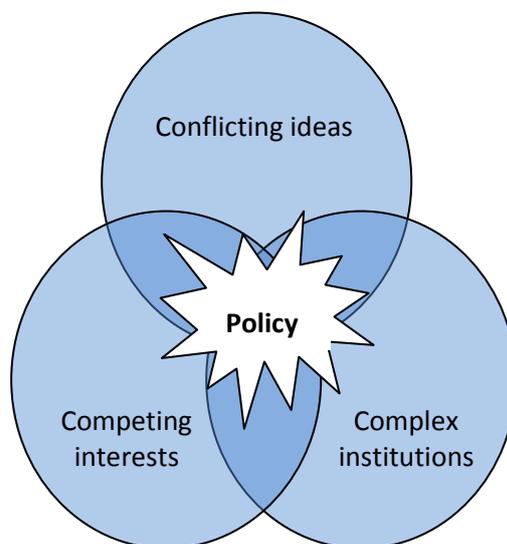
2.4.3 Other Policy Process Theories & Frameworks

Other policy process theories and frameworks were considered in the development of the conceptual framework below, such as the rational theory of policymaking and frameworks which incorporate the role of ideas into the policy process. The rational theory of policymaking was considered as it is often seen in contrast to theories which incorporate the role of ideas, such as faith utilization theories, which are discussed below. The 'rational theory' of policymaking claims that policymakers seek to identify the best possible policy option based on a "comprehensive evaluation of the various alternatives" (Baggott, 2007: 3). The rational theory assumes that policymakers develop policy in a rational and comprehensive way by identifying goals, recognizing and listing all alternative strategies, looking at all available evidence, assessing the consequences of each option, and choosing the strategy that best achieves the recognized goal (*ibid.*). This theory has been criticized greatly in the literature as many authors have recognized that rationality is limited in reality as not all options and solutions will be available to policymakers or could possibly be explored, and other factors such as values and beliefs will influence policymakers' decisions (*ibid.*).

It is often argued that the rational approach to policy formation is in fact an idealized prescriptive view of the way policy *should* be made, not how it *is* actually made. Theories which incorporate the role of ideas argue that the policy process is much more complex than the rational theory suggests, and that there are many more factors which influence how policies are made and implemented, such as beliefs, values, and interests. Ideation theory in particular is regarded as a theory about how policy is made (Lewis, 2005). As a theory of policy formation, ideation is primarily concerned with the process of meaning, actively seeking to find and distinguish “fundamental conceptions of the world” that are shaped by particular ideas, beliefs, or values held by actors (Lewis, 2005: 13). According to Lewis (*ibid.*), ideas are central to policy analysis. By shaping expectations and diffusing a conception of the world, actors use ideas for particular purposes, such as to give meaning or normative direction to thinking and action (*ibid.*). The theory of ideation is discussed in greater detail below under ‘individual faith utilization theories’. Because the rational theory of policymaking disregards the role of ideas, or beliefs and values, which due to the nature of faith-based organizations were hypothesized to be important factors within their HIV/AIDS prevention policy processes, it was not used to inform the study’s conceptual framework.

One framework that was considered alongside Walt and Gilson’s policy triangle was Buse et al’s (2008) “conceptual framework for understanding the interplay between ideas, institutions and interests in policy processes” (Dickinson & Buse, 2008: 1). The framework is represented in Figure 3.

Figure 3 – Ideas, Institutions, and Interests in the Policy Process



According to Dickinson and Buse (*ibid.*), within this framework institutions are defined as “the structures and rules which shape how decisions are made”, interests are defined as “the groups and individuals who stand to gain or lose from change”, and ideas are defined as “discourses, arguments and evidence”. The framework theorizes that conflicting values, interests, and institutions are the main drivers of policy change at the national level (*ibid.*). While this framework was used to inform my conceptualization of policy processes (particularly in relation to the role of conflicting ideas), which informed the conceptual framework for the study, it was not used as the main theoretical framework due to its focus on actors’ political incentives or different interest groups at the national level, which would have been difficult to extrapolate to the institutional level. In addition, within this framework ‘ideas’ includes values, morals, beliefs, and epidemiological or scientific evidence. As religious ‘ideas’, or values and beliefs, were the main focus of this study, and scientific evidence was hypothesized to contradict religious ‘ideas’, the framework’s conceptualization of ideas was not regarded as appropriate for this study. The role of ideas is explored in greater detail in the following section, which discusses how faith, or religious ideas and beliefs, is used within faith-based organizations and the policy process.

2.4.4 Faith Utilization Theories

According to some authors, what makes FBOs distinct from secular organizations and other FBOs is their particular faith identity – the role and influence of faith in their mission, organizational structure, services, programmes, policies, relationships, leadership, and culture (ARHAP, 2006; James, 2009). The importance of understanding the influence and role of faith within FBOs is being increasingly recognized (ARHAP, 2006; Benedetti, 2006; Clarke, 2008; Sider & Unruh, 2004). Clarke states, for example, that there is a “clear need for more careful efforts to distinguish between the ways in which FBOs are constituted and through which they deploy faith constructs in their organizational philosophies and their activities on the ground” (Clarke, 2008: 35). As a result, there has been recent interest in describing and researching FBOs in terms of how faith is utilized within organizations and by actors. The term ‘faith utilization theory’ has been specifically created for this study. It has been developed from literature about the way faith is used by organizations and individuals. Faith utilization theories can therefore be divided into theories relating to overall organizational use of faith, and theories relating to actors’ use of faith. In reality it is difficult to separate the two, as each

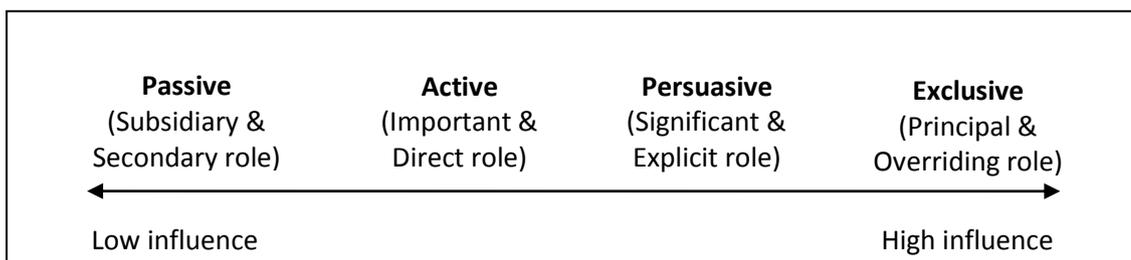
influences the other; however, as findings of this research demonstrate, an organization's overall use of faith, and actors' use of faith within the organization can be different.

2.4.4.1 Organizational Faith Utilization Theories

As discussed above, FBOs are a diverse set of organizations – both across faith traditions and within sub-types of FBOs – and one of the main differentiating factors is the way faith is used. According to Clarke, for example, FBOs “differ to the extent that faith discourse provides the impulse for action and that the goals for which they strive are rooted in the teachings and principles of the faith or sub-faith” (2008: 32). This variation becomes important as donors and partners are often wary of working with FBOs whose goal is to proselytize or seek advantage for their faith community (*ibid.*). When the role of faith is discussed within the literature, faith is often placed on a continuum – from being a secondary or tertiary consideration for action to being the principal consideration for action (Benedetti, 2006; Clarke, 2008; Sider & Unruh, 2004). At the same time, the role of faith within an organization is fluid, meaning it may differ with regards to separate aspects of an organization or organizational activities.

Clarke (2008), for example, identifies four ways in which faith influences organizational motivation and actor mobilization, and the identification of beneficiaries and/or partners within an organization. According to Clarke (*ibid.*), faith can influence an organization passively, actively, persuasively, or exclusively. Where the categories fit on the continuum is depicted in Figure 4, while each term is defined in greater detail below.

Figure 4 – The Role of Faith within FBOs – Clarke's Typology



(Figure developed from: Clarke, 2008)

Passive: The teachings of the faith (or sub-faith) are subsidiary to broader humanitarian principles as a motivation for action and in mobilizing staff and supporters and play a secondary role to humanitarian considerations in identifying, helping or working with beneficiaries and partners (Clarke, 2008: 32).

Active: Faith provides an important motivation for action and in mobilizing staff and supporters. It plays a direct role in identifying, helping or working with beneficiaries and partners, although there is no overt discrimination against non-believers and the organization supports multi-faith cooperation (*ibid.*).

Persuasive: Faith provides a significant motivation for action and in mobilizing staff and supporters. It plays an explicit role in identifying, helping or working with beneficiaries and partners and provides the dominant basis for engagement. It aims to bring new converts to the faith (or a particular branch of the faith) and/or to advance the interests of the faith or sub-faith at the expense of others (*ibid.*).

Exclusive: Faith provides the principal or overriding motivation for action and in mobilizing staff and supporters. It provides the principal or sole consideration in identifying beneficiaries. Social and political engagement is rooted in the faith, or a branch of the faith, and is often militant or violent and/or directed against one or more rival faiths (*ibid.*).

Certain types of FBOs are often associated with a particular faith category. Clarke (*ibid.*) argues, for example, that the passive stance is often associated with development organizations linked to the mainstream Christian churches, as their faith-based principles are often secondary to broader humanitarian principles. It is not always as clear how other development organizations from different faith traditions, such as Muslim organizations use faith in their work, or to which category they might belong. With regards to Islamic development and charitable organizations recent work has suggested that they “wear their faith as lightly and unobtrusively as their Christian counterparts” who might be regarded as belonging to the “passive” category (Clarke, 2008: 35). Having such differentials are useful when conceptualizing the role of faith in FBOs and its influence on organizational activities; however, as Clarke rightly acknowledges, more work is still needed to better distinguish between the ways FBOs employ and utilize faith within their work.

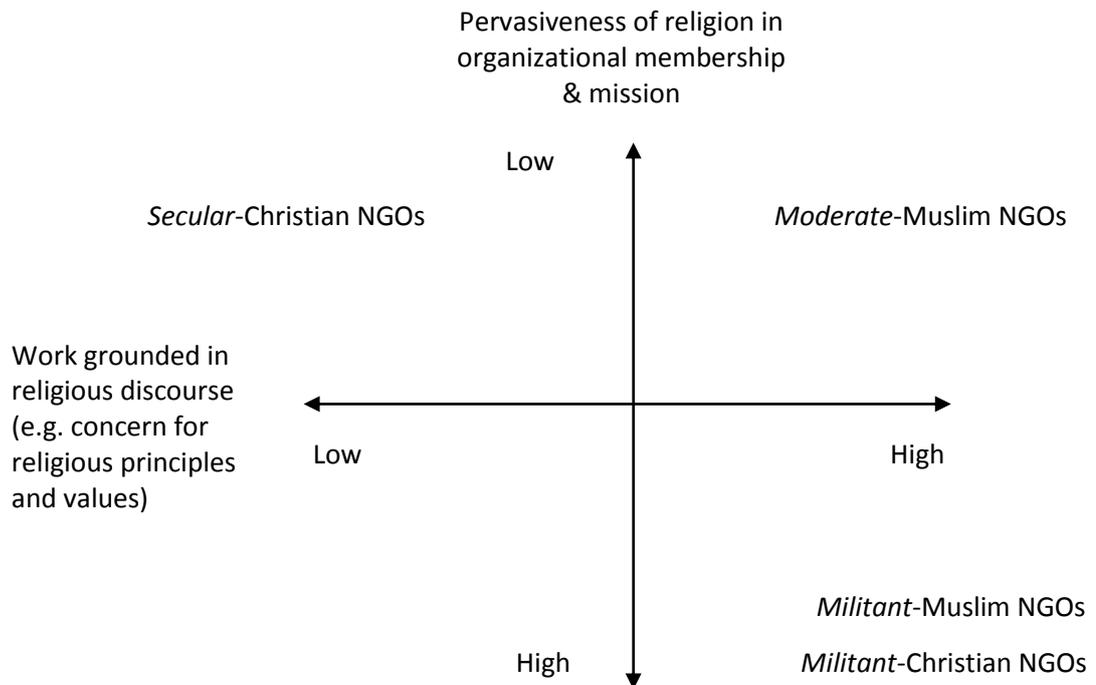
Similar to Clarke, Benedetti (2006) analyses the role of faith in FBOs by identifying 'ideal' types of faith-based NGOs based along a similar continuum. Benedetti, however, distinguishes between the role of faith in Christian and Muslim faith-based NGOs by creating two separate continuums – one for Christian NGOs and one for Muslim NGOs. Using a framework for the analysis of religious NGOs developed by Berger (2003), which looks at the religious, organizational, strategic, and service dimensions of an organization, Benedetti argues that there is a differentiating polarization of the way faith is used between Christian and Muslim NGOs. As a result, Christian NGOs are placed along a continuum from *Secular-Christian* NGOs to *Militant-Christian* NGOs; and Muslim NGOs are placed along a continuum from *Moderate-Muslim* NGOs to *Militant-Muslim* NGOs. These organizations are considered 'ideal' in that they form the absolute ends of the continuum in which real NGOs are situated.

Secular-Christian NGOs are organizations with low religious pervasiveness in their membership and mission. They are similar to secular NGOs in their language, and their operations are often indistinguishable; however, they differ in that they use Christianity in their mission as a reference point and ideology, and venture "beyond notions of social responsibility to assertions of 'Rights' and 'Wrongs', 'Truths' and 'Untruths' (Beger 2003 quoted in Benedetti, 2006: 853). These are contrasted with *Militant-Christian* NGOs that have high religious pervasiveness in their membership and mission (*ibid.*). Benedetti (*ibid.*) argues that the humanitarian principle of neutrality and impartiality is not as relevant to them as it is to *Secular-Christian* NGOs, as these organizations actively seek to proselytize and convert others, and it is common for them to give preferential treatment to Christians in their aid.

Muslim organizations differ from their Christian counterparts in the way that faith is used within the organization. On the one end of the continuum are *Moderate-Islamic* NGOs with low religious pervasiveness in their membership, unlike *Secular-Christian* NGOs they "are strongly grounded in [...] religious discourse in their publicity and concerned with traditional Islamic categories of the needy" (*ibid.*: 856). Like *Secular-Christian* NGOs they share traditional humanitarian principles. At the other end of the continuum are *Militant-Islamic* NGOs, with high religious pervasiveness in both their membership and their mission. Unlike *Moderate-Islamic* NGOs, they give preferential treatment to Muslims in their aid, and participate in *dawa*, which is similar to the Christian concept of proselytization (*ibid.*). In this classification the main difference between the Muslim organizations and their Christian counterparts is that Muslim NGOs, at both ends of the spectrum, are strongly grounded in religious discourse and actively

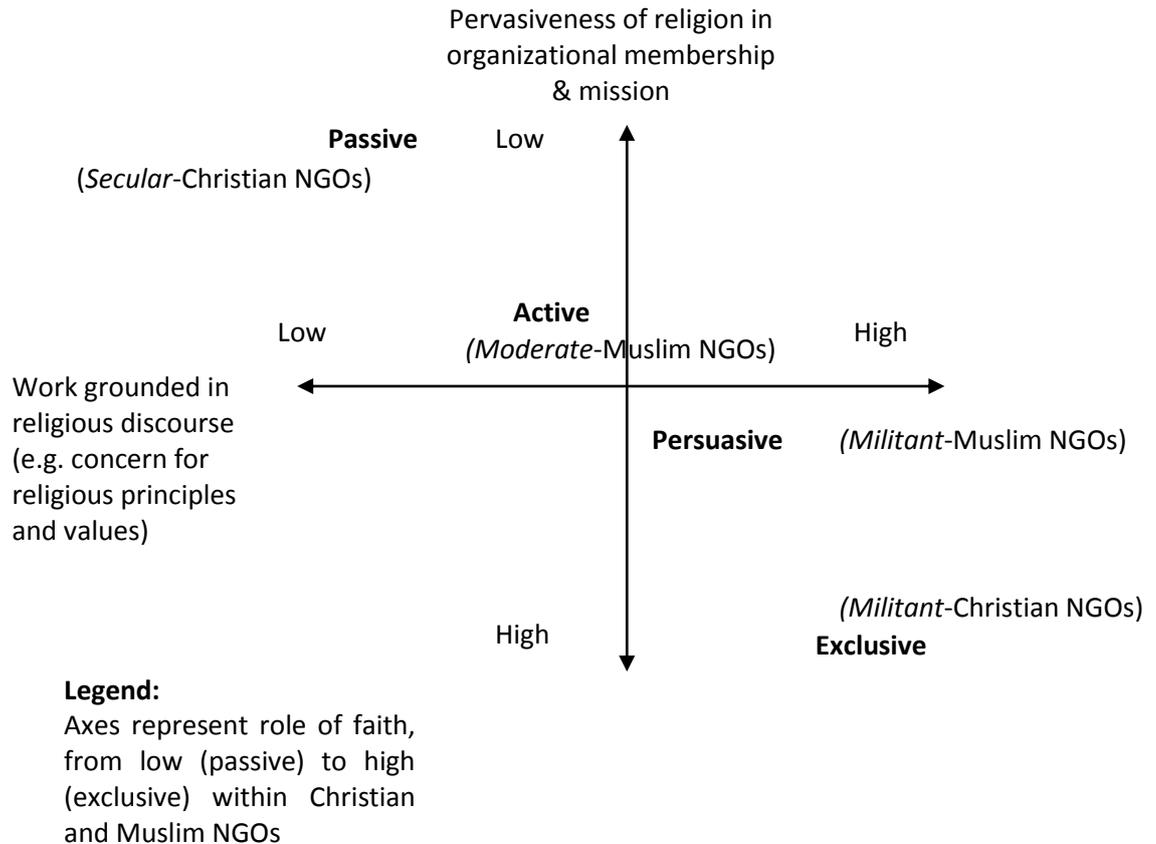
concerned with religious principles and values – the difference between the Muslim organizations is in the way that faith motivates and in the way that it is promoted. Benedetti's typology is represented in Figure 5.

Figure 5 – Role of Faith within Christian and Muslim NGOs – Benedetti's typology



Strong parallels can be drawn between Clarke's typology of the role of faith in the work of FBOs, and Benedetti's typology of the role of faith within faith-based NGOs. In each, FBOs are situated along a continuum where on one end faith is a primary influencing and motivating factor within the organization, while on the other it is a secondary or tertiary factor. Bringing the two faith utilization theories together can provide a useful framework for analysing the role of faith within and between organizations of different faiths. Figure 6 brings Clarke's and Benedetti's typologies together to show the role of faith within Christian and Muslim FBOs.

Figure 6 – Faith Utilization within Christian and Muslim NGOs



The above framework shows where Benedetti's four types of faith-based NGOs fit when placed on Clarke's continuum. Benedetti's four types of Christian and Muslim NGOs are placed on the framework to show where they would fit in relation to Clarke's continuum. The framework is useful as it exemplifies the difference between the role of faith with Christian and Muslim faith-based NGOs that Benedetti found in her work, showing the scope of influence between Christian and Muslim organizations. Such a diagram could be further used to exemplify the role of faith within organizations of different faiths, such as Catholic or Anglican organizations, or the role of faith with different types of FBOs, such as representative bodies or development organizations, by replacing the type of organization on each axis. The diagram will be used to illustrate the role of faith within each organization in the study in Chapter 8, and the different typologies were used to inform the study's conceptual framework in relation to the role of faith within FBOs – for example whether faith is used actively or passively and whether this differs between Christian and Muslim FBOs. This is further discussed in Chapter 8. As stated above, faith is used at both the organizational and individual levels. The following section explores the use of faith at the individual level.

2.4.4.2 Individual Faith Utilization Theories

The above classifications look at the role of faith in the overall work of FBOs. At the same time, it is also important to distinguish how faith might be utilized by individual actors within the organizations, as each will influence the other. There is less research and theory regarding how faith is utilized by individual actors within an organization. One such theory, however, can be extrapolated from theories of ideation, which look at how ideas shape expectations and diffuse conceptions of the world to inform decision-making and action (Lewis, 2005). At their base, ideation theories argue that ideas shape individuals' understanding of the world, determining preferences and action. Religion and the religious beliefs of actors within a FBO, which can be considered as religious ideas, can therefore have the potential to be an important and influential determinant of such preferences and actions, particularly with regard to decision-making in the policy process.

Ideational theories categorize and distinguish ideas in order to better conceptualize how ideas (in this case religious ideas) influence action. Like the above organizational faith utilization theories which place FBOs on a continuum depending on the role of faith within the organization, ideational theories place ideas and beliefs on a continuum, from those that are deeply held and strongly resistant to change, to those that are adaptable and open to change. Knowing where an actor places certain religious ideas and beliefs (in relation to non-religious ideas and beliefs for example) can help to determine how faith influences that actor's decision-making and actions. One such categorization is Goldstein's and Keohane's (1993) worldviews, principled beliefs, and causal beliefs. Religious beliefs or ideas can often be found at the level of worldviews and principled beliefs.

Worldviews are the most fundamental level of ideas, and include those which are deeply embedded and least receptive to change. Ideas at this level affect modes of thought and discourse and provide people with a framework in which to interpret their environment. It is at this level where ideas have their broadest impact on human decision-making and action. Principled beliefs differ from worldviews in that they are normative ideas and beliefs which identify criteria for distinguishing right from wrong and just from unjust, providing a moral or ethical lens in which the world is viewed. These are justified in terms of larger worldviews, which are expansive enough to include multiple and opposing principled beliefs. The same principled beliefs therefore are not always held by those who subscribe to a similar worldview. In comparison causal beliefs are most adaptable and open to change. Ideas at this level are

beliefs about cause-effect relationships which derive authority from a shared consensus of recognized elite, such as village elders or researchers within elite institutions. Causal beliefs suggest feasible action and provide guides for individuals and institutions as to how to reach their objectives. 'Evidence', for example, can form the basis for causal beliefs, providing prescriptions for social ailments and suggesting courses of action. Causal beliefs differ from worldviews and principled beliefs in that they are receptive to change when new information or 'evidence' is gained.

While this categorization is useful in order to understand how ideas can influence an individual's decision-making, in reality the categories are not neatly separable or distinguishable as actors may also be influenced by separate and sometimes competing ideas. In the case of HIV/AIDS, for example, while an actor may be a member or employee of a FBO and subscribe (or be forced to subscribe) to its worldview, they may also be a member of a professional medical community or other worldview whose beliefs about the causes of, and ways to prevent, HIV/AIDS may differ. How that actor mediates between the two sets of beliefs within their decision-making in the HIV/AIDS policy process will be dependent upon a complex set of factors, factors which this study will illuminate. As the above discussion demonstrates, faith can therefore have an influence at both the organizational and individual level.

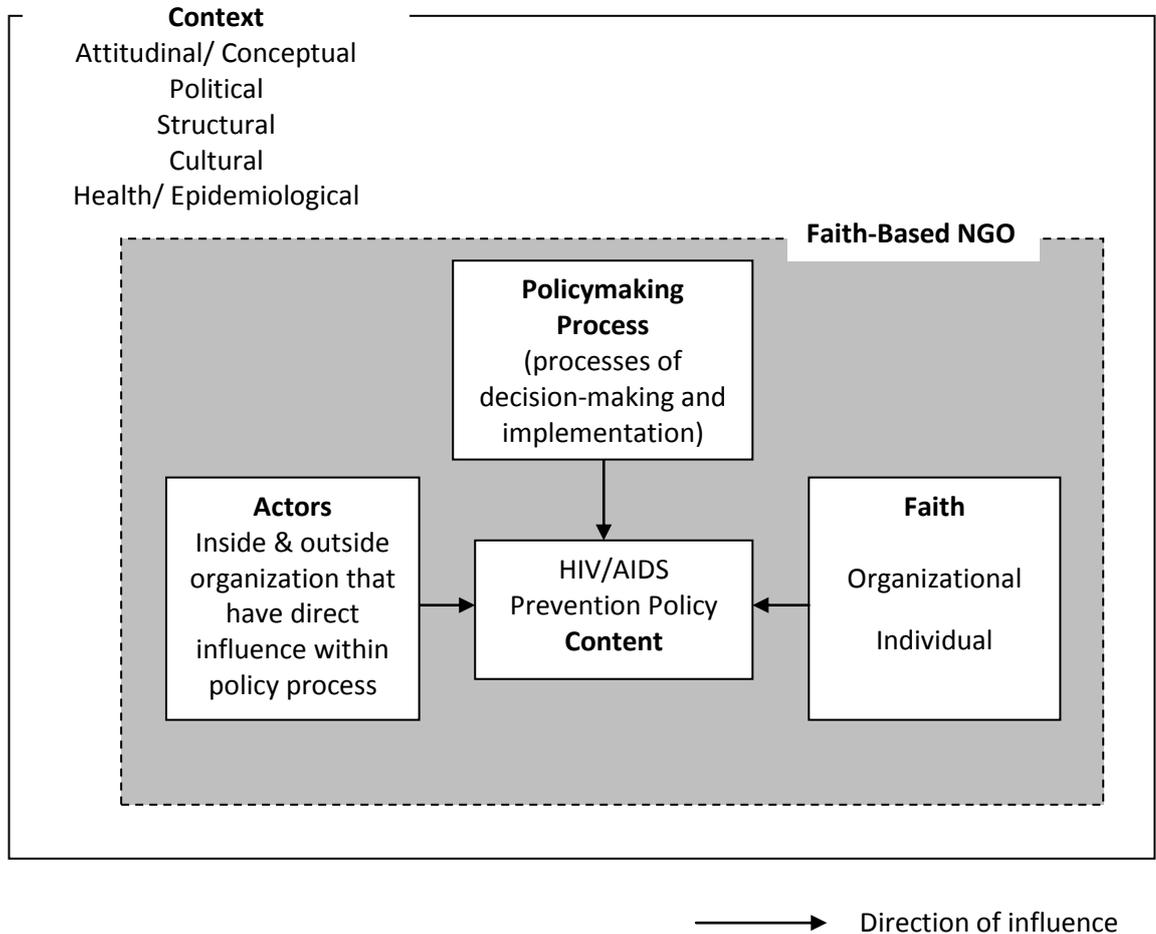
2.5 Conceptual Framework

The above policy analysis framework and faith utilization theories informed the development of the conceptual framework used to inform the study's research questions, data collection, and analysis. The health policy analysis framework provides a useful starting point in which to situate and explore the role of faith, in relation to other factors, in the HIV/AIDS prevention policy processes of faith-based NGOs. However, as the health policy analysis framework explicitly omits the role of values or beliefs, of which faith is a large part of, it was expanded upon in order to represent the potential importance of faith within faith-based NGOs' HIV/AIDS prevention policy processes. The conceptual framework developed therefore combines the health policy analysis framework with the faith utilization theories described above in order to explore the role of faith in relation to other factors in the HIV/AIDS prevention policy process of faith-based NGOs. Religious ideas were given a distinct category as I hypothesized that the role of faith would play a large role within the organizations' HIV/AIDS prevention policy process, due to the faith-based nature of the organizations and the

theological challenges inherent within HIV/AIDS prevention discussed above. At the same time, I recognized the importance of other factors in the policy process, such as context and actors. Context was separated into five categories: wider attitudinal/ conceptual factors, cultural factors, political factors, structural factors, and health/ epidemiological factors, in order to assist data collection and analysis. These categories were chosen based on a reading of the literature.

The conceptual framework was developed under the understanding that it would be tested within data collection and analysis and revised if necessary. Accordingly, the conceptual framework has since been modified and the new framework will be described within Chapter 8. Although the framework was applied to faith-based NGOs, I hope that it could be applied outside of faith-based NGOs, for example with regards to secular organizations or public policy in terms of organizational or actors' worldviews and values. Definitions of the key factors within the framework are provided below the conceptual framework, which is presented in Figure 7.

Figure 7 – Conceptual Framework Informing Study



Each element in the above framework is defined as follows:

Process: the process in which policies are identified, initiated, formulated or developed, communicated, negotiated, implemented and evaluated.

Context: systemic factors (both internal and external to the organization) which may have an effect on the policy process, including attitudinal/ conceptual factors, political factors, structural factors, cultural factors, and health/ epidemiological factors.

Actors: individuals and groups of individuals that have direct influence on the organization's policy process. This includes both external actors outside the organization and internal actors within the organization that have direct influence on the policy process. Actors also include

actor-related factors that can have a direct influence on an actor's ability to influence policy, such as power, leadership, and legitimacy.

Content: the output of the policy process (i.e. the product of the different factors). This includes both written and unwritten policy within the organization as well as practice. Organizational policies can include: objectives, visions, decisions, strategies, targets, plans, guidelines, or directives, and may be formal or informal, implicit or explicit. Practice refers to actors' actions at the implementation level.

The above conceptual framework helped to inform data collection and analysis, which are discussed in Chapter 3. In the conclusion of this thesis, the conceptual framework will be discussed in relation to the study's findings.

2.6 Chapter Summary

This chapter explored the relevant literature in relation to the study, in addition to the theoretical perspectives that informed the study's conceptual framework, research questions, data collection, and data analysis. In order to situate the faith-based response within the HIV/AIDS literature and overall prevention response efforts, an overview of key historical influences on national and international HIV/AIDS responses, the key drivers of the epidemic, and HIV/AIDS prevention paradigms was given. In order to place the study's three faith-based NGOs within the wider faith-based response to HIV/AIDS, this was followed by a discussion of FBOs and HIV/AIDS, with particular attention paid to the FBOs' HIV/AIDS prevention response. This section also explored dominant criticisms to the faith-based HIV/AIDS response, which included the reduction of HIV infection to issues of individual morality and sin, and the perpetuation of HIV/AIDS-related stigma, particularly gender-related HIV stigma. With relation to the prevention paradigms discussed FBOs' apply a behavioural approach to HIV/AIDS prevention, seeing HIV/AIDS prevention as an individual's responsibility and actively attempting to influence individual attitudes, knowledge, and behaviour.

The latter part of the chapter explored the dominant theoretical perspectives which informed the study's conceptual framework, data collection and data analysis. A definition of policy was provided, and the prominent health policy analysis framework – Walt and Gilson's health policy framework – that was used as the starting point for the conceptual framework was described. This was followed by a description of organizational and individual faith utilization

theories, which were developed from the literature. Different organizational theories were brought together to create a framework for exploring the role of faith within FBOs, in order to distinguish its role with different types of FBOs and within FBOs of different faiths. This framework will be used to analyse the role of faith within the three case studies in Chapter 8. The chapter concluded with a discussion of the study's conceptual framework that informed the study design, data collection, and analysis. The next chapter sets out the study's research methodology, including the key data collection methods used, in addition to the data analysis process.

Chapter 3 – Research Methodology

3.1 Introduction

This chapter aims to provide a detailed discussion of the research methodology used to address the overall research aim, objectives, and questions, which were discussed in Chapter 1. The chapter begins with a discussion of the overall research methodology, including case study selection, data collection methods, and data analysis. This is followed by a discussion of other methodological considerations, such as methods used to ensure rigour, ethical considerations, and study limitations.

The study was conducted in Dar es Salaam, Tanzania. Tanzania was chosen as a case study location as it met key criteria, which are discussed below. Data collection took place from June to November 2009. Three faith-based NGOs were included in the study – a Catholic, Anglican, and Muslim NGO. A brief overview of each organization is presented below, while a more detailed description is given in Chapter 4. This research used an exploratory, qualitative comparative case study approach. Ethical approval was granted from the University of Leeds Institute of Health Sciences Ethics Committee and the National Institute for Medical Research in Tanzania. In addition, research clearance was granted from the Commission for Science and Technology in Tanzania. Data collection included semi-structured interviews, document review, and observation. In total seventy interviews were conducted, twenty-eight contextual interviews with governmental officials, NGO organizations, FBOs, and donor officials, and forty-four interviews with case study employees and volunteers. Overall eighteen organizational policy documents were analysed, which included organizational policies, constitutions, and reports. In addition, observations of the organizations' meetings and environment were recorded and analysed. Framework analysis, a thematic approach to data analysis, was used to analyse the data.

3.2 Research Methodology

As stated above, this study utilized an exploratory, qualitative approach of inquiry. According to Hansen, a qualitative approach is best suited to research problems that need to be understood in relation to wider social, cultural, political, and economic contexts that involve exploration into the processes of how these factors relate and interact, through which generalizing about the problem would “not give an accurate picture of the situation” (2006: 9).

This is in contrast to quantitative research approaches which assume there is an independent reality, or truth, unrelated to context, that can be explored, measured, and replicated through deductive “hypothesis-testing designs, [... and] statistical analysis” (*ibid.*: 4). According to Golafshani, unlike quantitative researchers, “who seek causal determination, prediction, and generalization of findings, qualitative researchers seek instead illumination, understanding, and extrapolation of similar situations” due to the context-specific nature of a research problem (2003: 600). As evidenced throughout the literature, policy processes need to be understood in relation to the wider context of which they are a part, and it is the interaction between these factors that will influence the overall policy process (Buse, et al., 2005; Walt, 1994). As a result, due to the context-specific nature of policy analysis, a quantitative approach which sought to generalize about the problem would not have been an appropriate study design.

In addition, in order to explore the factors influencing the HIV/AIDS prevention policy processes of faith-based NGOs this study employed a comparative case study approach in a single country. A case study approach focuses on “instances of a particular phenomenon with a view to providing an in-depth account of events, relationships, experiences or processes occurring in that particular instance” (Denscombe, 2007: 35). A case study approach is suitable for policy analysis in particular as it emphasises exploration into the interrelations between processes and relationships within complex social settings, offering the opportunity to unravel the complexities of a given situation (*ibid.*). As the factors influencing the policy process are often part of complex social settings, conducting a comparative case study within a single country allowed for an in-depth exploration into the complexities of the particular setting and its influence on organizational policy processes. Due to the context-specific nature of the policy process, comparison between case studies within a multi-country study would therefore not have been as in-depth, as many factors may not have been comparable.

A comparative case study approach within a single country allowed for an in-depth exploration into the context, actor, and process factors that influenced the overall HIV/AIDS prevention policy process of faith-based NGOs, and how the factors interacted to form HIV/AIDS policy content. Three case studies were therefore chosen in order to allow for in-depth comparison between the cases in order to identify factors that might have otherwise been lost if only one case study was included. More than three case studies would not have been feasible within the study’s timeframe. As stated above, the data collection tools used were interviews,

observation, and document review. The choice of each method is discussed in greater detail below. In comparison, conducting a survey or postal questionnaire of twenty or more organizations would not have allowed for the same in-depth exploratory approach to the study, as relevant factors found to influence the policy process during data collection could not have been explored in greater detail. Other qualitative approaches were considered but deemed inappropriate for policy analysis due to their emphasis on one aspect of the social setting, such as culture (ethnography), or on individuals' perceptions, beliefs, or emotions (phenomenology).

As discussed in Chapter 1, in order for there to be a more comprehensive understanding of the faith-based response to HIV/AIDS prevention and mitigation in Africa, many authors have called for research to be carried out on the HIV/AIDS responses of FBOs from different faiths (ARHAP, 2006; Thomas, et al., 2006; Tiendrebeogo & Buyckx, 2004a). Currently, Christian FBOs are the most active (among FBOs) in HIV/AIDS prevention and mitigation in Africa; however, many authors are recognizing that Muslim FBOs are becoming more active (Tiendrebeogo & Buyckx, 2004a). As a result, in order to provide a more comprehensive understanding of the faith-based response to HIV/AIDS prevention, faith-based NGOs of both Christian and Muslim faiths were chosen for inclusion in the study. Including different faiths is useful as it allows for the potential to explore whether organizations from different religions are influenced by faith in different ways. Faith-based NGOs were selected due to their long tradition of providing relief and social service delivery in Africa, particularly in the area of HIV/AIDS. In addition, faith-based NGOs were found to be an under-researched sub-section of both FBOs and NGOs. The following section discusses the key methodological considerations within the study, such as the selection of country location, case study selection criteria, methods of recruitment, and data collection methods. An overview of the entire research process, including the timing of research activities, is provided in appendix B.

3.2.1 Selection of Country Location

As stated previously, the research was conducted in Tanzania. In choosing Tanzania as a case study, the following criteria were used: the religious demography of the country in order to include both Christian and Muslim NGOs, the country's HIV/AIDS prevalence rate to ensure there would be a faith-based response to HIV/AIDS, and the role of FBOs within the national HIV/AIDS policy response in order to assess whether and how FBOs were part of national response efforts. Other considerations included: whether the country was a hospitable

location to conduct fieldwork in order to ensure the safety of the researcher, how prevalent spoken English was throughout the country in order to aid in the data collection process, and whether peaceful relations between religious communities and the government existed. Tanzania matched all of these criteria.

The following outlines why Tanzania was chosen based on the above criteria:

1. **Religious demography:** The religious demography of the country lends itself well to a case-study of Christian and Muslim faith-based NGOs. Although official statistics are unavailable, it is currently estimated that the Christian and Muslim communities within Tanzania are relatively equal, each accounting for 30 to 40 percent of the population, with the remainder of the population consisting of members from other faiths or traditional indigenous religions⁴ (Bureau of Democracy, 2007, 2008; World Factbook, 2011; Zou, et al., 2009). As a result, Tanzania was regarded as a suitable case study location for exploring HIV/AIDS policy processes and response in both Christian and Muslim faith-based NGOs.
2. **HIV Prevalence:** The HIV prevalence rate in Tanzania is among the highest in the world, and HIV/AIDS is the top cause of death in the country (WHO, 2006). In 2007-2008 it was estimated that 5.7% of adults (15-49 years) were living with HIV, and although it has declined from 7.0% in 2003-2004, it still remains relatively high (TACAIDS, et al., 2008). HIV/AIDS prevalence within Tanzania will be further explored in Chapter 4. Due to the high prevalence rate, and the research evidencing FBOs' involvement within HIV/AIDS, it was highly likely that FBOs would be actively involved in HIV/AIDS prevention within Tanzania.
3. **Role of FBOs in National HIV/AIDS Policy Response:** Tanzania has a National Policy on HIV/AIDS, the overall goal of which is to provide a "framework for leadership and coordination of the national multi-sectoral response to the HIV/AIDS epidemic", including "formulation, by all sectors, of appropriate interventions which will be effective in preventing transmission of HIV/AIDS and other sexually transmitted

⁴ According to the International Religious Freedom Report, "recent information suggests that 62 percent of the population is Christian, 35 percent is Muslim, and 3 percent are members of other religious groups" (Bureau of Democracy, 2009). As this estimate is relatively recent and most studies and reports quote Christianity and Islam each accounting for 30 to 40 percent of the population respectively, these numbers are referenced here. However, it should be noted that while the discrepancies in the data make it difficult to determine the exact prevalence of Christianity and Islam in the country, what is known is that both are considerably represented.

infections” (URT-PMO, 2001). The policy specifically recognizes FBOs as potential partners in its framework, stating that the “local government councils will be the focal points for involving and coordinating public and private sectors, NGOs and faith groups in planning and implementing of HIV/AIDS interventions” (ibid.). In addition, the National Multi-Sectoral Framework on HIV/AIDS (NMSF) recognizes that state actors cannot implement the national response alone, and that civil society organizations (CSOs) “across the country are important implementation partners and complement the government driven intervention initiatives”, already having made substantial contributions to the national response (URT-PMO, 2007: xv). With regards to FBOs in particular, the NMSF recognizes that the involvement of FBOs in the national HIV/AIDS response is essential if its goals and objectives are to be met.

These policies, although not legally binding, are intended for use by all actors working in HIV/AIDS prevention and mitigation. At the same time, however, the NMSF recognizes that while all FBOs working in the area of HIV/AIDS have to operate within the framework, not all will support all the recommended strategies due to their organizational values and beliefs. In such cases, the NMSF states that organizations are allowed to select their own preferences but are asked to “refrain from contradicting other elements of the NMSF” (ibid.). FBOs’ inclusion in these policies, and the recognition of their differences, indicates a willingness to include FBOs in national HIV/AIDS prevention and mitigation efforts. As a result, the faith-based response to HIV/AIDS has greater potential for influencing overall response efforts within the country.

3.2.2 Case Study Selection Criteria

Three case studies were included in this study: a Catholic, Anglican, and Muslim NGO. I felt that by including three faith-based NGOs of different faiths a more robust picture of the role of faith in the HIV/AIDS policy process of FBOs could be developed, in addition to an understanding of the different faith-based NGOs’ HIV/AIDS responses. The case studies selected were chosen in a purposive manner. According to Maxwell, the goal of purposive sampling is twofold: “to make sure one has adequately understood the variation in the phenomena of interest in the setting, and to test developing ideas about that setting by selecting phenomena that are crucial to the validity of those ideas” (1992: 293).

As discussed in Chapter 2, faith-based NGOs are defined as “formal organizations whose identity and mission are self-consciously derived from the teachings of one or more religious or spiritual traditions [...] which operate on a non-profit [...] basis to promote and realize collectively articulated ideas about the public good (Berger, 2003: 16). In order to be considered a FBO, organizations therefore had to meet one or more of the following characteristics to be included in the study: (1) defined themselves, or self-identified, as faith-based in their mission statement or objectives; (2) were formally affiliated with a religious body; and/or (3) had a “governance structure where selection of board members or staff is based on religious beliefs or affiliations and/or decision-making processes based on religious values” (Bano & Nair, 2007; Jayasinghe, 2007: 624). In addition, in order to be considered an NGO involved in HIV/AIDS prevention organizations had to be non-profit, have aims and objectives developed to “promote and realize collectively articulated ideas about the public good”, and be actively working in HIV prevention at the time of data collection. For reasons described in Chapter 4, not all faith-based NGOs are registered within Tanzania, or are registered under different bodies and therefore not officially recognized as an NGO; as a result, this study is not using registration as a criterion for selection. For comparative purposes only those organizations working at the local level were included in the study, meaning those organizations working at the regional or international level were excluded. A brief description of each case study is provided below, while a more detailed description of each organization is provided in Chapters 5-7.

The Catholic organization is a social service agency operating under the Roman Catholic Archdiocese of Dar es Salaam, Tanzania. It is fully donor funded. It provides services for around 18,000 people, providing care and support to people infected and affected by HIV/AIDS, such as voluntary counselling and testing (VCT), home-based care (HBC), prevention of mother-to-child transmission (PMTCT), tuberculosis services, anti-retroviral treatment (ART), care and support to orphans and vulnerable children (OVC), and preventative services. At the time of data collection it had approximately 150 professional staff and over 700 volunteers, many of whom are also clients. It is registered under the Ministry of Health and Social Welfare (MOHSW) as a health facility and the staff and volunteers come from different religious denominations.

The Anglican organization is a registered NGO operating under the Anglican Diocese of Dar es Salaam, Tanzania. The organization is fully donor funded. It provides HIV/AIDS and malaria

services, which have included: Nets-for-Life, distributing mosquito nets and health education literature; HIV/AIDS VCT; outreach and microfinance loans to over 200 CSWs; peer support and microfinance loans to about 100 PLWHA; an AIDS orphan program providing emergency aid, health care and education to around 150 AIDS orphans; an AIDS treatment program; and a HBC program. The organization has 22 employees, in addition to up to 300 volunteers, which are recruited from all religious backgrounds.

The Muslim organization is a registered NGO within Tanzania. It has no external donor support and relies solely on members' contributions. The organization's activities have included: life skills training for Muslim leaders (2001), Community Mapping and Theatre against HIV/AIDS (2002-2006), formulation of and participation in Council Multicultural AIDS Committees (2003), training of trainers for Muslim Family Health Life Education (2006), stigma and discrimination education to sheikhs, madrasa teachers, and the Muslim community (ongoing), and home-based care support (ongoing). Its head office is located in Dar es Salaam. Since its inception it has expanded to include up to eight branches throughout Tanzania. As a whole, it is not accountable to any coordinating body or structure. Membership is voluntary and total members vary between branches depending on the size of the community. At the two branches included in the study, one had approximately twenty-five members while the other had one hundred. Members within the organization share a uniform faith – Islam.

3.2.3 Methods of Recruitment outside Case Studies and Selection of Case Studies

Data Collection took place from June 2009 to November 2009. Selection of case studies took place in-country due to the difficulty of obtaining an accurate picture of faith-based NGO involvement in HIV/AIDS while outside of Tanzania (for example, at the time of data collection many faith-based NGOs did not have an online presence). Therefore, in order to gain a picture of faith-based NGOs working in the area of HIV/AIDS in Tanzania, and identify suitable faith-based NGOs for inclusion in the study, the first two months of data collection involved background interviews in Dar es Salaam. A number of contextual interviews also took place after research had begun within the case studies if additional key informants were identified. Selection of informants throughout the study was purposive, based on identifying key individuals who could provide rich information in relation to the phenomena under study (Hansen, 2006). Initial informants were identified through a contact at the MOHSW who was familiar with the health and HIV/AIDS context in Tanzania, as well as through document review. Informants were also identified through snowballing, where respondents were asked

to recommend additional informants to be included in the study. A timeline for the fieldwork, including different research activities, is provided in appendix C.

All informants were initially contacted either in person by visiting their office, or by telephone when the number was located online or provided by a key informant. In total twenty-eight contextual interviews were conducted, fifteen of which were tape recorded. The interview process is described in section 3.3.2. A breakdown of contextual interviews is presented in Table 2.

Table 2 – Breakdown of Contextual Interviews

Type	Number
Umbrella FBO – Christian	6
Umbrella FBO – Muslim	3
Umbrella NGO - secular	3
Government	7
Muslim organizations	3
Church Bishops	2
Donors	2
Development organizations	2
Total	28

Due to the complexity of registration of FBOs in general in Tanzania and the lack of overall coordination of FBOs, which is described in detail in Chapter 4, many respondents were only able to identify national umbrella⁵ faith-based NGOs working in the area of HIV/AIDS. As a result, identifying suitable organizations for inclusion in the study was challenging. It became apparent that many local faith-based NGOs were only known in the areas in which they worked or by informants who were directly involved with the organization. As a result, the majority of faith-based NGOs identified were located in Dar es Salaam. A list of faith-based NGOs was generated from the NGO registry under the Ministry of Community Development, Gender and Children; from the Office of Home Affairs, which registers civil society organizations; from the Tanzanian Commission for HIV/AIDS (TACAIDS); through interviews with key respondents; and by word of mouth. The list was used to identify case studies that fit the above inclusion criteria.

From this list two Christian faith-based NGOs and two Muslim faith-based NGOs in Dar es Salaam that appeared to meet the above criteria were selected as potential case studies. Each

⁵ An umbrella organization is a national organization which coordinates and/or represents many smaller organizations located throughout the country.

was contacted either by phone or e-mail and a meeting set up with the head of each organization in order to discuss the study. All four organizations were willing to take part in the study; however, only three were identified as fully meeting the above criteria, as the fourth organization was only in its infancy and HIV/AIDS was only a small part of its overall work. In the end, a Catholic, Anglican, and Muslim organization was selected for inclusion. Approximately one month was spent within the Catholic organization (due to the relatively large size of the organization), and two weeks, respectively, within the Anglican and Muslim organizations. Each organization was asked if the organization's name could be identified within any final publications. Both the Catholic and Muslim organizations agreed to be identified; however, in order to protect the identity of respondents, the Anglican organization chose not to be identified.

3.3 Data Collection Methods

In order to provide a more in-depth picture of the HIV/AIDS policy processes within faith-based NGOs, multiple data collections methods were utilized. The data collection methods used in this study were: semi-structured interviews, document review of selected documents from each case study, and observation. Each method was selected due to its appropriateness for the research problem and methodology selected, and is discussed more in detail below. Multiple data collection methods and sources were used in order to obtain a fuller, more complex and accurate picture of the phenomena under study (Hansen, 2006).

3.3.1 Methods of Recruitment within Case Studies

Once the case studies were identified and access was granted, in most instances, the head of the organization introduced me to the organization's employees or volunteers at a staff gathering or meeting. In such cases, I introduced myself and explained the purpose of the research and the methods of data collection. When such a gathering could not take place, often due to the people being located outside the area of the organization's headquarters, the head of the organization contacted members by phone to discuss their involvement in the study. As discussed previously, all respondents were selected in a purposive manner, based on whether the respondents had a potential contribution to make, or because they held a key position inside or outside the organization (Denscombe, 2007). Through this process key decision and policy makers within each organization were identified for recruitment. In order to corroborate the above key respondent interviews, further key informants outside the organizations with possible direct influence over the policy process were identified, such as

religious leaders or donors through discussion with the initial key informants (using the snowball technique). The majority of respondents were contacted in person during my time at each organization, with only a few contacted by telephone prior to initial contact.

3.3.2 Key-Informant Interviews

Semi-structured interviews were the main data collection tool used. Semi-structured interviews consist of open-ended questions around the explored topic area and are conducted on the basis of a loose structure in which the interviewer is free to pursue ideas or responses that emerge during the interview. Semi-structured interviews were chosen as the main data collection tool as they allow for the exploration of more complex and subtle phenomena, allowing in-depth information to be gained, for example, around people's behaviour, experiences, values, opinions, feelings, and knowledge (Britten, 2006; Denscombe, 2007). All interview respondents were identified in the manner discussed above. In total seventy-two interviews were conducted. A breakdown of the interviews is presented in Table 3.

Table 3 – Breakdown of Interviews

Type	Number
Contextual	28
Catholic NGO	24
Anglican NGO	10
Muslim NGO	10
Total	72

The difference between the number of interviews within the case studies is due to the relative size of each organization – in comparison the Catholic organization was much larger than the other two organizations, with a greater number of decision and policy makers. Interviews ranged from forty minutes to two hours in length, with the majority of interviews being around sixty minutes in length. The length of the interview was dependent on such things as how much time the respondent had available, the ability and willingness of the respondent to answer questions, the depth of the answers the respondent provided, and the rapport between the interviewer and interviewee.

A semi-structured topic guide was used throughout each interview. Questions were developed prior to fieldwork based on *a priori* themes developed in relation to the research aim, objectives, and questions, as well as the conceptual framework. During fieldwork the topic guide was further developed and questions were changed based on emerging themes

that arose during preliminary and ongoing analysis and reflection. For example, it became evident that some topics initially included in the topic guide were not deemed important by the respondents and were subsequently excluded. Other topics were identified as important and therefore subsequently included. In addition, using a semi-structured topic guide allowed for flexibility in the style and order of the questions, allowing topics to be further explored and expanded upon based upon interviewees' responses (Britten, 2006; Denscombe, 2007). The Catholic organization was the first organization to be included in the study, the topic guides used in the Anglican and Muslim organizations were developed based on the responses from the Catholic organization; at the same time, questions were also included to allow for the exploration of new findings that were not previously identified. Separate topic guides were used for the contextual interviews which depended on the position of the interviewee (e.g. government, NGO, or FBO respondent). For examples of the topic guides used in the Catholic, Anglican, and Muslim organizations, as well as the contextual interviews, see appendix D.

All contextual interviews were conducted in English, due to the multi-lingual capabilities of the respondents. The majority of the case study interviews were also conducted in English, however, a proportion of interviews were conducted in Kiswahili with the aid of an experienced interpreter. Although I attended Kiswahili lessons during the first month of my stay in Tanzania, my knowledge of Kiswahili was not sufficient to conduct the interviews. Out of the forty-four case study interviews, sixteen were conducted in Kiswahili – three at the Catholic organization, five at the Anglican organization, and eight at the Muslim organization. The same interpreter was used throughout the data collection process. At the start of the interviews, the interpreter was told the importance of interpreting as accurately as possible, in order to ensure information was not lost. There were two interviews within the Catholic organization that would have benefited from the use of interpreter; however, an interpreter was not contacted in such instances as the respondents' grasp of English was misjudged. The ethical considerations included within this process, such as informed consent and anonymity, are discussed in section 3.6.

3.3.2.1 Interview Challenges

During the interview process, there were a few factors that appeared to affect the overall quality of the interviews. The location of the interview appeared to have an effect on its quality. In most cases the interviews were conducted in a private, quiet room with little disturbance, however, there were a few instances when the interview had to be conducted in

an open office. Such instances changed the dynamic of the interview as other staff members are able to hear the questions being asked as well as the answers, which ultimately inhibited respondents' answers. It is also recognized that there are added ethical considerations to 'public' interviews, such as confidentiality and anonymity. Although there was little that could be done to change the location of the interview, in such instances respondents were given the option to not conduct the interview or answer any questions if they did not want to do so.

In addition, my own initial inexperience as an interviewer also affected some of the interviews. For example, in some cases an inappropriate topic guide that was aimed at a different group of respondents was used. In one instance the clients of an organization were interviewed in order to get their opinion about the role of faith within the organization; however, it became apparent during the interview that many of the questions needed to be rephrased as they were not easily understood by the respondents. In such cases it became apparent that questions could not be asked directly to the respondents, but instead it was more beneficial to elicit stories about their experiences in the hopes of eliciting a response that would be worthwhile to the study. This was a fault in the interview topic guide that was not developed for this type of audience. This was only an issue in two of the interviews and in most instances the interview topic guide was appropriate for the position of the interviewee.

During the interview process it was also important to reflect on the 'interviewer effect'. Research on interviewing has concluded that people respond differently depending on their perception of the interviewer and the interviewer's identity (Denscombe, 2007; Hansen, 2006). The interviewer's age, sex, ethnic origins, social status, and educational qualifications will therefore have an effect on the information that respondents are willing to disclose and their honesty during the interview; ultimately affecting the data generated (Denscombe, 2007). However, not all interviewees will respond to the researcher's identity in the same way, which is particularly the case when sensitive issues are discussed. Prior to data collection, I recognized that my identity as a young, female, Caucasian PhD student of Canadian nationality would have had an impact on the interview process, and may be a contributing factor as to why building rapport and trust was easier with some respondents than others. Because I was asking sensitive questions regarding religion and sexual issues surrounding HIV/AIDS, the respondents' willingness to be open regarding these issues might have been affected by my identity. Although personal characteristics cannot be changed, they were mediated through self-presentation, for example, by being polite and punctual, neutral and receptive, and

adhering to conventional norms in relation to dress and courtesy. This was done in order to create, in the case of interviews, “the right climate for an interviewee to feel comfortable and provide honest answers” (Denscombe, 2007: 184), and limit any detrimental effects that my identity may have had on the research setting. In addition, all interviews began with general questions, such as asking about the respondent’s role within the organization, in order to allow the respondent time to get comfortable with the interview process before the more sensitive questions were asked (Britten, 2006).

3.3.3 Document Review

Document review is often used in qualitative research as documents can be important resources for data triangulation, increasing the comprehensiveness and validity of a study (Miller & Alvardo, 2005). Documents are valuable sources of data, as: they are produced within their local context, drawing on and relating to other documents; they show the competence, knowledge, and sometimes the opinions and values of their producers; they are “actively and collectively produced, exchanged, and consumed”; and they are “produced in and reflect specific social and historical circumstances” (ibid.: 349). As a result, document review can provide important insights into a particular case or circumstance. In particular, when conducting policy analysis, document review is important as it provides a way of investigating the ‘outcome’ of an organization’s policy processes through their written documents in addition to their intended plans or strategies, regardless of whether implementation of a policy has occurred (Abbott, et al., 2004).

During fieldwork, eighteen key policy and programme documents from the three case studies were collected and subsequently reviewed. Documents collected included: key organizational policy documents; constitutional documents; final reports; educational and reference materials; informational material such as brochures; training guides; and funding applications. For a list of documents reviewed see appendix E. The extent documents were available within each organization varied, in addition to the access granted. The Catholic organization, for example, had more material available than either the Anglican or Muslim organization, partly because of it being active for longer, but also because of its organizational structure and size. However, there were some documents that I was not permitted access to while in the organization, such as minutes from staff meetings, as these were viewed as internal documents not open to the public. Due to the Anglican organization only being active for a few years, and the fact that it had only recently relocated at the time of data collection, there

were very few documents available, and only limited access was granted to what was available. In comparison the documents collected from the Muslim organization were much more informal in nature, taking the form of training documents, informational material, and funding applications. Other key HIV/AIDS and health policy documents were collected from umbrella FBOs and reviewed where applicable to the case studies – such as the Catholic Church’s HIV/AIDS policies. In addition, key contextual documents, including HIV/AIDS and health sector policy and programme documents were collected from the national level and reviewed, such as the National Policy on HIV/AIDS and the National Multi-Sectoral Framework on HIV and AIDS, as all organizations working in the area of HIV/AIDS within the country are expected to work within these guidelines.

Organizational case study documents were read in relation to the key informant interviews in order to assess the validity of the respondents’ comments, as well as relate organizational policy to organizational practice. A document pro-forma was used with the case study documents in order to assess the documents in relation to the theoretical framework, as well as the study aim, objectives, and questions (see appendix F). A critical perspective was taken when reading these documents as it was recognized that authors do not always take an objective approach when preparing written documents, but instead attempt to make their organization appear in a positive light to attract additional funding or satisfy current funders, and minimize any negative outcomes (Denscombe, 2007; Hartwig, 2001). The process of document analysis is described in section 3.4.3.

3.3.4 Observation and Field Notes

Observation was used alongside key-informant interviews and document review as a data collection tool due to its ability to acquire background data and provide context to the other collected data (Hansen, 2006). There are two kinds of observation in qualitative research: observation without participation and participant observation (Hansen, 2006). The extent of participation has been described as a continuum and in most cases a researcher will move between the two (Patton (1990) quoted in Hansen, 2006). Initially participant observation was suggested as a main form of data collection as it allows the researcher to understand better the contextual factors explaining the process or event through their own experience, which can only be gained from an insider’s perspective (Denscombe, 2007; Hansen, 2006). I also felt that such an approach would be beneficial to the aims of the study as it would allow me to gain appropriate contextual information, become acquainted with the research setting, build

rapport with the participants, and identify interview participants (particularly at the start of the study). However, I also recognized that the organizations may not be willing to grant that level of access; if this was the case, non-participatory observation would be used (for example, observation of meetings or activities).

Early on in the fieldwork it became evident that participant observation was not a feasible option for this study. This was due to the structure of the organizations being studied, their limited capacity to include an additional participant, and the limited time-frame of the study. As a result, non-participant observation was applied when appropriate. An observation schedule was developed prior to data collection (see appendix G), and was used throughout data collection as a reminder about possible factors that could be observed. The observation schedule applied the principles of focused observation which focuses on and seeks out elements that are relevant to the research aims and objectives. The observation scheduled was referred to before and after visits to the organizations in order to ensure relevant focused observations were being made.

Field notes were taken during interviews, in addition to all observed events. These events included: morning prayers, staff meetings, client meetings, home-based care (HBC) visits, and community sensitization and education visits. In addition, field notes were taken about the general surroundings and environment, such as where the organization was located, and religious objects, or lack thereof, found within each organization. When events were attended detailed observational notes were recorded within twenty-four hours of the event. At these events descriptive observation was used in order to get an overall sense of the event. Descriptive observation focuses on the setting, people, activities, and events in order to provide a general picture of what is on the surface by asking the question: "What is going on here?" It explores such questions as: '*Who* is present?', '*What* is happening?', '*When* does the activity occur?', '*Where* is this happening?', '*Why* is this happening?', and '*How* is this activity organized?'. An example of observation notes taken during data collection is provided in appendix H. Similar to document review, the number of events that it was possible to attend during data collection and the level of access granted by each organization differed. For example, the Catholic organization, due to its size, had many more organizational events. At the Catholic organization I was able to attend morning prayer sessions, lunch-time staff gatherings, a clients' meeting, an HBC visit, and a community education visit. At the Anglican

organization I was able to attend morning staff meetings and prayer sessions and an HBC visit. At the Muslim organization I was able to attend a home-based care visit⁶.

Using observation as a method also presented other challenges. The varying level of access granted at each organization, for example, affected the role of observation as an overall data collection method. As stated above, during data collection it became evident that participant observation was not feasible for this study due to the structure of the organizations, their limited capacity, and the limited time frame of the study. As a result, non-participant observation was used. The level of observation that could be carried out within each organization differed due to the size of the organization and number of events that I was given access to. This restricted the extent to which observation was used within each of the three organizations, limiting overall data analysis and triangulation. An additional limitation to such observation is that only those events that occurred during the data collection period could be attended, which means that there are events that may have been missed. Language barriers also made making detailed observational notes difficult in some situations, such as the clients' meeting and staff meetings which were conducted in Kiswahili. However, some of the sessions were conducted in English. When a session was conducted in Kiswahili I was often able to have a staff member or my interpreter translate for me (when present). Due to the language barriers observational findings could not be as in-depth as the key informant interviews, and I recognize that some information may have been lost. As a result of the above, interview transcripts and organizational documents were the primary sources of data used during data analysis.

3.4 Data Analysis

The following section discusses the data analysis process. Framework approach, a thematic approach to data analysis, was used to analyse interview and observation data, while documents were analysed using document analysis. Each approach is discussed in greater detail below.

3.4.1 Data Preparation and Management

Prior to beginning data analysis all recorded interviews were transcribed in their entirety by me to ensure accuracy, and filed according to their organization. Only those interviews

⁶ At a separate branch of the Muslim organization I was unable to attend an HBC visit although the head of the organization ensured this was possible, which lead me to believe that the actual frequency of such visits within this branch is minimal.

conducted within the three case studies were analysed, as the contextual interviews were used to gain a picture of the overall faith-based response to HIV/AIDS in Tanzania and identify case studies. All recorded interviews and transcripts were kept in a password protected folder on the computer, copies of which were kept in a locked filing cabinet. As the Kiswahili interviews were translated directly during the interview (from English-Kiswahili-English), for these transcripts I transcribed each English section of the interview. A Kiswahili speaker was not used to transcribe the interviews due to financial and time restraints. The limitations of this are discussed in section 3.7.

All respondent identities and the corresponding interview transcripts were assigned a code which was used to identify respondents after interviews had been transcribed. Respondents' names and positions within organizations and their corresponding identification numbers were stored separately from all interview transcripts in a locked filing cabinet. All documents were organized and filed according to their organization and all observation and field notes were typed and filed according to their relationship with the respondents or organizations. Where applicable, all respondents' names were omitted from documents or observation notes. Interview transcripts and observation notes were then uploaded onto NVIVO 7, a qualitative data analysis software package which aids in the organization and exploration of data. All material was kept within a locked filing cabinet or within password protected folders on the computer.

3.4.2 Framework Approach

There are a number of approaches to data analysis (see: Ezzy, 2002; Hancock, et al., 2007; Hansen, 2006), which are selected according to the main focus and aims of the study (Spencer, et al., 2003). Ethnographic accounts are mainly descriptive, detailing an individual's or group's way of life; narrative analysis identifies the story being told, focusing on the way it is constructed; while conversation analysis focuses on how a conversation is structured (*ibid.*). Within this study framework analysis was used to analyse the data (see: Ritchie & Spencer, 1993; Ritichie, et al., 2003). Framework analysis is "a matrix based analytic method which facilitates rigorous and transparent data management such that all the stages involved [...] can be systematically conducted" (Ritichie, et al., 2003: 220). In addition, although the general approach of framework analysis is inductive, it allows for the inclusion of *a priori* as well as emergent themes (Lacey & Luff, 2007). The systematic and visible stages of framework

analysis allow for a documentary trail of the analysis process allowing the interpretation of the data, as well as the overall analysis process, to be reviewed if needed.

Framework analysis is not only an analytically useful approach, but also works well with research projects that have *a priori* issues which need to be addressed (Lacey & Luff, 2007). This research lends itself particularly well to framework analysis as specific *a priori* issues were identified for exploration through its conceptual framework (i.e. context, actors, process, content, and faith). During data collection key factors under each area were also identified through preliminary analysis and included within an analytical framework to aid the analysis process. Due to the context specific nature of policy analysis, however, it was also important to allow for the inclusion of emergent concepts. Using framework analysis allowed for the inclusion of emergent concepts to the analytical framework where applicable. This facilitated a more in-depth exploration into the factors influencing the HIV/AIDS prevention policy process within each organization.

Framework analysis involves five key stages (Lacey & Luff, 2007; Pope, et al., 2006; Ritchie & Spencer, 1993; Ritichie, et al., 2003), these are:

1. **Familiarization:** immersion in the raw data through reading, studying, and transcribing data;
2. **Identifying a thematic framework:** developing an initial coding framework identified from *a priori* issues as well as key concepts, issues, and themes that emerge from the familiarization stage. A detailed coding index of the data is the end-product of this stage, “which labels the data into manageable chunks for subsequent retrieval and exploration” (Pope, et al., 2006: 73). The thematic framework is developed and modified throughout the process accordingly;
3. **Indexing:** applying the thematic framework systematically to all data, using codes to identify specific pieces of data which correspond to identified themes, which can be aided through qualitative analysis software;
4. **Charting:** forming charts of data comprising of the main themes and sub-themes from the thematic framework, so that it can be easily read across the dataset. Each main theme is then printed off and ‘charted’ within its own matrix, “where every

respondent is allocated a row and each column denotes a separate subtopic” (Ritichie, et al., 2003: 220). Data from each respondent is synthesized within the appropriate section of the matrix, using the main themes and sub-themes (*ibid.*); and,

5. **Mapping and interpretation:** the exploration of themes and sub-themes for patterns, concepts, associations, and explanations in the data. Data is explored across respondents (rows) and themes (columns) using the charts produced during the charting stage. This process is influenced by the original research objectives and emergent concepts.

Each of these stages was applied throughout the data analysis process. Familiarization took place through transcribing each of the interviews and reading transcripts, documents, and observation notes. An initial coding framework was identified through the identification of *a priori* issues from the initial literature review and through identifying key concepts and issues during the data collection process and familiarization stage. The initial coding framework was applied to the data from each organization during the indexing stage, and was further developed and modified for each organization accordingly, depending upon the key issues and themes that emerged throughout the process. The final thematic framework used for each organization is presented in appendix I. The thematic framework was used to chart the data, across themes and participants. During the charting stage data from each participant was synthesized on to charts according to each theme and sub-theme. A section of a chart used for analysis is provided in appendix J. The charts were then used to further explore the data across the main themes and sub-themes during the mapping and interpretation stage. During this stage each theme was explored across the participants (columns) and each participant was explored across themes (rows). During this stage the data was examined for variations, similarities, key concepts, explanations, and associations. As stated above, this process was influenced by the research questions and emerging concepts. In addition to framework analysis, document analysis was used to analyse relevant national and organizational documents. The process used during document analysis is described below.

3.4.3 Document Analysis

Document analysis was used to analyse organizational and policy documents. Documents need to be analysed according to their content and context. Their content was explored through content analysis, which focuses on documents as independent sources of evidence,

while their context was explored through context analysis, which focuses on documents as sources embedded in and stemming from their social context (Miller & Alvarado, 2005). Content analysis was important as it provided information regarding what was in the text. Content analysis, for example:

Reveals....	By measuring...
1. what the text establishes as relevant	What is contained (e.g. particular relevant words, ideas)
2. The priorities portrayed through the text	How frequently it occurs; in what order it occurs
3. The values conveyed in the text	Positive and negative views on things
4. How ideas are related	Proximity of ideas w/in the text, logical association

(Source: Denscombe, 2007: 238)

Context analysis, on the other hand, was used “to provide insight into individual and collective actions, intentions, meanings, organizational dynamics, and institutional structures” – interpreting the social reality revealed in the documents (Miller & Alvarado, 2005: 351). Context analysis was used to explore any contextual issues that might have influenced the document’s development or dissemination, by looking at, for example, who developed the document, who it was intended for, and what, if any, were the ideological or political assumptions or positions underlying the document.

Information from each document was recorded in a document pro-forma, which explored the content of the document in terms of its context, actor, process, content, and faith-related factors (see appendix F). When the content related to the key themes, it was recorded on the pro-forma. Through this I was able to explore what the text established as relevant, what priorities were portrayed, which values were conveyed, and how ideas were related. Contextual issues were also included on the document pro-forma, such as who the document was intended for (the audience), the characteristics of the audience that might affect the content of document, the circulation of the document, any political or ideological purposes underpinning the document, any obvious biases detected, and whether the document related to any others. This allowed me to explore the meaning or intention of the document, and any underlying influences of the document’s content. The document pro-forma was useful in that it allowed me to analysis each document in relation to the study’s conceptual framework.

3.5 Ensuring Rigour

Applying techniques to improve rigour in qualitative research is important so as to ensure the validity of the overall research design, process, and findings (Creswell & Miller, 2000; Long & Johnson, 2000; Maxwell, 1992). Maxwell claims that validity “is not an inherent property of a particular method, but pertains to the data, accounts, or conclusions reached by using that method in a particular context for a particular purpose” (1992: 284). Validity, therefore, pertains not only to the data collected, but to the inferences drawn from it (*ibid.*). Effort was made to ensure that rigour was maintained throughout the research process, within which the following techniques were used: triangulation, transparency of methods and analysis, and researcher reflexivity; each is discussed below.

3.5.1 Triangulation

Throughout the study multiple data collection methods were used (interviews, observation, and document review) in order to “develop a fuller, more complex picture of the problem or phenomenon under study” (Hansen, 2006: 56); as well as to strengthen the study by cross checking and validating the data (Creswell & Miller, 2000; Golafshani, 2003). In addition, multiple data sources (interview participants), both internal and external to the case studies, were used to validate respondents’ comments and find common themes throughout the data (Creswell & Miller, 2000). The findings from framework and document analysis were also triangulated in order to corroborate any interpretations of the data by searching for similar and/or alternative or contrary examples. This was done by reviewing the charts and document pro-formas.

3.5.2 Transparency of Methods and Analysis

How the research was conducted, case study and participant selection, the characteristics of the cases, the methods used, and how the analysis was conducted is described as fully as possible. In addition, examples of the data (quotations, etc.) are given to support analysis where appropriate and allow the reader to consider their own interpretations of the data in relation to the interpretation provided (Hansen, 2006; Hartwig, 2001; Maxwell, 1992). This is done to allow the reader to extend the account of the case studies to other organizations, settings, and times, where applicable (Maxwell, 1992). To aid this, the case studies were specifically chosen in a purposive manner, as described above.

3.5.3 Researcher Reflexivity & the Role of the Researcher

In reference to the role of the researcher within qualitative research, Maxwell states that

“[a]s observers and interpreters of the world, we are inextricably part of it; we cannot step outside our own experience to obtain some observer-independent account of what we experience. Thus, it is always possible for there to be different, equally valid accounts from different perspectives” (1992: 283).

It is therefore important for researchers to reflect on their position as a researcher throughout the research process (Creswell & Miller, 2000). According to Long & Johnson, “[r]eflection is an essential part of qualitative research” (2000: 33). Through reflection researchers report on their own beliefs, values, assumptions, and biases that may shape and influence the research process (Creswell & Miller, 2000). Doing so allows the reader to understand the researcher’s position, as well as allowing the researcher to “bracket or suspend [their...] biases as the study proceeds” (*ibid.*: 127). Throughout the research process I have attempted to recognize my own positions and how they might impact on the data collection and analysis process, which are discussed more in detail below.

At the start of the research process I attempted to recognize how my own identity and beliefs could influence the data collection and analysis process, particularly my beliefs about religion, gender, and health. I recognized, for example, that my identity is grounded in a feminist, secular worldview. As an individual I am non-religious and strongly believe in the separation of church and state; at the same time I recognize the importance of an individual’s right to freedom of religion. While I recognize this freedom and acknowledge the positive role religion has played in many people’s lives, at the same time, I have difficulty in seeing past the role religion has played in the marginalization and suppression of women throughout the world and its effect on sexual and reproductive health. In addition, my own thinking is grounded in a public health perspective, which includes the belief that no one should be denied the right to access effective health care interventions (as determined by bio-medical and other evidence), especially due to others’ values or beliefs. For example, while again I acknowledge the positive role FBOs can play within HIV prevention response efforts, I have difficulty accepting many FBOs’ position on condoms. Although I believe behavioural HIV prevention strategies are necessary, in order for HIV/AIDS prevention strategies to be effective on a population level, they must be combined with structural prevention strategies, as discussed in Chapter 2.

I recognize that such beliefs and assumptions have the potential to strongly bias the research process. At the same time, I think it is important to acknowledge that in a study about religion, coming from a particular religious worldview can be equally as biasing as coming from no religious worldview at all, as each will struggle with objectivity in its own way. Recognizing my own biases has allowed me to the best of my ability suspend them and approach the research process as objectively as possible – while maintaining the critical discernment that is required of academic research. At the same time, my own beliefs and experiences will have shaped and influenced the data collection and analysis process. In addition, my account and interpretation of the phenomena in question, based on my own worldview and experience, is one of several possible interpretations.

3.6 Ethical Considerations

There are some ethical issues that arise in qualitative research (Hansen, 2006; Lipson, 1994). In order to address the ethical issues that arose during the research process, the following measures were put in place.

3.6.1 Ethical Approval Process

Prior to commencement of data collection, ethical approval was sought from the University of Leeds Institute of Health Sciences Ethics Committee. Once granted, ethical approval was also sought and granted from the National Institute for Medical Research (NIMR), a parastatal service organization under the Ministry of Health and Social Welfare in Tanzania. In addition, a requirement for conducting research in Tanzania and obtain a visa for research is to acquire research clearance from the Commission for Science and Technology (COSTECH), also a parastatal organization within Tanzania. Research clearance for health related research will only be granted once ethical approval is obtained from NIMR. In total this process took eight months as all approval was sought from the United Kingdom. All forms were collected within Tanzania before data collection began. Once case studies were selected and access was granted additional research clearance had to be sought from each of the district municipal offices in which the organizations were located. There are three district municipalities within Dar es Salaam, and each organization is located in a separate district. Research clearance was therefore sought and granted from each Municipal office.

3.6.2 Informed Consent

At the beginning of each interview, all interview participants were made fully aware of what their involvement in the research would entail, the purpose of the research, and how their private information would be handled, which was outlined in an information sheet (see appendix K) and consent form (see appendix L). In addition, the participants were ensured that participation in the study was completely voluntary and they were free to withdraw from the study at any time. Both the information sheet and consent form were offered in English and/or Kiswahili, and each were read by or read to the participant prior to the start of the interview. All respondents were asked to sign the consent form and each respondent signed a consent form before participating in the study.

Depending on the appropriateness of the environment, respondents were also asked if they would agree to the interview being recorded; all respondents except two agreed to the interview being recorded. In situations where the environment was not deemed appropriate for recording (e.g. the respondent was in a noisy open office or the interview was conducted outside), the interview was deemed to be more informal in nature, or the respondent did not agree, detailed notes were taken during the interview and typed within 24 hours of the interview taking place. The recorder did not appear to have a significant effect on the respondents' answers, and in most cases the respondents appeared to have forgotten about its presence. However, in one or two occasions it was felt that the recorder did inhibit the respondents' answers; as a result, it is possible that information was lost in such instances.

3.6.3 Confidentiality and Anonymity

All information obtained about research participants was not, and will not be, used for any other purposes besides what has been agreed to by the participants. Each participant was made aware about the confidentiality of the information they provided before they agreed to participate in the study. To ensure confidentiality, anonymity of the participants has been maintained throughout the research process; the true identity of each participant is only known to the researcher. In addition, the interpreter was informed that they were required to keep all information about the study confidential, especially the respondents' true identities. Care was taken to ensure that participant identities were kept confidential throughout the study by assigning a unique participant identification number to each participant and storing all study material in a locked filing cabinet and/or password protected computer files. All interview transcripts and related field notes (where appropriate) were coded with their

corresponding participant identification number. The participants' names with their corresponding identification numbers were kept separately from their transcripts and related field notes. Permission was sought to identify each of the case studies within final publications. As stated previously both the Catholic and the Muslim organizations agreed to be identified, while the Anglican organization chose to remain anonymous. To maintain confidentiality, all case study participants' organizational roles have remained confidential, with all quotes associated only to their organization. All quotes attributed to respondents outside of the three case studies are reported generically with no direct association to their organization, however, for contextual purposes generic labels relating to their organizations have been referenced (for example, umbrella faith-based organization, government, donor). In addition, information that might identify respondents was and will be omitted from any final publications.

3.6.4 Protection from harm of respondents and researcher

This study carried no direct risks to the participants. Respondents were told that if they became uncomfortable for any reason during the interview process, the interview would be terminated. However, at no time during the data collection process did participants appear uncomfortable. Although the study was dealing with potential sensitive topics – religion and HIV/AIDS – because the questions were focused at the organizational level and not the personal level the potential for harm of respondents was minimized. However, I recognized that participants may have felt a degree of “professional risk”, where they fear that what is disclosed may have negative consequences for themselves or their organization (Hartwig, 2001). Effort was made to reduce this risk by ensuring all comments made would remain confidential, as described above. In addition, care was taken to ensure that any potential harm or distress to the researcher was minimized or eliminated by making sure that all data collection was undertaken as safely as possible, for example, by ensuring the interviews were conducted in a safe environment.

3.6.5 Reciprocity and Dissemination

Reciprocity is an important ethical consideration when conducting research. Lipson asks what obligations researchers have to the people who take part in research, and to whom this obligation is owed to (Lipson, 1994). Are researchers, for example, obligated only to the people who took part in the research, to the community in which the participants live, to the government, to the funder, or to a combination thereof? (*ibid.*). The issue of reciprocity

became particularly important when the head of one organization expressed their concern over western researchers undertaking research within the organization, but not disseminating any of the findings once the research was completed. This concern was so great that this issue came up several times, and it became apparent my access into the organization was dependent upon the assurance that I would feed back the results of the study. The issue of dissemination, however, was considered from the beginning of the study. A summary of the results, as appropriate, will be disseminated through post and e-mail to each of the organizations that took part in the study. In addition, the final thesis, all published papers, and a summary of the results will be sent to NIMR and COSTECH, as stipulated within the research clearance documents. A summary of the results of the study will also be sent to each of the three municipal district offices. No monetary incentives were given to the participants within the study, as I wanted to ensure participants were voluntarily taking part and not being influenced by a monetary incentive. However, travel expenses were compensated for at the end of the interview to the two clients who participated in the study at the Catholic organization. As most interviews took place in the participants' place of work, and due to the economic situation of the majority of the participants, as compared to the organizations' clients, no travel expense compensation was offered to the other participants.

3.7 Study Limitations

No research study is left without limitations. It is important to recognize these limitations so that their potential impact on the research process and findings can be recognized and mediated where possible. By doing so it allows the reader to make an informed decision about the validity of the study findings and whether they can be transferred to other settings. Through data collection and analysis I was able to collect data from a variety of sources and interview a variety of people within each organization who were involved in HIV/AIDS prevention. At the same time, there are a number of factors that have limited the scope and depth of analysis. These include: research bias, limitations to the study design and methods, inability to access some organizational documents, the representativeness of the organizations included in the study, and time and resource constraints.

Researcher bias, for example, can affect the research process and subsequent findings. Potential researcher biases were discussed above, and include my individual biases in relation to, for example, religion, gender, and health. I recognized that individual biases have the potential to influence all stages of a research project, including shaping the research design,

questions, data collection, analysis, and interpretation of results. I have attempted to be transparent about my individual biases, data collection, and analysis in order to allow readers to assess my interpretation and see where my own biases may have led to a particular direction, and add their own interpretations to my findings where applicable.

The use of an interpreter within a study can bring additional biases. Just as the researcher's identity, beliefs, and assumptions can affect the research process, so can the translator's identity, beliefs, and assumptions. In addition, through translation, information can be misinterpreted and/or lost. In an attempt to mediate the affects, the translator was briefed on the study's aims and objectives and sent an interview schedule prior to the interviews taking place. The translator was also made aware of the importance of translating as accurately and precisely as possible, although it became apparent that a verbatim translation was not always possible. I recognize that some information may have been lost within the interviews conducted in Kiswahili. In addition, I recognize that by not having a Kiswahili speaker to translate each of the Kiswahili interviews, further information may have been lost. As stated above, a Kiswahili speaker was not used due to financial and time restraints. In an attempt to mediate the effects of this, a Kiswahili speaker reviewed a selection of interview tapes and transcripts to check the accuracy of the translation. Through this process the interpreter confirmed that the translations were accurate and re-transcribing these interviews was not necessary.

Another potential limitation is the lack of generalizability or representativeness typically found in case study research. Because case study research focuses on only one or two cases, for example, there are often questions about the representativeness of the findings and how far the results can be generalised to similar cases. Denscombe (2007) offers three lines of arguments in defence of this criticism:

1. Cases are single examples of a broader class of things (they are one of a type);
2. Generalizability of findings depends on "how far the case study example is similar to others of its type" (ibid.: 43). This will depend on the similarity of the case's characteristics and profile in which comparison can be made to other cases; and,

3. Readers are in a position to make an informed judgement on the generalizability of the case to other instances as sufficient comparable detail about the case is often presented. As such, the reader is in a position to assess “how far the findings have implications across the board for all others of the type, or how far they are restricted to just the case study example” (ibid.).

Although the study’s findings are context specific, as much detail as possible about the case studies and context is given to allow the reader to make an informed judgement on the generalizability of the case to other instances. However, I recognize that although the case studies represent examples of a broader class of things – they are all faith-based NGOs working in the area of HIV/AIDS – substantial organizational differences existed between the three cases. This, therefore, had the potential to limit comparison across the three cases. Despite these differences, enough similarity was found across the organizations to make comparisons regarding their HIV/AIDS prevention policy process. When organizational differences made comparison invalid, each case was analysed independently as a single example of a faith-based NGO.

Although through data collection and analysis a level of saturation was reached, meaning no new concepts or ideas emerged, data collection and analysis was restricted due to varying organizational access between the three organizations. As stated above, this affected the role of observation as a data collection method and the organizational documents that were available. For example, only those events and documents that I was given access to could be observed or analysed. With regards to organizational documents, the Catholic organization had much more documents than either the Anglican or Muslim organizations. At the same time, however, not all relevant documents were made available within each organization, while others simply lacked written policy documents. The level of access within each organization will therefore have affected the scope and depth of analysis within and between each organization.

3.8 Chapter Summary

This chapter described the research methodology used to address the research aim, objectives, and questions. An overall qualitative case study approach to inquiry was used, through which interviews, observation, and document review were carried out in three faith-based NGOs of different faiths. The research used both framework and document analysis to

analyse the findings. This chapter also discussed other methodological considerations, such as the techniques implemented in order to ensure rigour of the overall data collection and analysis process, the ethical considerations applicable to the study, and study limitations. In order to situate the three case studies within their national context, the following chapter provides a detailed description of the Tanzanian context in relation to the study topic.

Chapter 4 – The Tanzanian Context

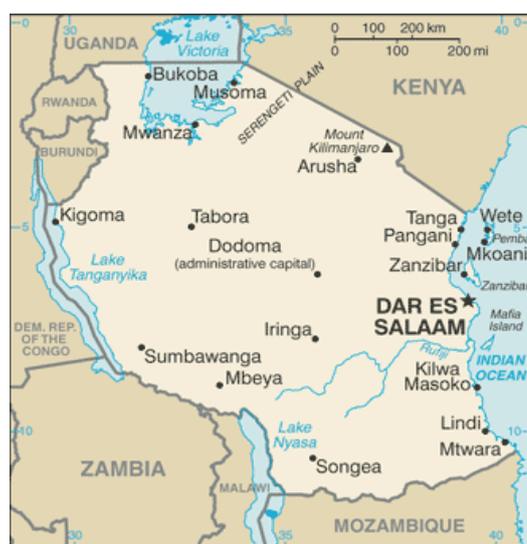
4.1 Introduction

This chapter situates the study within Tanzania's national HIV/AIDS context. Only those contextual aspects which are deemed relevant to the study and the study's findings are discussed. The chapter begins by providing an overview of the country, followed by a discussion about the religious context within Tanzania. This is followed by a discussion about non-state private sector organizations within Tanzania, particularly non-governmental organizations (NGOs) and faith-based organizations (FBOs), and FBO involvement in health service provision. The chapter concludes with a discussion of the country's HIV/AIDS situation and the national and FBO HIV/AIDS response within Tanzania.

4.2 Country Overview

Tanzania is a country within East Africa (see Figure 8), and is a former German and British Colony. It (then Tanganyika) became independent from Britain on December 9, 1961, joining Zanzibar on April 26, 1964 to form the United Republic of Tanzania (Tanzania) (Bureau of African Affairs, 2009; NBS, 2005).

Figure 8 – Map of Tanzania



(Source: World Factbook, 2011)

The total population of Tanzania in 2007 was estimated at around 40 million (WHO, 2009). Dar es Salaam is the largest city, with a population of around 3.2 million (World Factbook, 2011).

According to the Tanzania National Bureau of Statistics (NBS), while the population has “nearly tripled in the last four decades, the country is still sparsely populated, though population density is high in some parts of the country and has been increasing” (*ibid.*: 2). The population is predominately rural, at around 75%, although the percentage of urban residents has been increasing over time (NBS, 2005; WHO, 2009). The high growth rate is the result of high fertility (5.2 per woman in 2007) and declining mortality levels (*ibid.*). According to the World Health Organization, life expectancy at birth for Tanzanians is 52 years (WHO, 2009). Key demographic data is presented in Table 4.

Table 4 – Tanzania Key Demographic Data

Demographic Data	Estimate	Year	Source
Total Population ('000s)	40 545	2007	WHO World Health Statistics
Population under 15 (%)	44	2007	WHO World Health Statistics
Population 16-59 (%)	55	2007	WHO World Health Statistics
Population over 60 (%)	5	2007	WHO World Health Statistics
Annual population growth rate (%)	3.1	1987-	WHO World Health Statistics
		1997-	
		2007	
% of population in urban areas	19	1990	WHO World Health Statistics
		2000	
		2007	
Total Fertility Rate (per woman)	6.1	1990	WHO World Health Statistics
		2000	
		2007	
Crude birth rate (births per 1000 population)	39.5	2007	UNAIDS/WHO URT Fact Sheet
Crude death rate (deaths per 1000 population)	13.1	2007	UNAIDS/WHO URT Fact Sheet

(Adapted from: UNAIDS & WHO, 2008; WHO, 2009)

Tanzania remains one of the least developed countries in the world (MOHSW, 2009; URT, 2009). In 2006, for example, the average national income per person was \$350 USD (*ibid.*), and in 2007 approximately 25% of the population was living below the poverty line – rural incidence of poverty was 38%, while urban incidence was 24% (although in Dar es Salaam it was 16%) (MOHSW, 2009; URT, 2009). As discussed in Chapter 2, poverty is a major driver of the HIV/AIDS epidemic. Due to the high incidence of poverty within Tanzania, it therefore not only exacerbates the spread of HIV/AIDS, but continues to remain a challenge for the implementation of effective prevention strategies within the country.

4.3 Religion in Tanzania

As this research is exploring the HIV/AIDS policy process within faith-based NGOs of different faiths, it is important to gain an understanding of the religious demography and historical religious developments within Tanzania, as each will influence religious communities' HIV/AIDS response efforts. The larger a religious community, for example, the more likely it is to be involved in HIV/AIDS. However, as will be discussed below, despite each community's similar size, the Christian community within Tanzania is much more active than the Muslim community in HIV/AIDS, some of which can be explained by the historical religious developments within the country. Religious demography of Tanzania is difficult to determine, as current statistics are unavailable due to the government's policy not to gather religious identification data in its census – religious surveys, for example, were eliminated from the census after 1967 (Bureau of Democracy, 2007, 2008, 2009). It is estimated that on Tanzania mainland Christian and Muslim communities are relatively equal, each accounting for 30 to 40 percent of the population, with the remaining members from other faiths and traditional indigenous religions (Bureau of Democracy, 2007, 2008; World Factbook, 2011; Zou, et al., 2009). However, according to the International Religious Freedom Report, "recent information suggests that 62 percent of the population is Christian, 35 percent is Muslim, and 3 percent are members of other religious groups" (Bureau of Democracy, 2009). Due to the unavailability of official statistics about religious demography in Tanzania, it is difficult to know for certain the precise situation.

On Tanzania mainland Muslim communities are mainly situated in the coastal regions, with some large communities also in the urban areas, such as Dar es Salaam. The Muslim community consists of 80 to 90 percent Sunni, the remainder being made up of several Shia subgroups (Bureau of Democracy, 2009). The Christian community consists of Protestants (for example: Lutherans, Anglicans, Moravians, Baptists, Mennonites, Methodists, and Presbyterians), Roman Catholics, Pentecostals, Seventh-day Adventists, members of the Church of Jesus Christ of Latter-day Saints (Mormons), and Jehovah's Witnesses (Bureau of Democracy, 2009; CCT, 2007-2009). Other active religious groups in Tanzania include: Buddhists, Hindus, Sikhs, Baha'is, and African traditional religions (Bureau of Democracy, 2009).

Historical religious developments within Tanzania have influenced the present day situation of Christianity and Islam. There is not the space here to provide a detailed historical account of

Christianity and Islam in Tanzania; as a result, only a brief overview is given. Within Tanzania Islam was established along the coast prior to Christianity's arrival, which was brought over by the Portuguese to Tanzania in the 16th century (Mbogoni, 2005). Since then Christian-Muslims relations in Tanzania have been relatively harmonious, with the exception of a few clashes (Mbogoni, 2005). Both Mbogoni (2005) and Rasmussen (1993) argue that since the advent of European colonial rule the scales have been tipped in favour of Christianity, with the Church as an institution being closely linked to the colonial structure. According to Mbogoni (2005), this has led to a belief that there has been systemic marginalization and discrimination of Muslims in the areas of education and politics.

Understanding the past treatment of Christians and Muslims in Tanzania is important in understanding their present involvement, or lack thereof, in social service provision, particularly in the areas of health and education. Such treatment has contributed to a set of structures that is either particularly well- or ill-equipped in such provision. During the German colonial period in Tanganyika a dual system of Government and Mission schools was introduced which was maintained throughout British colonial rule. However, during this time Mission schools were much more prominent than Government schools; in 1935, for example there were 8,105 public schools and 217,736 Mission-funded schools (Mbogoni, 2005). Mbogoni (*ibid.*) argues that such schools alienated Muslims through a focus on the proselytization and teachings of Christianity.

By 1955 there were 656 government primary schools, 1,692 Christian-funded primary schools, and 28 Muslim-funded primary schools (Mbogoni, 2005). During this time it was difficult for Muslims to finance and build their own schools due to a lack of government aid (*ibid.*). The Government explained the discrepancy between Christian and Muslim grant-aided schools as "a differential in efficiency and educational enthusiasm between Christian and Muslim voluntary agencies, rather than Government partiality for the former" (*ibid.*: 118). At the same time, Christian-funded health centres were also being developed, as the "provision of health services was a part of the evangelical endeavour in central Tanzania" during this colonial time (*ibid.*: 93). After independence, the importance of Christian-funded hospitals and health centres was evident when, during the government's attempt to bring all private organizations under state control, the only institutions which maintained a degree of autonomy were those associated with faith-based organizations, such as religiously run schools and hospitals (Hartwig, 2001; Mercer, 1998). At the same time, however, the Government encouraged

religious plurality by giving primacy to national unity or politics over religion, and viewing equality as fundamental (Rasmussen, 1993). At the same time, particular religious institutions, such as polygamy in Islam and monogamy in Christianity, were respected. Both Mbogoni (2005) and Rasmussen (1993) argue that as a result of this approach, Christian-Muslim relations in Tanzania have to this day remained relatively harmonious.

Hence, as we have seen above, the historical development of Christians and Muslims in Tanzania affects the way in which each community is involved in social service provision – particularly in the areas of health and education. Due to the greater development of Christian run schools and health facilities during colonial rule, for example, the Christian community in Tanzania is now in a much better position to provide health service provision, particularly around the area of HIV/AIDS, as compared to the Muslim community. The Muslim community, although involved in health and health care service provision to some extent, appear to have had a much higher interest and involvement in education, which has continued to this day⁷.

4.4 Non-State Private Sector Organizations in Tanzania

This section explores the non-state private sector within Tanzania, of which faith-based NGOs are a part. Non-state private sector organizations are made up of voluntary organizations, which include non-governmental organizations, faith-based organizations, and private for-profit organizations (MOHSW, 2009). The following section discusses the organization, coordination, and role of NGOs and FBOs in health service provision in order to provide a greater understanding of the position and role of faith-based NGOs within HIV/AIDS response efforts in Tanzania.

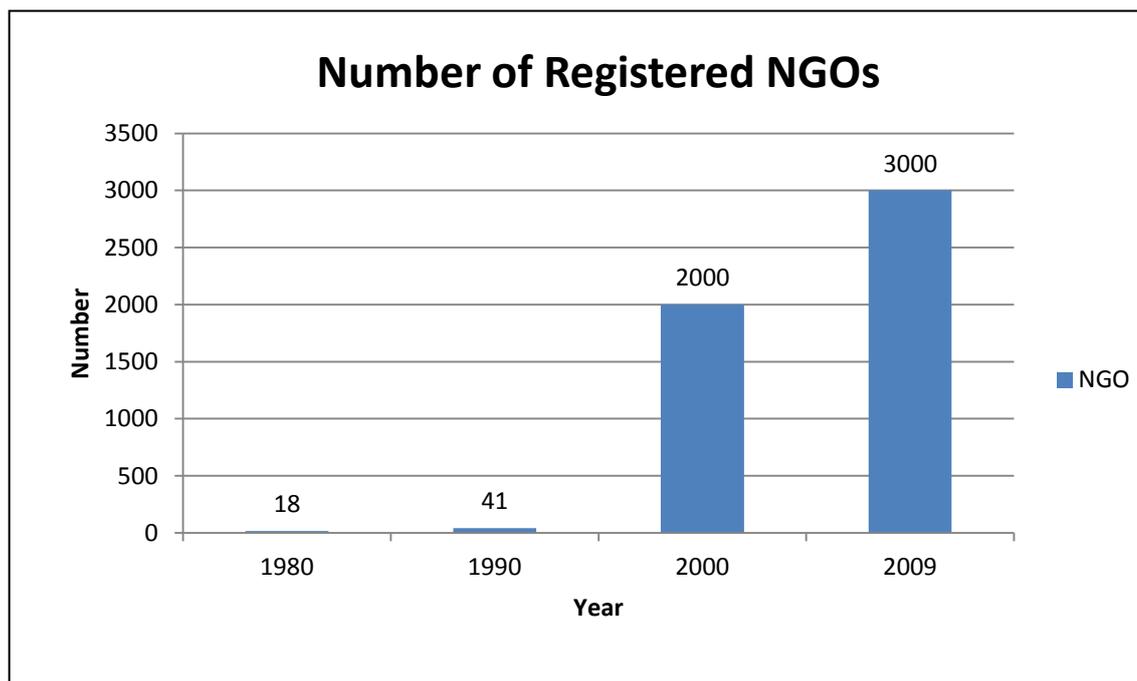
4.4.1 Non-Governmental Organizations

The non-governmental organization (NGO) sector in Tanzania has grown massively over the last twenty years. This is mainly due to the rapid political and economic change that has occurred in the country during that time (Mercer, 1998). In the mid-1980s, for example, Tanzania embarked on a process of economic and political liberalization, which allowed for huge transformations to occur in the non-state sector, contributing to the burgeoning of the sector as a whole (*ibid.*). Prior to this time there were few NGOs registered in Tanzania; from

⁷Another possible reason for the increased interest and involvement in education by the Muslim community is that education is often also viewed as a mechanism for promoting Islam, through for example the creation of Madrassas – Quranic schools where young children receive an Islamic religious education. In fact, Mbogoni (2005) argues that there was an overall Muslim antipathy to secular education, in favour of Quranic schools, which is sometimes used to explain the discrepancy in education among Christians and Muslims in Tanzania before and after independence.

1961-1978, for example, only 17 new NGOs registered with the Ministry of Home Affairs, although the exact number of unregistered NGOs is unknown (*ibid.*). The dominant NGOs that were present during this time were those associated with religious institutions, such as Christian or Muslim organizations, and religiously run schools and hospitals (Hartwig, 2001). Other NGOs which had a presence were western-based international development organizations, such as Oxfam, World Vision, Save the Children, and the African Medical Research Foundation (AMREF) (*ibid.*).

The relaxing of state controls, in addition to increased donor funds allocated for NGO activities over the last twenty years, has contributed to a massive growth of the NGO sector in Tanzania. Chapter 2 discussed how international organizations such as the World Bank and IMF, as well as large inflows of international aid during the 2000s, contributed to this expansion. While at the end of 1980, for example, there were only 18 NGOs existing in the official NGO registration records, by 1990 41 NGOs existed, and by the year 2000 around 2000 NGOs existed (*ibid.*). At the end of 2009, there were just over 3000 local and international NGOs registered in Tanzania (VPO, 2001). This growth of the NGO sector in Tanzania reflects the worldwide growth of the NGO sector in general over the last two decades, which was discussed in Chapter 2 (Mercer, 1998). The increase in NGO registration is shown in Figure 9.

Figure 9 – Number of Registered NGOs⁸

(Source: Graph drawn by author using data from Hartwig, 2001; Mercer, 1998)

The Tanzanian Government recognizes the potential contribution of NGOs within the health sector, and development in general. The National Policy on Non-Governmental Organizations, for example, recognizes the significant “role and contributions of NGOs in the society and considers them as important partners in the development process,” and that it is “in the interest of the Government to create a conducive and enabling environment to ensure that NGOs’ potential is fully utilized” (VPO, 2001: 7). The government therefore sees the importance of working in partnership with NGOs in the delivery of public services in all sectors, and allows NGOs to be subcontracted to implement programmes “where NGOs have comparative advantages and have expressed interest” (*ibid.*: 8). NGOs have therefore been granted tax and VAT exemptions under existing tax laws⁹ (*ibid.*).

⁸ There is a discrepancy in the data around the number of registered NGOs between the year 2000 and 2009. The National Policy on Non-Governmental Organizations states that in 2001 there were around 3000 local and international NGOs in Tanzania; however, Hartwig writes that the draft National Policy on NGOs in Tanzania written in 1999 states that there were around 2000 NGOs present in the country (Hartwig, 2001). As specific registration of NGOs did not begin until 2002 after the passing of the Non-Governmental Organizations Act, it must be recognized that both figures are estimates and the source of the data is unclear. What is important to recognize is the drastic increase in the number of NGOs from 1990 to 2000 – from 41 NGOs to around 2000 NGOs.

⁹ Faith-based organizations, as a separate category of organizations, have also been granted tax and VAT exemption in Tanzania under the existing tax laws. Tax exemptions, are provided for a variety of reasons, one of which is to provide support for NGOs and religious organizations in the provision and delivery of public services.

4.4.2 Faith-Based Organizations

A definition of faith-based organizations was provided in Chapter 2. The FBOs that are most involved in health service provision are representative bodies, such as Churches or mosques, and development organizations, such as faith-based NGOs. As will be discussed below, due to registration procedures within Tanzania, it is not possible to obtain an accurate number of faith-based NGOs within the country. According to Leurs et al., there are “847 Catholic parishes, 1,800 smaller Anglican parishes and over 1,104 Lutheran congregations in Tanzania” (2011: 27). In addition, “there are between five and ten thousand Pentecostal churches [and a] number of other Christian churches are also active (e.g. the African Inland Church, the Seventh Day Adventists, the Mormons, the Jehovah’s Witnesses and the New Apostolic Christians)” (*ibid.*). According to Leurs et al., although it is unknown how many of these churches are engaged in service provision, the Catholic Church is recognized “as the biggest Christian provider of health and education services, followed by the Lutheran and Anglican churches” (*ibid.*). While it might be expected that Pentecostal Churches would be the largest social service provider (given their numbers), in practice it is the mainstream churches created during colonial times that are the most active (*ibid.*). Pentecostal churches are perceived to focus more on evangelizing than development activities, compared to the other churches (*ibid.*). Although the exact number of mosques in Tanzania is unknown, Leurs et al. state that it is estimated that “there are more than 6,000 ‘minor’ mosques (focused solely on religious activities) and 2,800 ‘major’ mosques, which are also involved in some kind of development activity” (2011: 28).

Many FBOs in Tanzania are represented by umbrella FBOs, whose main role is advocacy, coordination, and capacity-building of and for their member organizations. Within Tanzania Christian FBOs are coordinated and represented by the Tanzania Episcopal Conference (TEC) (TEC, 2002), which represents the Catholic Church and Catholic organizations; and the Christian Council of Tanzania (CCT) (CCT, 2007-2009), which represents Protestant Churches and Protestant organizations. Each body has its own organizational structure in which parishes, churches, faith-based hospitals, and faith-based NGOs are situated. In issues related to health and education both TEC and CCT are represented by the Christian Social Service Commission (CSSC), which was established in 1992 under the “Memorandum of Understanding” that was developed between the Churches and the Tanzanian government (CSSC, 2004-2009).

Compared to Christian FBOs, Muslim FBOs are less coordinated within Tanzania. The two most important Muslim apex bodies in Tanzania are Baraza Kuu La Waislamu Tanzania (BAKWATA), the National Muslim Council of Tanzania (established in 1968), and the Supreme Council of Islamic Organizations and Institutions in Tanzania, known as Baraza Kuu (established in 1992) (Leurs, et al., 2011). BAKWATA, however, is the official apex organization of all Muslims in the country (*ibid.*). According to Leurs et al. (*ibid.*), BAKWATA works on a smaller scale than either the TEC or CCT, and has less influence on policy. BAKWATA is also organized differently, “following administrative (regional and district) rather than diocesan and parish boundaries” (*ibid.*: 31). In addition, it does not appear to have a clear membership base, and due to its organizational ties with the government at its inception, is not well perceived by all Muslims and Muslim organizations in Tanzania (Rasmussen, 1993). Baraza Kuu’s membership base includes mosques, Muslim NGOs, and groups that are a part of mosques (Leurs, et al., 2011). According to Leurs et al., the Muslim community with Tanzania is perceived to “lack a clear leadership hierarchy, most obviously when contrasted with the Catholic Church, which [is] perceived to co-ordinate and promote church-related development work more effectively at the national level” (2011: 32). In addition, mosques are seen to be more autonomous and decentralized, than churches, contributing to the perceived legitimacy problems of BAKWATA by the Muslim community (*ibid.*). Historical religious developments in Tanzania that have contributed to the above differences between the Christian and Muslims community were discussed in section 4.3. As a result of these differences, the scale of Muslim involvement in health, and therefore HIV/AIDS, is much less compared to Christian communities.

4.4.2.1 NGO & FBO Registration

In order to clarify the distinction between FBOs and faith-based NGOs, the requirements for registration of NGOs and FBOs are discussed (Leurs, et al., 2011). Currently organizations within Tanzania can be registered with one of four bodies: the Ministry of Home Affairs; the Registration, Insolvency, and Trusteeship Agency (RITA), the Ministry of Community Development, Gender and Children (MCDGC); the Business Registrations and Licensing Agency (BRELA); and the Ministry of Health and Social Welfare (MOHSW). Organizations register under each body depending on their activities or purpose. Although there is currently a main NGO registry in Tanzania, in actuality NGOs, and therefore faith-based NGOs, are registered under each of these bodies. Each of the organizations within this study, for example, is registered with a different body. An overview of NGO registration is provided in Table 5. FBOs (including faith-based NGOs) can be found under each body.

Table 5 – Overview of Organization Registration

Government Body	Registered As
Ministry of Home Affairs	Society
Registration, Insolvency, and Trusteeship Agency (RITA)	Trusteeship
Business Registrations and Licensing Agency (BRELA)	Company
Ministry of Community Development, Gender and Children	NGO
Ministry of Health and Social Welfare (MOHSW)	Health Facility

The development of a National NGO policy began in 1996, but was not finalized until 2001 (VPO, 2001). All NGOs established after 2002 are therefore required to register with the NGO Registry. Those NGOs which registered with a different body prior to 2002, and meet the requirement of being an NGO under the definition of an NGO in the NGO Act, are required to apply for a certificate of compliance and satisfy the conditions of the 2002 NGO Act (Mmanda, 2008). Under the 2002 NGO Act, an NGO is defined as:

a voluntary grouping of individuals or organization which is autonomous, non-partisan, non-profit making which is organized locally at the grassroots, national or international levels for the purpose of enhancing or promoting economic, environmental, social or cultural development or protecting environment, lobbying or advocating on issues of public interest of a group of individuals or organization, and includes a non-governmental organization, established under the auspices of any religious organization or faith propagating organizations, trade union, sports club, political party, or community based organization; but does not include a trade, union, a social club or a sports club, a political party, a religious organization or a community based organization (URT, 2002: 4).

As the above definition suggests, religious organizations, such as churches or mosques, are differentiated in the registration process from NGOs “established under the auspices of any religious organization”. Within this definition, therefore, faith-based NGOs are distinguished from churches or mosques, which are not considered as NGOs. Organizations which may meet the definition of an NGO, but which provide health care services, are registered with the Ministry of Health as a health facility. Although these organizations may fit the definition of an NGO, as they are considered health facilities they are not recognized under the NGO Act.

While the numbers presented above suggest a massive increase in NGOs in Tanzania over the last two decades, it is difficult to know the exact number, and therefore growth, of NGOs that are present, as NGOs are registered across multiple bodies and the current estimate of NGOs is based on those organizations that are registered with the NGO Registry. In addition, not all

NGOs which are registered with one of the other bodies will have applied for a certificate of compliance, and therefore will most likely not be known to the NGO Registry. Currently, there is no enforcement or time restraint attached to applying for a certificate of compliance. In June 2009 there were 3,263 NGOs registered under the 2002 NGO Act, however, faith-based NGOs are not distinguished from secular NGOs so it is not possible to obtain a number of registered faith-based NGOs (organizations' names do not always identify them as FBOs) (Leurs, et al., 2011). As the above discussion indicates, there is not a clear framework for classifying or registering FBOs in Tanzania, particularly faith-based NGOs. It can therefore be difficult to identify and know the exact extent of FBOs' involvement in different sectors, such as the health sector. As discussed above, many FBOs, including faith-based NGOs, are represented by national umbrella organizations, which aid in the coordination of FBOs' activities. It is therefore possible to get an indication of the level of FBO involvement in health service provision in Tanzania, which is discussed in greater detail below.

4.4.2.2 FBO Involvement in Health Provision

This section briefly outlines FBOs' involvement in health service provision in Tanzania. According to the Annual Health Statistical Abstract 2008, there are 223 hospitals, 565 health centres, and 4940 dispensaries in Tanzania. The government is the main provider of health services in Tanzania, providing approximately 67% of all health services, the remaining 33% being provided by Christian faith-based organizations, parastatal organizations¹⁰ and private organizations (DPP, 2008; MoFA & GoT, 2009; MOHSW & WHO, 2007). According to data from the Annual Health Statistical Abstract, the government and faith-based organizations each own 40% of hospitals in Tanzania (DPP, 2008). The remaining hospitals are owned by parastatal and private for-profit organizations. Table 6 provides a summary of the distribution of health facilities in Tanzania by type and ownership.

¹⁰ Parastatal organizations are semi-autonomous organizations which work with the government in an unofficial capacity.

Table 6 – Health Facilities in Tanzania by Ownership 2006

Ownership	Health Facility				
	Hospitals	Health Centres	Dispensaries	All Health Facilities	Percentage
Government	89	379	3348	3816	66.6%
Faith-Based Organization	90	125	658	873	15.2%
Parastatal	8	12	123	143	2.5%
Private for-profit	36	49	801	886	15.5%
Total	223	565	4940	5728	

(Source: DPP, 2008)

At the highest level of health care, there are four referral and four specialized hospitals. Government owns and operates four of these hospitals – the remaining two are owned and operated by Christian FBOs (MOHSW & WHO, 2007). FBO owned hospitals are church run, for example by the Evangelical Lutheran Church in Tanzania, the Tanzania Catholic Church, or the Anglican Church of Tanzania. Similarly, FBO health centres and dispensaries are primarily church run; however, some are run by faith-based NGOs acting underneath the umbrella of the Church. All Christian FBO health facilities in Tanzania are coordinated by the Christian Social Services Organization (CSSC), as discussed above. It is estimated that there are approximately 700 hospitals and dispensaries currently under CSSC in Tanzania.

It is clear from the above that FBOs play a large role in health service provision in Tanzania. As discussed above, Christian FBOs have traditionally played a more prominent role in Tanzania than Muslim FBOs. In addition, Christian organizations are also heavily involved in HIV/AIDS prevention, which will be discussed more in-depth below. Muslim involvement in health care and HIV/AIDS is much more minimal. There are very few hospitals or health-care facilities that are run by Muslim organizations in Tanzania, particularly locally run organizations. For example, according to Leurs et al. (2011), BAKWATA runs 110 dispensaries within Tanzania. An exception may be the Aga Khan Hospitals in Dar es Salaam and Moshi run by the Aga Khan Development Network under the Aga Khan Foundation, a private not-for profit international organization. Although the Aga Khan Foundation has roots in Islam, it does not overtly identify

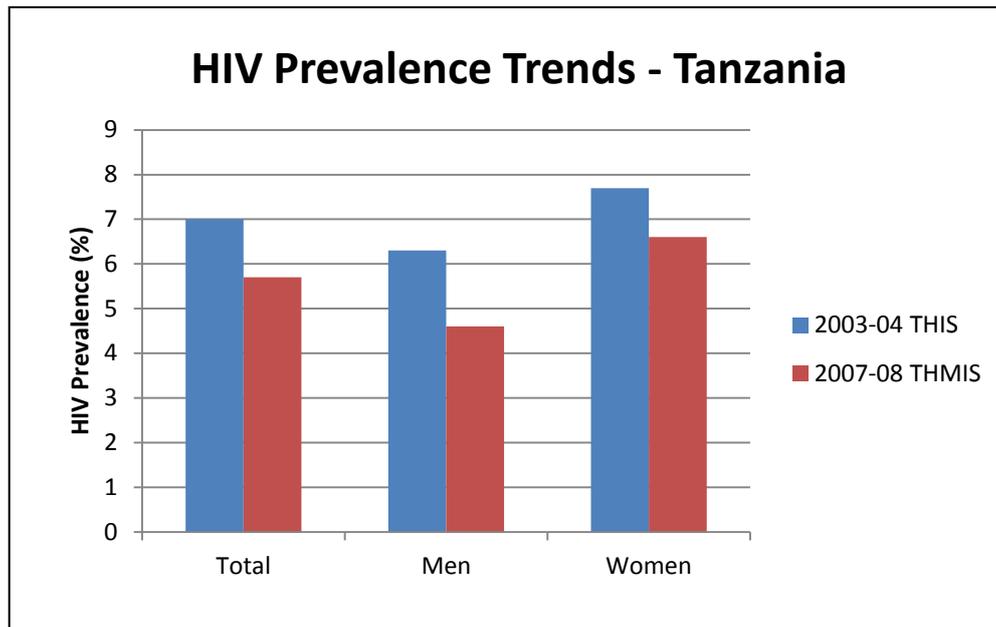
as a faith-based organization (AKDN, 2007). The faith-based response to HIV/AIDS in Tanzania is discussed below, following a discussion about the overall HIV/AIDS situation within Tanzania, including national HIV/AIDS response efforts.

4.5 HIV/AIDS in Tanzania

The HIV/AIDS epidemic was discussed in Chapter 2, including key historical influences on national and international responses, drivers of the epidemic, and HIV prevention paradigms. Tanzania first encountered HIV/AIDS in 1983 in the Kagera Region of Western Tanzania when the first three cases were diagnosed (NACP, 2008; NBS, 2005; Setel, 1999). By 1986 all regions in Tanzania reported cases (NACP, 2008; NBS, 2005). Since then the HIV/AIDS epidemic has continued to spread, and by the mid-1990s Tanzania was one of the countries in sub-Saharan Africa most severely affected by HIV/AIDS (Setel, 1999). In 1995 Tanzania had reported more AIDS cases to the World Health Organization (WHO) than any other country in sub-Saharan Africa (53,247) (*ibid.*). That same year it was projected that 1.6 million Tanzanians were infected with the virus (*ibid.*). The most common form of transmission of HIV continues to be through heterosexual contact, which accounts for 80% of all new infections (MOHSW, 2007; NBS, 2005). It is estimated that mother to child transmission account for 18% of new infections, while the remaining infections are “through blood transfusion, unsafe injections or traditional practices, including male circumcision or female genital cutting” (MOHSW, 2007: 13).

In recent years HIV prevalence has declined slightly from 7.0% in 2003-2004 to 5.7% in 2007-2008 (TACAIDS, et al., 2008). HIV prevalence continues to be higher among women than men, with “women aged 15-49 years living with HIV representing 56% of the total HIV infected population” (MOHSW, 2007: 15). In 2007-2008 the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) reported HIV prevalence among women to be 6.6%, whereas HIV prevalence among men was reported at 4.6% (NBS & Macro International Inc, 2009; TACAIDS, et al., 2005). HIV/AIDS rates continue to remain high throughout the country, making HIV/AIDS a continued health challenge. Figure 10 shows a summary of HIV prevalence in Tanzania.

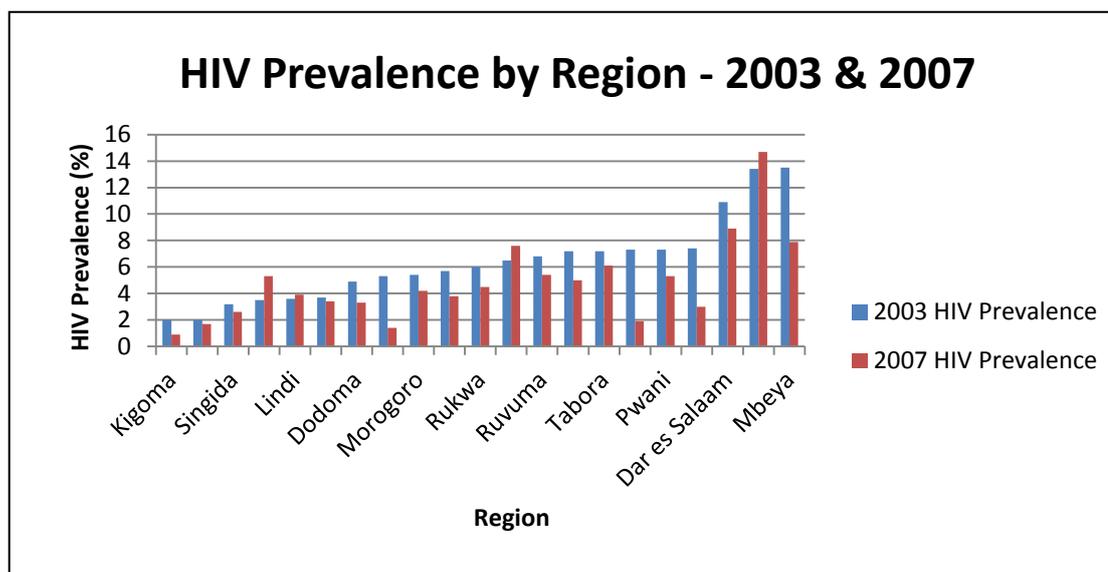
Figure 10 – HIV Prevalence Trends in Tanzania



(Source: Graph drawn by author using data from NBS & Macro International Inc, 2009)

The national average masks the regional variation within the country. In 2007-2008 regional variance on Tanzania mainland ranged from 1.5% (adult prevalence) in the Manyara region to 15.7% (adult prevalence) in the Iringa region in 2007-2008 (TACAIDS, et al., 2008). Regional HIV prevalence, however, has not remained constant, with some regions witnessing a substantial increase or decrease in HIV prevalence. Figure 11 shows regional HIV prevalence in 2003 and 2007, illustrating an increase or decrease in HIV prevalence per region.

Figure 11 – HIV Prevalence by Region – 2003 & 2007



(Source: Graph drawn by author using data from TACAIDS, et al., 2005; TACAIDS, et al., 2008)

Despite the overall decrease in HIV prevalence, HIV/AIDS rates continue to remain high throughout the country, making HIV/AIDS a continued health challenge.

4.5.1 High risk groups in Tanzania

Like most low income countries, the HIV/AIDS epidemic in Tanzania is generalized instead of localized (MOHSW, 2007), meaning that it affects the whole population, compared to countries where it is largely confined to specific sub-groups, such as intravenous drug users and commercial sex workers. At the same time, however, there are specific sub-groups in Tanzania who are at a higher risk of contracting HIV/AIDS and are currently carrying a disproportionately high HIV burden (ASAP, 2008). Such groups include: commercial sex workers, fishing communities, truck drivers, females affected by sexual and domestic violence, intravenous drug users, and men who have sex with men (*ibid.*). Both commercial sex work and men having sex with men is illegal and highly stigmatized with Tanzania, furthering these groups vulnerability to HIV infection.

In addition, the HIV/AIDS epidemic in Tanzania is characterised by clear gender inequalities, affecting more women than men. As mentioned previously, women are more likely than men to become infected with HIV at a younger age and in all age categories (except the 35-39 category) more women than men are infected. In addition, the MOHSW reports that “the

most vulnerable group in Tanzania, as elsewhere in Africa, has been shown to be married women who are least likely to have protected sex” (MOHSW, 2007: 15). Exposure to HIV in this group is most likely to occur through a woman’s husband (*ibid.*). HIV prevalence has been shown to be related to marital status, and according to the MOHSW is highest among those who have been formerly married (18.4%) (*ibid.*).

4.5.2 Risk Factors and Drivers of the HIV epidemic in Tanzania

As stated in Chapter 2, there are some common drivers and risk factors which facilitate HIV infection that are found across countries with high prevalence rates. At the same time, however, there are some factors that are highly localized, as evidenced by the regional variation in HIV prevalence in Tanzania. Common drivers and risk factors were discussed in Chapter 2. This section gives a brief overview of some of local risk factors and drivers that have been identified as facilitating HIV infection in Tanzania.

According to the MOHSW, the HIV epidemic in Tanzania “is largely driven by unsafe sexual behaviour by males, on one hand, and by female subordination and lack of economic independence, on the other” (2007: 15). As an example they report that more than 70% of out-of-school girls who are sexually active reported having relationships with older men and granting sexual favours to meet daily needs (*ibid.*). Other local drivers and risk factors within Tanzania, as identified in the AIDS Strategy & Action Plan, include: traditional dances (by encouraging unsafe sexual practices); alcoholism; widow inheritance and cleansing; misconceptions about condom use; lack of condom availability, especially in rural areas; and traditional beliefs about HIV (ASAP, 2008). Due to regional variation of HIV prevalence, it is important to understand the context specific nature of an HIV epidemic in order to create HIV prevention messages that address both common and local risk factors and drivers. Tanzania’s national HIV/AIDS response efforts are situated within the above HIV/AIDS context. The following section explores that national response to HIV/AIDS, including the role of civil society organizations.

4.6 The National HIV/AIDS Response

Tanzania’s national HIV/AIDS response has evolved since 1983 after the first AIDS cases were reported. In 1985 a National AIDS Task Force and a Short Term Plan (STP) were established by the MOHSW (MOHSW, 2007). The National AIDS Control Programme (NACP) was then launched in 1988 with the “overall aim of reducing the incidence of HIV infection and its

associated morbidity and mortality” (NACP, 2008). Between 1987 and 2002 the MOHSW developed three five-year HIV/AIDS Medium Term Plans (MTPs): MTP-I (1987-1991); MTP-II (1992-1996); and MTP-III (1998-2002). HIV/AIDS was initially viewed purely as a health problem, and as a result the initial response to combat the emerging epidemic involved only the health sector through the NACP (URT-PMO, 2001). The HIV/AIDS response consisted of strategies to prevent, control, and mitigate HIV/AIDS (*ibid.*); however, despite the above efforts, HIV infection rates within the country continued to rise, reaching a peak in the mid-1990s (URT-PMO, 2007).

The MTP-II (1992-1996) first recognized the multi-sectoral nature of the HIV/AIDS epidemic, involving the education, labour, and agricultural sectors, and the need for cross-sector collaboration; however, it was not until 1999 when the President declared AIDS to be a “national disaster,” and called for a concerted multi-sectoral response to address it, that such a response was set in motion (URT-PMO, 2007). This resulted in an enquiry “into the factors that were behind the slow multi-sectoral response to the epidemic”, the recommendations of which resulted in the development of the National Policy on HIV/AIDS in 2001, and the establishment of the Tanzania Commission for AIDS (TACAIDS), whose role was to provide overall leadership and coordination of the national multi-sectoral response (URT-PMO, 2007: 12).

The inception of TACAIDS was followed by the development of the first National Multi-Sectoral Strategic Framework (NMSF) (2003-2007) on HIV and AIDS, followed by the second NMSF (2008-2012) on HIV and AIDS. Through the NMSFs, “public and private sectors, local and international NGOs and institutions were urged to initiate interventions aimed at addressing [...] four major thematic areas: prevention, care and treatment, impact mitigation and the enabling environment (cross-cutting issues)” (*ibid.*: 12-13). The MOHSW was the first to respond to the call by establishing the Health Sector Strategy for HIV and AIDS (2003-2006), which was followed by the Health Sector HIV and AIDS Strategic Plan (HSHSP) 2008-2012. In addition, the HIV and AIDS (Prevention and Control) Act was established in 2007 as a law for the protection and health promotion of people living with or at risk of HIV/AIDS (URT, 2007).

4.6.1 National HIV/AIDS Policies

The National Policy on HIV/AIDS and the 2008-2012 NMSF currently constitute the two main HIV/AIDS policy documents in the country and are meant to guide all sectors, institutions,

communities, and individuals working in the area of HIV/AIDS. The overall goal of the National Policy is “to provide for a framework for leadership and coordination of the national multi-sectoral response to the HIV/AIDS epidemic” (URT-PMO, 2001: 11). Its specific objectives include: the prevention of HIV transmission; the promotion of HIV testing and counselling; the provision of care and support for PLWHA; the strengthening of the roles and capacity of all sectors, including public, private, NGOs, faith groups, and PLWHA; the promotion of HIV/AIDS research; and the creation of an HIV/AIDS legal framework. The National Policy on HIV/AIDS set the context for the 2003-2007 NMSF and the 2008-2012 NMSF builds on both.

According to the 2008-2012 NMSF it was developed along the “Three Ones” Principle: one coordinating structure, one implementing plan and one monitoring and evaluation system at central, regional and local levels (URT-PMO, 2007). The overall vision of the NMSF is “Tanzania united in its efforts to reduce the spread of HIV and to provide the best available care for those infected and affected by the virus within a human rights and empowerment framework” (*ibid.*: 29). In attempting to achieve this overall vision it sets out specific goals and priorities for the national multi-sectoral response in an attempt to guide “the approaches, interventions and activities which will be undertaken by all actors in the country regardless of whether they are coming from the public or private sector, the civil society groups, the business communities or the bilateral and international partners of the government of Tanzania” (*ibid.*: vi). According to the NMSF, all actors responding to HIV/AIDS within Tanzania are therefore expected to work in line with the strategies and interventions promoted by the NSMF, including faith-based organizations, the role of which is described below.

The first priority of the NMSF is the reduction of new HIV infections (*ibid.*). The NMSF (*ibid.*) outlines nine prevention areas, the strategies of which aim to decrease the risk of infection among the general population; these include:

1. Promotion of abstinence, delayed sexual debut, partner reduction and consistent condom use among young people in and out of school.
2. Reduction of risk of HIV infection among the most vulnerable populations.
3. Expansion of workplace interventions, with special attention for mobile and migrant workers.
4. Prevention, treatment and control of other sexually transmitted infections (STIs).
5. Promotion and expansion of HIV testing and counselling services.

6. Prevention of mother to child transmission of HIV.
7. Promotion and distribution of condoms.
8. Prevention of HIV transmission through blood transfusion, exposure to contaminated body fluids and contaminated instruments.
9. Introduction of new prevention interventions, such as male circumcision.

The role of civil society, including faith-based organizations, in the above prevention response is outlined below.

4.6.2 Role of Civil Society in the National HIV/AIDS Response

According to the NMSF, civil society is made up of non-governmental organizations (NGOs), faith-based organizations (FBOs), and community-based organizations (CBOs), of which there are several thousand involved in the HIV/AIDS national response in Tanzania (URT-PMO, 2007). The NMSF recognizes that state actors cannot implement the national response alone, and that civil society organizations (CSOs) “across the country are important implementation partners and complement the government driven intervention initiatives”, already having made substantial contributions to the national response (*ibid.*: xv). Although the potential role of civil society is recognized within the NMSF, the policy also recognizes that the rapid development and increase in CSOs, as witnessed throughout the last two decades, has at times created challenges with regards to the control and quality of services and interventions, as well as the supervision of CSOs. According to the NMSF, improving adherence to the national guidelines and improving the standards of quality among CSOs continues to remain a challenge.

While the NMSF recognizes the involvement of FBOs in the national HIV/AIDS response, it is clear that the government is critical of FBOs’ involvement in HIV prevention, especially with regards to some FBOs’ ‘disabling’ views regarding commercial sex activities and condom promotion (*ibid.*). For example, the NMSF identifies unbalanced condom messages regarding their effectiveness in the prevention of HIV infection as a challenge to overall prevention efforts, as it leads to confusion among the population. The role of condoms with regards to discordant couples, where one or both partners is HIV/AIDS positive, is particularly recognized, as it is the only available method to reduce HIV infection apart from abstinence. Advocacy with religious leaders to be more tolerant towards condom use, especially in relation to discordant couples, is identified as a key strategy within the NMSF. The NMSF recognizes that

overall more advocacy work is needed with FBOs “to provide greater understanding of the dynamics of the epidemic as well as the promoting of interventions that are evidence based, culturally accepted and scientifically valid and with which they may not always agree with” (*ibid.*: 86). While all FBOs working in the area of HIV/AIDS have to operate within the framework, the NMSF does recognize that not all FBOs will support all the recommended strategies due to their own convictions and mandates. According to the NMSF, in such cases organizations are permitted to select their own preferences but are asked to “refrain from contradicting other elements of the NMSF” (*ibid.*: 86). Within the NMSF, however, no indication is given about what “contradicting other elements of the NMSF” means, and what happens, if anything, when organizations are found to do so. It is therefore likely that the government lacks the capacity to regulate and monitor civil society organizations to ensure they are working within the framework of the national response.

4.6.3 National HIV/AIDS Response Funding

The Government of Tanzania receives 40% of its overall budget through donor assistance (URT-PMO, 2007). The HIV/AIDS budget in particular receives 80% of its funding from donor assistance, the majority of which comes from three main donors: the United States Government, the Global Fund to fight AIDS, TB and Malaria, and the World Bank (*ibid.*). In terms of the financial stability of the national HIV/AIDS response, this reliance on international donors, and in particular a limited number of donors, is seen as a major concern. The distribution of HIV/AIDS funding is disproportionate, as 64% of all funding goes to care and treatment, 14% to prevention, 8% to cross-cutting issues, 8% to multi-purpose interventions, 4% to policy and administration, and 2% to impact mitigation (*ibid.*). According to the NMSF, inequalities in the distribution of funding across the country are also witnessed, as urban areas tend to be favoured and at present there are no guidelines on equitable access to treatment and care in Tanzania (*ibid.*).

The NMSF recognizes that due to significant financial constraints it is unlikely that all aspects of the framework will be funded in their entirety, and instead a balance has to be reached which may compromise the needs of those already infected with the long-term needs of the country to ensure that the remainder of the uninfected population remains uninfected (*ibid.*). At an operational level this would mean scaling up the prevention and impact mitigation areas of the national response and the more efficient utilization of existing resources, including using established CSOs as health service providers (*ibid.*).

4.6.4 Challenges to the National HIV/AIDS Response

Although many achievements have been attained regarding the national multi-sectoral response to HIV/AIDS, there are significant challenges that still need to be met that the 2008-2012 NMSF attempts to address. Such challenges were recognized after the 2003-2007 NSMF and include:

1. A continual lack of high level political commitment and accountability for the HIV response;
2. Weak and insufficient HIV programmes by government ministries, departments, and agencies, especially at regional, district and community outreach levels;
3. An overburdened national coordination structure (TACAIDS);
4. Difficulties in applying the “Three Ones” principle at central and district levels;
5. Insufficient participation of CSOs and PLWHA, especially at district and community level in planning and implementing HIV responses;
6. Continual delays and difficulties in providing timely funding to districts and communities;
7. Stigma and discrimination remain high in many areas and parts of the country;
8. Prevention efforts do not sufficiently address sexuality matters and often lack continuity;
9. Gender inequalities are not sufficiently and comprehensively addressed;
10. Correct and consistent condom use remains problematic, and access is limited in most rural communities;
11. Coverage of prevention efforts in rural areas is insufficient; and,
12. Access to anti-retroviral therapy (ART) remains largely concentrated in urban centres (URT-PMO, 2007: xi).

The above list is not exhaustive. In addition, the role of FBOs in helping to meet these challenges is controversial, particularly with regards to stigma and discrimination, access to condoms, and lack of continuity of HIV prevention messages. As discussed in Chapter 2, depending on how FBOs respond to the epidemic can affect their role and influence within overall response efforts. At the same time, as stated above, the NMSF recognizes the need for a national multi-sectoral response to HIV/AIDS and the importance of involving all actors in the response efforts – particularly if the above challenges are to be met.

4.7 Faith-Based Organization HIV/AIDS Response in Tanzania

Many faith-based organizations are involved in HIV/AIDS response efforts – through churches, faith-based hospitals or health facilities, and faith-based NGOs (local, national, and international). The overall faith-based response to HIV/AIDS was discussed in Chapter 2. Within Tanzania most FBOs' HIV/AIDS response efforts are coordinated through the FBO umbrella organizations that were discussed above (CSSC, TEC, CCT, and BAKWATA). In addition, many FBOs' HIV/AIDS services are provided through their health facilities or affiliated organizations, such as faith-based NGOs. As a result, the umbrella FBOs have created health and HIV/AIDS departments to help with coordination efforts and streamline the faith-based response to HIV/AIDS, and/or have developed their own HIV/AIDS policies. TEC, under the Catholic Church, for example, has both a health department, which employs a HIV/AIDS policy coordinator, and a HIV/AIDS policy. Likewise, CCT has an HIV/AIDS department and at the time of data collection was drafting its own national policy on HIV/AIDS. Similarly, BAKWATA has developed the BAKWATA National HIV/AIDS Program (BAK-AIDS) and an Islam and AIDS policy guide to help with its HIV/AIDS response efforts. The following section discusses TEC's and BAKWATA's HIV/AIDS policies as these relate to the organizations in the study. The Anglican FBO, although under the Anglican Church, is not a member of CCT, so is not expected to follow CCT's HIV/AIDS policy; as a result, this policy is not discussed here. However, as the policy was still in draft form at time of writing, it is possible that the organization may use it as a reference in the future.

4.7.1 Tanzania Episcopal Conference HIV/AIDS Policy

The purpose of TEC's HIV/AIDS Policy is to provide a framework for a coordinated HIV/AIDS response within the Catholic Church hierarchy in Tanzania, which includes all Catholic dioceses, parishes, church communities, and organizations (TEC, 2004). Its general objective is to "combat HIV/AIDS and provide pastoral care to all Church communities in Tanzania who are affected by the epidemic" and is meant to guide prevention, treatment, and mitigation (*ibid.*: 2). According to TEC's HIV/AIDS policy, all "HIV/AIDS related activities should be in line with Gospel values and the teaching of the Universal Church" (*ibid.*). In addition, the policy states that, it "supersedes all other HIV/AIDS secular policies in matters of ethics and morality" (*ibid.*). According to a representative from the Catholic Church, this relates predominately to the issue of condom use and promotion. The policy advocates for prayer, advocacy, training, and service in the fight against HIV/AIDS, in addition to positive behavioural change through abstinence for those who are not married and fidelity for those who are. The provision and

education of condoms is omitted from the Catholic policy, which is the main area where it differs from national policies. The policy also differs in its focus on the role of the Church “in the war to stop the spread of HIV/AIDS” (*ibid.*: 4) in the following ways: its promotion of pre-marital testing; its attention to prayer and pastoral care in the provision of HIV/AIDS care and treatment; and through the promotion of voluntarism to carry out HIV/AIDS activities within the Church and Church communities. The Catholic organization included in the study was expected to follow this policy.

4.7.2 BAKWATA AIDS Policy Guide

BAKWATA’s HIV/AIDS policy was developed in response to the NMSF, which called for sectors to create their own institutional approaches and operational plans to HIV/AIDS within the framework of the NMSF. According to the policy, it “complements the existing National Framework and provides a rational approach to the fight against HIV/AIDS according to Muslim principles” (BAKWATA, 2007: 4), and is meant to guide the Muslim community and its believers in their HIV/AIDS response efforts. Its overall goal is to “provide guidance for stakeholders in the control of the epidemic [...], help build positive attitudes towards those infected and promote health and safety amongst its believers” (*ibid.*: 5). Its objectives include: establishing and coordinating appropriate interventions; guiding decision-making on HIV/AIDS issues; directing prevention measures; providing guidance on care and support for PLWHA; and promoting the rights of PLWHA (*ibid.*). As with the other faith’s HIV/AIDS policies it differs from national policies in its approach to prevention, which is led by the “Quran, Sunnah, and other new developing laws in Islam and periodic fatwa¹¹” (*ibid.*: 7). Its prevention messages include behaviour change, such as practicing abstinence and fidelity and avoiding alcohol. It differs from Christian policies in its recognition of sero-discordant couples (where one is HIV positive and one is negative), where it states that in such cases “the issue will be handled with wisdom based on both medical advice and Islamic principles” (*ibid.*: 7). Overall, the policy document is meant to help coordinate and streamline the Islamic HIV/AIDS response in Tanzania by acting as a guide for those working in the area of HIV/AIDS. Although the Muslim organization included in the study was not required to follow BAKWATA’s HIV/AIDS policy, according to respondents it was used as a reference within the organization.

¹¹ Sunnah refers to the Prophet Mohammed’s recognized customs, deeds, habits, and practices, which is seen as an ideal for Muslim behaviour and is passed down by example and personal teaching (Denny, 1994). Sunnah is preserved, documented, and communicated by means of *hadiths* – collections of Islamic texts which are seen to supplement and elaborate the Quran, which is the most authoritative source for Islamic doctrine and practice (*ibid.*). Fatwa are learned religious opinions, or rulings, issued by Muftis, concerning Islamic law, known as Sharia (*ibid.*).

4.8 Chapter Summary

This chapter discussed the Tanzanian context in relation to the study. Tanzania remains one of the least developed countries in the world, with a population of around 40 million, 25% of which live below the poverty line. Christian and Muslim communities are estimated to be relatively equal, each accounting for 30 to 40 percent of the population. The historical developments of each community have influenced their current involvement in health service provision and HIV/AIDS prevention and mitigation. The Tanzanian government recognizes that non-state private organizations, such as NGOs and FBOs, are important actors in overall health service provision. The relaxing of state controls, in addition to increased donor funds allocated for NGO activities over the last twenty years, contributed to a massive growth of this sector from 1990-2000. NGOs and FBOs are registered under one of five bodies, depending on their activities or purpose. There are many FBOs in Tanzania, most of which are represented by umbrella FBOs. The NGO registry estimates that over 3000 NGOs are currently working within Tanzania, due to registration procedures it is difficult to know how many of them can be described as faith-based NGOs. Compared to Christian FBOs, the organization and coordination of Muslim FBOs within Tanzania remains weak. Christian FBOs in particular are highly involved in health service provision, operating many of the country's health facilities.

HIV/AIDS continues to remain a challenge within Tanzania. High risk groups in Tanzania include: commercial sex workers, fishing communities, truck drivers, females affected by sexual and domestic violence, intravenous drug users, and men who have sex with men. In addition to the common drivers and risk factors identified in Chapter 2, there are also local drivers and risk factors within Tanzania that facilitate HIV/AIDS infection, which include: unsafe sexual behaviour, female subordination and lack of economic independence, widow inheritance and cleansing, misconceptions about condom use, lack of condom availability, and traditional beliefs around HIV. The national HIV/AIDS response in Tanzania has evolved since 1983 and includes two main policies: the National HIV/AIDS policy and the NMSF. The contribution of FBOs to HIV/AIDS prevention and mitigation is recognized in both policies; however, it is recognized that not all FBOs will be able to support all recommended strategies due to conflicting beliefs. In such cases, FBOs are specifically asked to refrain from contradicting other elements of the NMSF. In addition, the NMSF recognizes specific challenges to national HIV/AIDS response efforts, some of which FBOs might be actively contributing to, such as inconsistency in prevention messages. Within Tanzania most FBOs' HIV/AIDS response efforts are coordinated through FBO umbrella organizations (CSSC, TEC,

CCT, and BAKWATA), many of which have developed their own HIV/AIDS policies for their member organizations to follow.

This chapter highlighted the context in which the three case studies included in the research are operating. Many of the factors discussed influence the organizations' HIV/AIDS prevention policy process and response. The following three chapters present the findings from the three case studies in relation to the study's conceptual framework. Each chapter discusses the key factors that were found to influence the HIV/AIDS prevention policy process within each organization. Chapter 8 compares the findings from each organization and discusses the implications of the findings for research, policy, and practice.

Chapter 5 – Policy Processes within the Catholic Organization

5.1 Introduction

This chapter explores the factors influencing the HIV/AIDS prevention policy process within the Catholic NGO. Chapter 3 outlined the data collection and analysis process used to identify these factors, while Chapter 4 explored the study context. This chapter begins with a description of the Catholic organization, followed by a discussion of the organization's HIV/AIDS prevention approach in terms of policy and practice. This is followed by a discussion of the main factors found to influence the organization's HIV/AIDS prevention policy process in relation to the conceptual framework presented in Chapter 2. The main findings are therefore presented according to process, context, and actors; the role of faith is explored in relation to each where applicable. Although government and donors can be considered actors, within the chapter they are discussed within context as no immediate government or donor actors were found to directly influence the policy process, only aspects of each, such as policies or guidelines. How the factors inter-relate to form policy content in terms of written and unwritten policy and practice is discussed throughout the chapter. The factors presented are not exhaustive, but are those that were identified to be most influential within the organization's HIV/AIDS prevention policy process. The quotations are based on interviews with respondents from the Catholic organization, unless otherwise indicated. The chapter concludes with a summary of the main findings.

5.2 Overview of Organization

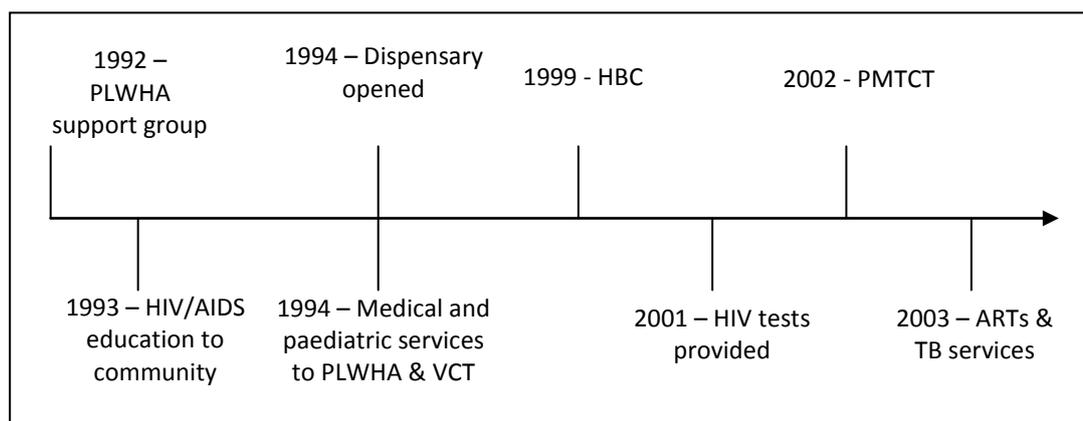
Pastoral Activities and Services for People with AIDS Dar es Salaam Archdiocese (PASADA) is a social service agency operating under the Roman Catholic Archdiocese of Dar es Salaam, Tanzania (PASADA, 2006). It can be described as a faith-based professional organization: an organization that self-identifies itself as faith-based and is formally affiliated with a religious body, while employing staff based on their professional qualifications as opposed to their faith. PASADA's relationship with the Catholic Church is mediated through the Bishop and Advisory Board, each of which is discussed below under 'actors'. At the time of data collection PASADA had approximately 150 professional staff and over 700 volunteers, many of whom were also clients (interview with PASADA employee). Although PASADA self-identifies as a FBO, it predominately defines itself as a social service agency under the Catholic Church. It is registered under the Ministry of Health and Social Welfare (MOHSW) as a health facility and

the staff and volunteers come from different religious denominations and/or professional backgrounds.

The organization was started in 1992 when a group of people infected with HIV gathered to seek aid and support, and the Archbishop of Dar es Salaam mandated a local Reverend to “initiate a pastoral service to respond to the needs of people suffering from HIV and AIDS” (PASADA, 2006: 7). The group remained a self-support group until a dispensary was opened in 1994; by the end of 1994, 150 people living with HIV/AIDS (PLWHA) were receiving services (*ibid.*). Since 1994, PASADA grew rapidly in order to respond to the needs of PLWHA in Dar es Salaam, and by 2006-2007 around 18,000 PLWHA were accessing services at PASADA. Today, according to *PASADA Best Practices*, the organization “has developed into a comprehensive service unit”, with a holistic approach to the HIV/AIDS pandemic (*ibid.*: 8).

According to organizational documents, PASADA’s services have evolved gradually over time. The organization began providing spiritual counselling to PLWHA and support for orphans and vulnerable children (OVC). Through this the needs of people affected and infected with HIV/AIDS were recognized and services expanded to include social assistance (food, money for rent, and emergency assistance). PASADA began providing HIV/AIDS education at the community level in 1993 in an attempt to prevent new infections of HIV. In 1994, after the opening of the dispensary, PASADA began to offer free medical and paediatric services to PLWHA to combat the many recurrent opportunistic infections experienced by PLWHA, in addition to voluntary counselling and testing (VCT), which operated separately from spiritual counselling. However, it was not until 2001 that PASADA started carrying out its own HIV tests. In 1999 home-based and palliative care (HBC) services were started to respond to the needs of bed-ridden PLWHA suffering from opportunistic infections and HIV/AIDS. In 2002, PASADA began to offer prevention of mother-to-child transmission (PMTCT) services, and in 2003 tuberculosis (TB) diagnosis and treatment services were offered. It was also in 2003 that an anti-retroviral treatment (ART) programme was started, motivated by the growing number of clients who needed treatment (*ibid.*). Figure 12 shows a timeline of PASADA’s HIV/AIDS services.

Figure 12 – Timeline of PASADA’s HIV/AIDS Services



The Archdiocese’s motivation for starting PASADA is outlined by Cardinal Pengo, the Archbishop of Dar es Salaam, in the document *Building on Hope: PASADA Best Practices*:

The problem of HIV and AIDS was felt more in the big cities and Dar es Salaam was one of the regions most affected by the pandemic at that time. We cannot provide or do pastoral work without addressing HIV and AIDS. The Church wanted people to get correct answers for the questions that they were posing regarding the disease [...] The Church has a moral responsibility and a central role to play in guiding the moral formation of the people and that it cannot therefore remain silent when witnessing the destruction of ethical principles and that the prevention of new infections should address the root cause of the problem (ibid.: 8).

According to Cardinal Pengo (*ibid.*), PASADA was started in order to provide a pastoral approach to the HIV/AIDS epidemic. A pastoral approach which, as demonstrated by the above quotation, would prevent new infections by guiding the moral formation of people in order to address what the Church viewed as the root cause of the problem – the destruction of ethical principles. Although not explicitly stated within the quotation, it can be inferred that the ethical principles the Cardinal is referring to relate to sexuality and the Church’s policy on abstinence before marriage, fidelity after marriage, and the non-use of condoms.

PASADA’s mission is outlined in *PASADA Best Practices*:

Responding to the call of faith, PASADA strives to provide and maintain quality caring and compassionate services and support to people affected by HIV and AIDS in the Archdiocese of Dar es Salaam, with particular attention to the poorest and most needy, through a holistic approach and with special emphasis on the values of justice and solidarity (ibid.: 9).

PASADA prides itself on having a holistic approach to HIV/AIDS service provision that “considers not just the impact of the pandemic on the health of individuals, families and communities, but also the social and economic implications of the same” (*ibid.*: 13). According to *PASADA Best Practices*, their mission statement forms the basis of their approach to the people it serves. PASADA’s inception was therefore grounded in faith, which according to its mission, continues to serve as a motivational guide.

The current organization is sub-divided into separate departments which have their own specific objectives and activities; however, according to respondents each department works in collaboration with the others due to the cross-cutting nature of the issues affecting PLWHA. PASADA serves a wide catchment area, which includes the Dar es Salaam region and five districts in the Coastal region of Tanzania. The main site is located within Dar es Salaam, behind the walls of a Catholic Church compound. Since 2003 PASADA has begun to decentralize services to the community level through Catholic satellite dispensaries and parishes in the catchment area (*ibid.*). PASADA strongly maintains (both within its organizational documents and in individual interviews) that, although sponsored by the Catholic Church, “the services offered by PASADA are available to all individuals without discrimination of any sort and completely free of charge” (PASADA, 2007b: 2), which was seen as an important part of its professional identity. PASADA’s clients therefore come from all faith denominations, with over 45% from the Muslim community (PASADA, 2006).

Despite being located on a Catholic Church compound, at first glance it is not obvious that PASADA is a FBO. In addition, it is not obvious that it is a health facility; if it was not for the artwork displayed around the facility it would not have been apparent that it specialized in HIV/AIDS. On any given day there are large numbers of clients waiting to be seen by the various departments. The majority of the artwork that is displayed on the outside walls of the facility depicts images and symbols related to HIV/AIDS. As one walks throughout the communal rooms of the facility the faith-based identity of the organization becomes clearer as images of Jesus Christ on the cross and other religious images and symbols are displayed. Religious imagery or symbols within the individual offices is intermittent, depending on the individual beliefs of the people who use the room.

Morning prayer is an important part of the organization’s daily activities. At 8:00am every morning, morning prayers are held in the canteen, lasting about 5-10 minutes. At about

7:50am a bell is rung inviting people to take part, of which about 7-20 employees attend each day. At the beginning of the prayer session a religious song is sung and then one staff member is invited to lead the prayer. According to one respondent, at one time morning prayer was a mandatory activity and often “dominated by Catholics” (PASADA employee, respondent #15); as the organization grew morning prayers became optional, incorporating all religious denominations:

In the morning we pray [...]. I pray as a Protestant, I know there are people who are not, they don't even believe in anything sometimes. So you pray for what you believe. So we are not really strict Roman Catholic organization, no. [...] Whatever faith we have. We have Muslim employees, Protestants, Assemblies of God, and Roman Catholics, so cut across everywhere (PASADA employee, respondent # 16).

The shift from Catholic prayer to multi-denominational prayer reflects the organization's shift from a predominately self-support group run by religious volunteers to a health facility run by health professionals, as discussed above. The organization's current professional identity was often emphasized by respondents. As one respondent explained, for example:

I believe that we are here at PASADA, not because we are Christian, no. We are here because of our qualification, something like that, because we are professionals. And we are going to serve people who have all denominational categories because HIV and AIDS doesn't mean that it's there for Roman Catholics or for Muslims, it is there for everyone (PASADA employee, respondent # 21).

The importance of the organization's and actors' professional identity will be further discussed below.

Despite the organization's professional identity, the morning prayer was viewed as an important activity within the organization, as well as a way for it to distinguish itself from other organizations, as explained by the following respondent:

Ya, it is important, I'm saying it is an asset. That's what actually makes us also different, because we commit whatever we are going to do to God in the morning. [...] It re-awakens our conscience with regard to the services that we are offering. That yes we use our gifts, God to enlighten us, so that we can offer the services to these people with compassionate love. So you keep reminding, so that rather than becoming mechanical, the spiritual component of it, is very, very important (PASADA employee, respondent #15).

As the above quotation demonstrates, in addition to its professional identity, the morning prayer is believed to be an important aspect of the organization's faith identity, something which distinguishes it from its secular counterparts. Due to the highly religious nature of the Tanzanian context, however, it is difficult to know if this is the result of the organization's faith identity, or context in which the organization works.

Based on the above description, PASADA can therefore be described as a faith-based professional organization: an organization that self-identifies itself as faith-based and is formally affiliated with a religious body, while employing staff based on their professional qualifications as opposed to their faith. As will be discussed below, this identity creates conflict within the organization's HIV/AIDS prevention policy process, particularly in relation to policy implementation where actors are forced to mediate between competing demands. Before discussing the main factors that influence the HIV/AIDS prevention policy process within the organization, the following section discusses the organization's overall HIV/AIDS prevention approach, in terms of both policy and practice.

5.3 HIV/AIDS Prevention Approach

As outlined above, PASADA provides a range of services, which include both care and support of people infected and affected by HIV/AIDS, such as VCT, HBC, PMTCT, TB/HIV, ART, OVC, and preventative services. The organization's main preventative services can be divided into three categories: (1) HIV/AIDS prevention at the community level; (2) positive prevention; and, (3) HIV/AIDS prevention among vulnerable groups who are particularly susceptible to HIV infection, such as commercial sex workers (CSW), men who have sex with men (MSM), and youth. The organization's involvement in each category is described below. This involvement includes both organizational policy and practice, which includes how actors mediate between the inter-relating and sometimes conflicting factors that influence the overall HIV/AIDS prevention policy process.

5.3.1 Community HIV/AIDS Prevention

HIV/AIDS prevention at the community level is predominately provided by the Community Education department within PASADA. It is targeted at people within the community who are HIV negative or do not know their HIV status, particularly youth and pregnant women, with the overall aim of preventing new HIV infections. The department's HIV/AIDS prevention work includes educational messages about HIV/AIDS, the promotion of behavioural change which

facilitates HIV/AIDS prevention, the importance and promotion of HIV testing, and the promotion and teaching of life skills to youth and other groups. According to *PASADA Best Practices*, this work is conducted through “drama and music, [...] discussion, direct interaction with participants, distribution of informative pamphlets and other IEC [information, education, and communication] material, Stepping Stones Courses (life skills), targeted topic presentations, debates, and the use of selected videotapes” (PASADA, 2006: 46). Through its education and sensitization work the Community Education department also aims to reduce HIV and AIDS related stigma and discrimination, promote care and support for PLWHA and OVC, and promote PASADA and its services.

To aid in its community HIV/AIDS education and sensitization work, PASADA has created a tool for community educators titled: *Let’s talk about HIV/AIDS: A Tool for Community Educators* (PASADA, 2007a). The tool provides information to community educators about training sessions (i.e. activities and information to cover within the sessions), and is divided into 15 sections, each referring to a different HIV/AIDS-related subject. The HIV prevention section within the document highlights the main areas to cover during HIV/AIDS prevention education sessions, including: the importance of targeting cultural HIV drivers such as cultural practices which fuel the epidemic, encouraging participants to cultivate religious values by observing moral teachings, and the advantages of being faithful to a sexual partner and of abstaining from sex before marriage. In relation to HIV/AIDS prevention, religious values and moral teachings are often interpreted as referring to those relating to the Church’s position on abstinence, faithfulness, and condom use, which is outlined within the HIV prevention section of the guide:

The Catholic Church has always been firm on condom use even before the HIV pandemic. Condom use as a method of HIV prevention is not allowed by the Church. HIV, which is mainly spread through sexual intercourse, cannot be controlled by using condoms. Behaviour change and observance of religious teachings on the sanctity of sex before and after marriage is the only way that can significantly reduce the spread of HIV. Much effort should go into educating people on behaviour change.

The last two decades of the pandemic have been dedicated to the promotion of condom use to prevent transmission of the virus, but this has not managed to decrease the spread of HIV and, in some places, where condom promotion was very strong, the rate of infection has increased. Therefore, worldwide, more efforts are now going into promotion of faithfulness and abstinence. These aspects have been the main focus of the church from the beginning of the HIV pandemic.

Experience has it that in urban settings where condom promotion and condom availability is high, the rate of HIV infection is higher than in rural areas where condom promotion and availability is low. The church, whose role is to mould people morally, cannot promote something which it believes promotes immoral behaviour and can put many people at risk of acquiring HIV infection (PASADA, 2007a: 26).

According to the above quotation the Catholic Church does not condone the promotion of condoms in HIV/AIDS prevention, promoting instead faithfulness and abstinence. This position contradicts government policy, which sees condoms as “the most effective and easy to use barriers preventing the transmission of HIV” (URT-PMO, 2007: 50), through its insistence that condoms cannot help control HIV, and its suggestion that condoms increase the rate of HIV infection through promoting immoral behaviour. However, the *Tool for Community Educators* was the only place that the Catholic Church’s position on condoms was specifically written within the organization’s documents, and the views expressed within it did not appear to be shared or promoted by most respondents. Many respondents believed, for example, that condoms were an effective prevention tool that helps reduce the rate of HIV infection.

According to respondents, as a Catholic organization PASADA is expected to follow church policy, particularly in relation to condoms, which is exemplified by the following respondent:

There is no written policy about condoms, but it is understood by everybody, as this is a Catholic organization, and the stand of a Catholic organization is you don’t promote and you certainly don’t distribute condoms, [...] it’s clear that that is followed. It’s not written anywhere [...] but it’s clear to everybody (PASADA Employee, respondent #33).

As the above quotation suggests, although the organization does not have a formal written policy on HIV/AIDS prevention and condom promotion, the organization is expected to follow the Catholic Church’s position on condoms, which was well known within the organization. Despite not having a formal written policy, the organization’s employment contract does have a specific clause which is written broadly enough to be interpreted as including the Catholic Church’s position on condoms. According to the employment contract, for example:

PASADA functions under the auspices of the Roman Catholic Archdiocese of Dar es Salaam, therefore, the employee agrees to public respect for the teachings of the Roman Catholic Church (PASADA, 2009).

Although there are many teachings of the Roman Catholic Church which are related to HIV/AIDS prevention (e.g. compassion, respect for the poor, etc.), due to its contentious

nature, the Catholic Church's position on condoms was what was most acknowledged within the organization. Within PASADA's community HIV/AIDS prevention work, for example, this position was found to be most contentious at the stage of implementation, especially when condoms were brought up by the community. These tensions are further discussed below under 'actors'. As a result of this contention, respondents were found to mediate between conflicting factors in order to ensure that their HIV/AIDS prevention approach was not only in line with their own understanding of HIV/AIDS, but it did not overtly go against the position of the Catholic Church. The following section explores the strategies used by actors within this process.

The challenge of working within an organization that does not promote the use of condoms was expressed by some respondents, particularly those who viewed condoms as an important part of HIV/AIDS prevention work. Overall, however, there were varying responses with regards to whether respondents agreed with the Catholic Church's stance on condom promotion. Some respondents, for example, agreed with the Catholic Church, either due to their own personal beliefs or because they questioned the effectiveness of condoms. Others were found to disagree as a result of their position as a medical professional. In both cases, however, respondents saw it as their professional duty, regardless of their own personal beliefs, to give the bio-medical facts about condoms from a medical perspective. One respondent even saw the Catholic Church's stance on condoms to be in direct conflict with their own professional values and training. The following quotation exemplifies this conflict between respondents' professional position and religious understanding of HIV/AIDS prevention:

I'm a health professional, a Tanzanian trained, I was trained by the government initially, PASADA trained me also, and I might be obliged to talk about condoms, and maybe the government would like me to promote condoms. [...] I know facts about condoms, I know people use condoms, but it's not my duty to tell somebody use a condom. I see my role here is to give the correct information about the condom, the use of condom, but not tell somebody, please use a condom. It's up to her or him to decide. [...] The Catholic Church doesn't prevent me from giving the education about condoms (PASADA employee, respondent #20).

In the above example the stance of the Catholic Church conflicted with the respondent's position as a health professional trained by the government. In this instance the respondent mediated the two positions by distinguishing condoms education from promotion, which according to the respondent was permitted by the Catholic Church.

The distinction between condom education and condom promotion was often made by respondents who felt that, by doing so, a client was left to choose whether or not to use condoms, without being told directly what to do. Emphasizing individual choice was another way respondents were found to mediate between the two positions. The following two quotations exemplify both the distinction made between condom education and promotion, and the emphasis placed on individual choice:

Yes we do provide information. And we normally share with them, so it is a matter of her or them to have a choice. But we talk about the facts about condoms and then we leave it there. [...] we are not promoting but we talk about condoms (PASADA employee, respondent #21).

When we are meeting with the community, the level of the community, they ask many questions about condoms, about how to protect themselves. We are giving them all the ways of protection, but not telling them exactly what to do, because the decision to do something is from the person, so we are telling them, the way, the good way to protect yourself is maybe to use condom (PASADA employee, respondent #22).

Such a distinction can be interpreted as a way of placing the responsibility to decide whether condoms were an appropriate or effective prevention tool in the hands of the individual. By not promoting or discouraging condom use, for example, the community educator would not be held responsible if the client went against the Catholic Church by choosing to use a condom, or put themselves at risk by choosing not to use a condom. In such cases, if a client expressed that they would like to use a condom, they would be referred to organizations that distribute them.

In summary, because PASADA is a Catholic organization it does not promote condom use in its HIV/AIDS prevention work. Many respondents saw it as their professional duty to provide all HIV/AIDS prevention options to communities. A distinction was therefore made between condom promotion and education and respondents would educate about condoms where appropriate. According to respondents, they were permitted by the Catholic Church to educate about condoms but not promote them. The importance of allowing individuals within the community to decide for themselves whether or not to use condoms was particularly emphasized. This was interpreted as a way of taking responsibility away from the community educator and placing it within the hands of the individual. When individuals wanted to use condoms they were directed to an organization that supplied them. As will be discussed below, similar strategies were also used by respondents with regards to positive prevention.

5.3.2 Positive Prevention

Positive prevention is targeted at HIV positive clients, with the aim of preventing PLWHA from being infected with a different strain of HIV (re-infection) or infecting others. If a person is found to have HIV after testing, they are eligible to access PASADA's services, such as ART, HBC, PMTCT, TB/HIV, and counselling. PASADA holds "Now that you know" meetings with people that are found to be HIV positive, which are normally organized once a month. Through this meeting and counselling sessions, clients are taught about how to live positively with HIV/AIDS, how to protect themselves from re-infection, and how to prevent infecting others with the disease. Prevention of transmission is especially relevant for women who wish to have children (PMTCT) and discordant couples, where one partner is HIV positive and one is HIV negative.

The "Now that you know" meetings include a set of guidelines for counsellors running the sessions, outlining what should be covered in the session and how the session should be conducted. Topics that are covered in these meetings include: knowledge about HIV, participants' reactions about being HIV positive, prevention of new infections, diet for PLWHA, diseases associated with HIV, information about ART, importance of disclosure to partners and relatives who could be infected by HIV, and the services that PASADA offers for people affected by HIV. With regards to positive prevention specifically, as one respondent explained:

The guideline talks about positive prevention, that although they [clients] are HIV positive, they have the role and responsibility of protecting themselves from re-infection and protecting other people. And that really goes further into addressing the issues of sexuality, into addressing the issues of a person's expectations, for example, the issue of having a child, and what they should really do if they decide to have children. What they are supposed to do, to make sure that they get a child who is not infected, and in the effort of getting the child they don't infect other people (PASADA employee, respondent #15).

Similar to what the above respondent outlined, in the section on prevention of new infections among PLWHA in the "Now that you know" guidelines, counsellors are instructed to give the following information to participants (PASADA, Undated):

- Take all necessary care during sexual intercourse
- Try to protect your partner from new infections
- Protect other people by making sure they don't get infections from you
- Cure sexually transmitted diseases (STDs)
- Test the CD4 count before deciding to get pregnant

- Protect the foetus from being infected by seeking help from health workers
- Follow family planning.

The document, however, appears to purposively keep these instructions broad by, for example, not including how participants are to take “all necessary care during sexual intercourse,” or how they are “to protect [their] partners from new infections”. These topics are left up to the participants and facilitator to discuss. Similar to community HIV/AIDS prevention, although there is no written policy outlining the organization’s position on positive prevention, it is acknowledged by respondents that they are expected to adopt the Catholic Church’s official stance to HIV/AIDS prevention, advocating for abstinence and fidelity over condom use. With regards to positive prevention among discordant couples the issue of condoms was also found to be very contentious. Similar to community HIV/AIDS prevention, actors would again find ways to mediate between these conflicting factors in order to ensure that their approach to HIV/AIDS prevention was not only in line with their own understanding of HIV/AIDS, but did not overtly go against the position of the Catholic Church. The following section explores the strategies used by actors within this process.

With regards to discordant couples, there are only two options for HIV prevention – to abstain from sex or to use a condom. Respondents recognized the difficulty of such cases, particularly in relation to the Catholic Church, which until recently did not advocate the use of condoms in any situations¹². At the time of data collection, the Catholic Church in Tanzania did not condone the promotion or use of condoms. With regards to discordant couples in particular, many respondents disagreed with the Catholic Church’s position on condoms, and questioned the rigidity of the Church with regards to this issue during interviews. Some respondents, for example, questioned the Catholic Church’s fixation on condoms as a form of contraception as opposed to a mechanism of saving people’s lives, and wondered if it was appropriate in today’s context, as demonstrated by the following two quotations:

It’s an issue which is being debated all over the world within the Catholic Church, because it has nothing to do here with contraception, which is the basic stance, why the Catholic Church is basically against the use of condoms. It’s to do with saving lives, it’s to do with avoiding killing people, which is also part of the ethics of the Catholic Church. The issue is, each person has to individually, according to their own conscience, find their balance between

¹² As stated in Chapter 2, in an interview in 2010 Pope Benedict XVI stated that the use of condoms is acceptable in exceptional circumstances, such as with male prostitutes. Such news has been welcomed by many and is recognized as “a positive step forward” in the fight against HIV/AIDS (BBC NEWS, 2010). How this news translates to Catholic Church institutions worldwide is yet to be determined, which is arguably dependant on the Catholic Church structures and representatives within individual countries.

those two conflicts, but personally I would say don't kill and don't infect other people (PASADA employee, respondent #33).

When it comes to that [discordant couples], it's another issue. You see, the one who is positive has got a possibility of killing the other one who is not. So if our intention is to not kill people, that we could introduce condom somewhere, it makes sense somewhere (PASADA employee, respondent #25).

It is clear in the above two quotations that these respondents felt discordant couples were an exceptional case that should be recognized by the Catholic Church. As such cases were yet to be recognized, strategies were employed by respondents to ensure clients were adequately protected against HIV, while not overtly going against the position of the Catholic Church.

Similar to community HIV/AIDS prevention, important themes were the distinction between education and promotion of condoms, and individual choice. Through education on condoms, for example, respondents could impart their technical knowledge about condoms without influencing the client's decision. By doing so they left it up to the client to choose the most appropriate form of HIV prevention. The following quotation exemplifies not only the difficult position respondents felt they were in with regards to discordant couples, but also the distinction made between condom education and promotion and the emphasis placed on individual choice within the organization:

The issue of discordant couples is a very difficult issue, especially for Catholics. It's clear that, for example, you have in front of you a discordant couple, your main message is, ok let's try to keep the negative partner negative, and at the same time protect the person who is HIV positive. So the issue and the advice and the counselling that is given is based on this. Then of course that couple will say to you, ok what do we do? So you know your options are limited. Because either you stop having sex completely, so abstinence, or you protect yourself with the use of a condom. And that explanation is given. And then each couple, each individual has to make their own decision about what they're going to do. [...] So you know the advice might be, ok this is the technical advice I can give you and you have to see according to your own religion, your own faith, your, what you want to do, and we leave it up to the individual (PASADA employee, respondent #33).

As the above quotation suggests, respondents would use their position as a professional to provide technical advice about HIV/AIDS prevention. By leaving the choice to use condoms up to the client, however, respondents ensured they were not going against the Catholic Church. Similar to community HIV/AIDS prevention, when a client indicated that they would like to use a condom they were then directed to an appropriate institution.

At the same time, however, due to the limited options for prevention, there was evidence that respondents would attempt to influence a client's decision to ensure they were not putting themselves or others at risk of infection. As the following two respondents explained, for example:

Although I believe condoms may help you, I'll twist my question in such a way that the patient himself thinks that or says that maybe it's good that I use a condom. So I ask how are you going to use it? What things should you consider before using it, to make sure that you don't get the virus? So there is a little of, twisting the question instead of filling in for the patient, then you twist the question so that a client really chooses it, and then you probe on his knowledge about it (PASADA employee, respondent #15).

It depends on their beliefs, so I deal with them, I remind them as a Catholic, about the risk they're having on their health. So what do they prefer? To get HIV or to live safe? Putting aside their beliefs and faith. So it depends. If they say ok, we want to use condoms, I just refer to where they can get more information about condoms [...] If somebody says no I'm not going to use a condom, of course I show the risk they are having, the risk he's having. (PASADA employee, respondent #25).

As the above two quotations demonstrate, while the respondents could not directly tell clients to use a condom, they would use their position as a professional to influence the clients' decision. From this it can be interpreted that the Catholic Church's position on condoms was viewed as an obstacle to ensuring discordant couples were effectively protected from HIV infection. In both examples, the respondents found ways to mediate between two conflicting positions: their own professional understanding of HIV/AIDS prevention and the Catholic Church's position on condoms, in order to ensure their HIV/AIDS prevention approach was not only in line with their understanding of HIV/AIDS, but did not overtly go against the position of the Catholic Church.

In summary, positive prevention is a difficult and contentious issue within the Catholic Church; and as described above, some respondents openly questioned the Church's rigid stance towards condoms and discordant couples. Similar to community HIV/AIDS prevention, respondents found ways to mediate between their professional understanding of HIV/AIDS and Catholic Church regulations, such as distinguishing condom education from promotion or influencing a client's decision. Individual choice was also emphasized to ensure respondents were not held responsible for a client's decision.

5.3.3 HIV/AIDS Prevention among Vulnerable Groups

HIV/AIDS prevention among vulnerable groups is targeted at those groups who are particularly susceptible to HIV infection due to lifestyle circumstances or choices, such as commercial sex workers (CSW), men who have sex with men (MSM), and youth, with the aim of preventing HIV infection. Within PASADA this work is predominately carried out by the community education department, through their Stepping Stone's program, which "is a training package on HIV/AIDS focusing on relationships and communication skills, with the aim of reducing HIV transmission, improving sexual and reproductive health, and fostering gender empowerment" (ActionAid, 2006). Although the training was not originally designed to target "at risk" or vulnerable groups, PASADA predominately uses Stepping Stones to work with youth, CSWs, and MSM, in order to help these groups develop positive life skills, and encourage them to stop engaging in dangerous "at risk" practices. Within this category the issue of MSM was found to be most contentious, due to again, for example, conflicting religious and professional understanding of HIV/AIDS and HIV/AIDS prevention. Similar to both community HIV/AIDS prevention and positive prevention, respondents found ways to mediate between the conflicting factors in order to ensure that their HIV/AIDS prevention approach was again not only in line with their own understanding of HIV/AIDS, but did not overtly go against the position of the Catholic Church. The following section explores this process.

At the time of data collection, PASADA's work with MSM was new and PASADA had only worked with one group of about twenty men, with plans of targeting more men in the future. MSM were first recognized as a vulnerable group by an employee within the Community Education department, who approached the department's head and Executive Director for support to ask to target this group. A Stepping Stone course was then conducted with this group, and each participant was encouraged to test for HIV; out of the twenty, eleven were found to be HIV positive – a prevalence rate of over 50%. Due to this high prevalence, the importance of working with this group was recognized. At the same time, however, respondents recognized that working with MSM was a contentious issue due to the stance of the Catholic Church which condemns homosexuality, and the fact that MSM was a highly sensitive issue within the Tanzanian context, being both stigmatized and illegal. In order to continue working with this group the organization therefore needed to have the support of the Bishop. The Bishop, however, was only approached after the initial group of MSM had been tested and the prevalence rate of over 50% was found, information which was used to stress

the importance of working with this group. As the following quotation exemplifies, the Bishop's approval was important if the organization was to continue working with MSM:

[After] explanation, the rationale, the output, the methodology, how it will be conducted, [...the Bishop] agreed [to allow PASADA] to go on preparing such a project. If he said no, then we would not proceed with it (PASADA employee, respondent #34).

As the above quotation suggests, the support of the Bishop was extremely important for the organization to continue working with MSM, and PASADA would have had to stop working with the group without the Bishop's approval. The role of the Bishop within the organization is further discussed under 'actors'.

In seeking the Bishop's permission, respondents emphasized the importance of how the issue was framed. It was recognized, for example, that within the overall group of MSM there were two sub-groups – heterosexual men who have sex with men for money, and homosexual men who have sex with men for money, as exemplified by the following quotation:

Within this group of men there were two sub-groups. One is men, young men, who are male commercial sex workers purely because they have no other way of living, just as women go into commercial sex work, they do it themselves because they need to earn a living and they have no other, they don't have schooling, or they don't have access to other employment. And then the other sub-group are those who are actually homosexuals (PASADA employee, respondent #33).

Despite these two groups – heterosexual and homosexual men who have sex with men for money – the group was defined as male commercial sex workers who have sex with men; sexual practice was therefore placed above sexual orientation and homosexuality was not referenced. Regardless of the men's sexual orientation, they were viewed to be engaging in commercial sex work as a result of their environment (not their sexual orientation), and working with this group was seen as a way of empowering them to leave this behaviour. Due to MSM being highly stigmatized within the community, it was also recognized that many of these men's clients would be married with children, and would bring the infection home to their families if they were to be infected. By targeting MSM, respondents saw it as a way of reaching these men's families. The issue of MSM was therefore framed in a way that circumvented religious moral or ethical arguments to put the health of the men, their clients, and the clients' families first. It can be interpreted that as a result of the way the issue was framed, the Bishop gave his blessing for PASADA to continue working with MSM.

In addition, many respondents justified working with this group by recognizing the “reality of the situation” – it was a problem within the community that needed to be addressed, particularly as sex is a major transmitter of HIV, and MSM are a particular source of HIV infection. At the same time, it was recognized that the issue needed to be approached carefully and slowly, not only as a result of the Catholic Church’s stance on MSM, but also as a result of the beliefs of the employees of the organization, the majority of whom are Tanzanian with similar cultural views towards MSM. The need for creating a common attitude among the management team was emphasized and at the time of data collection a documentary film showcasing the lives and experiences of these men was developed to show at an upcoming management meeting to encourage management team’s support of the project even if they were personally against the practice. In the end, however, according to the Executive Director consensus from the staff or the management team was not needed, as the Executive Director had the final decision regarding whether PASADA would continue working with MSM (with the Bishop’s blessing), and there were enough staff already involved with the project to carry it forward. The organization’s work with MSM is therefore evidence of role of the Executive Director and Bishop within the decision-making process, which will be discussed below. For example, because MSM was seen as a religious issue, the Bishop’s approval was necessary for the organization to work with this group, and therefore he had the final decision. After the Bishop’s consent was given, however, consensus from the management team, although desired, was not necessary, as the Executive Director held decision-making power.

In summary, within the organization, working with MSM was recognized as a difficult issue, one which had to be approached carefully both within the Tanzanian and Catholic Church contexts. Many respondents justified working with the group by recognizing the “reality of the situation” and seeing this group as a vulnerable group that needed the organization’s help. It was not until after the organization had begun working with MSM and the extent of the problem of HIV within this group was recognized and documented, that the Bishop and management team were approached for support. In order to ensure the support of both groups, the way the issue was framed was very important. The support of the Bishop was particularly important; if he did not agree with the programme it would have been terminated. At the same time, if individual members of the management team or staff did not support the programme it still would have continued due to the support of the Executive Director.

HIV/AIDS deals with contentious and sensitive issues, particularly around sexuality. Many prevention issues pertinent to HIV/AIDS, like the promotion of condom use and the prevention of HIV among high risk and vulnerable groups like MSM, are issues that often clash with Catholic Church beliefs and can put Catholic service delivery organizations, like PASADA, in a difficult position. With regards to PASADA, this was particularly the case as it was staffed by professionals whose own understanding of HIV/AIDS and HIV/AIDS prevention clashed with the position of the Catholic Church. It is evident from the above discussion that, when factors were found to conflict, respondents found ways to mediate between them in order to ensure their HIV/AIDS prevention approach was not only in line with their understanding of HIV/AIDS, but did not overtly go against the position of the Catholic Church. Such strategies included, for example, distinguishing between condom education and promotion, emphasizing individual choice, and framing issues in a way that circumvented religious moral or ethical arguments. Such strategies, however, can lead to a discrepancy between organizational policy and practice, where practice on the ground does not always coincide with organizational policy, as will be discussed below. The remainder of the chapter explores the different factors which influence the HIV/AIDS prevention policy process within the organization. It presents the findings according to the conceptual framework, in relation to process, context, and actors, and how these relate to form content in terms of policy and practice; the role of faith is discussed where applicable.

5.4 Structures and Processes of Policymaking

This section discusses the process of policymaking within the organization. It explores the structures that facilitate, shape, and confine the overall policy process. The structures that are discussed here have been derived from the data, and appear to be formal in that they are habitual and well established within the organization. These structures are important as they influence who has decision-making power within the organization, what type of power they have, and where they can use that power. Overall, these structures were found to be based on a hierarchical system and, as will be discussed below, were both participative and authoritarian.

As mentioned above, PASADA is divided into departments, each of which has its own specific objectives and activities. There is a head of each department, who sits on the management team with the Executive Director. The management team meets regularly about once a month. Each individual department also holds regular departmental meetings, and

information is disseminated between the departments and the management team through the heads of departments. Policymaking within PASADA therefore takes place at two levels – the organizational level and the departmental level. Policymaking at the organizational level concerns organizational decision-making which affects the overall management of PASADA and mainly involves the Executive Director and the heads of departments. The Bishop and Advisory Board also play a role at this level – each is consulted when needed. Within this process the Advisory Board plays a consultative role, while the Bishop holds a degree of decision-making power, particularly over religious issues within the organization where he holds final decision-making power. The role of each is discussed below under ‘actors’. Policymaking at the departmental level concerns daily management decisions which affect individual and departmental roles, responsibilities, and activities and mainly involves the heads of each department along with department staff. The Bishop and Advisory Board hold less power over the process at this level, due to the technical expertise of the staff.

The types of policy decisions that occur at each level differ – for a definition of what policy includes see Chapter 2. Policy decisions at the organizational level include: organizational vision and mission, organizational goals and objectives, organizational strategies, organizational regulations and guidelines, and organizational directives. Policy decisions at the departmental level include: departmental vision, departmental goals and objectives, departmental programme strategies, departmental targets and implementation plans, and departmental guidelines and activities. As mentioned above, PASADA’s autonomy over the policy process varies depending on the type of policy and level of policymaking. As one respondent explained:

In general management and doing things day to day they (staff) are very much autonomous, but when it comes to policy areas, I think they are not. They are bound by the diocesan policy and the TEC (Tanzania Episcopal Conference) policy, and if they were not to abide by that, then there would be questions. But otherwise they do things on their own as such (Catholic Church representative, respondent #1).

Within the overall policy process, staff within PASADA have more autonomy with regards to departmental level policy decisions compared to organizational policy decisions, such as those stated above. When discussing the possibility of implementing changes at the departmental level, for example, one respondent explained:

As long as those changes can't affect the mission of the organization, I think it's not very difficult [to implement]. But you have to share it with the head of the department, then we discuss and decide what to do, and when we get a decision, we have to go to the director of PASADA. [...] So for some decisions it's not difficult. But maybe with the changes which will affect the organization and the church maybe it is difficult. But for those minor things which we can change in the department, which our beneficiaries will benefit [from], it's not difficult (PASADA employee, respondent #22).

As the above quotation demonstrates, at the departmental level the policy process is predominately participatory and collaborative. At the departmental level, for example, staff sit together to plan their activities, consulting with their head of department, as exemplified by the following quotation:

The initial planning for objectives, activities and budget comes from the departmental level. So every department sits together with the head of that department, plans together, sees the difficulties from the previous year, and what they think should be included for this year. So they do it together and submit it to the Executive Director (PASADA employee, respondent #21).

Departmental decisions are therefore made by staff within each department, and are sent to the Executive Director for review only after decisions are made.

While the policy process is predominately collaborative at the departmental level, the heads of department and management team maintain a level of authority and decision-making power over the policymaking process, as demonstrated by the following two quotations:

The staff defer to their managers, the senior management team have a certain amount of authority, and they certainly discuss everything regularly, and with the Executive Director who would potentially have the final say, but in a consultative process (PASADA employee, respondent #26).

Each department head is quite autonomous, because they are professionals. [...] Each department head has their own, has quite a lot of autonomy to decide what happens in the department (PASADA employee, respondent #33).

As the above quotations suggest, the structures that shape and facilitate the policy process at the departmental level are both participatory and authoritarian – participatory in that staff are consulted throughout the process, and authoritarian in that heads of department and Executive Director hold final decision-making power.

Policy structures at the organizational level are less collaborative than at the departmental level, and do not directly involve the individual staff members. At this level the policy decisions remain with the Executive Director and management team, as explained by the following respondent:

On many issues any policies that come out are the product of discussions at senior management level. There may be a few that are not really subject to discussion [...] because there might be policies that don't need management discussion. But the majority are a product of senior management discussion. And it's clear that the senior management, especially the heads of departments, we bring to the management meetings the feedback, the questions, the queries, that we have got from our own staff within the department. So in a way we represent our own staff at those meetings. But at the same time, we are senior management and therefore decisions may even be taken which even go against what our staff may want or think, but that's because the senior management thinks it's better that way (PASADA employee, respondent #33).

Authority for policy decisions at the organizational level therefore mainly lie with the heads of departments and Executive Director, and while the process tries to be as participatory as possible, senior management and/or the Executive Director may make decisions which go against what the majority of staff within the organization want.

At the same time, however, at the organizational level there are some decisions or policies that are directed from outside the organization, such as from the Catholic Church, donors, and the government. Policies from the Catholic Church are mediated through the Bishop and Advisory Board and include decisions relating to religious matters, such as, for example, the organization's position on condoms. Policies from donors, as will be discussed below, relate to how money is spent and monitored, while government policies include those within the national policy response discussed in Chapter 4. The implementation of these policies is carried out by PASADA staff who implement services and provide HIV/AIDS prevention and mitigation messages to the community, and volunteers who help staff within the community and at PASADA sites.

In summary, processes of policymaking are important as they influence who has decision-making power within the organization, what type of power they have, and where they can use that power. The policymaking process within PASADA takes place at two levels – the organizational and departmental level. The autonomy that the staff has over this process depends on the level of policymaking, the individual's role within the organization, and

whether the issue is related to a technical or religious matter. Overall, policymaking within the organization is both participatory and authoritarian. It is participatory in that staff contribute to the plans and activities of their departments, particularly in relation to technical matters. It is authoritarian in that the management team and heads of departments hold a level of authority over the technical policy decisions at both the organizational and department level, with the Executive Director holding the main responsibility and authority of the policymaking process within the organization. The Bishop and Advisory Board also hold a degree of authority over policy decisions at the organizational level. While the Advisory Board primarily plays a consultative role, the Bishop had decision-making power within the organization, particularly over religious matters. Other top-down policies within the organization come from donors and the government. In addition to the structures discussed above, there are multiple factors that influence the overall policy process within the organization. The following section discusses the main factors that influence the overall policy process, in relation to context and actors.

5.5 Contextual Factors influencing Policy Process

Context-related factors refer to systemic factors (both internal and external to the organization) which may affect the policy process. Policy processes take place within a complex local, national, and international context and there are many often inter-relating contextual factors, unique in both time and setting, which can affect the policy process. The contextual factors below are those factors which were identified throughout the data collection and analysis process as being most influential in the HIV/AIDS prevention policy process of the organization. They are by no means exhaustive and are presented in order to provide a picture of the key contextual factors which most affect the policy process. The factors identified include: the Catholic Church context, the government context, the donor context, and the community and cultural context. Although government and donors can also be considered actors, they are included within context as no immediate government or donor actors were found to directly influence the policy process, only aspects of each, such as policies or guidelines. The contextual factors relate to the Tanzanian context that was discussed in Chapter 4, as well as the international context that was discussed in Chapter 2.

5.5.1 Catholic Church Context

As stated above, PASADA is a Roman Catholic faith-based organization, operating under the Roman Catholic Archdiocese of Dar es Salaam, Tanzania. The Roman Catholic Church has 31

dioceses within Tanzania and is represented by the Tanzania Episcopal Conference (TEC), which, as stated in Chapter 4, is the official national organization of the Catholic hierarchy in Tanzania. PASADA's relationship with the Catholic Church is mediated by TEC through the Diocesan Health Board, the PASADA Advisory Board, and a prominent Catholic Bishop. Although the Catholic Church was viewed as a very strong and influential organ, there were diverse opinions about the exact nature of PASADA's relationship with the Catholic Church in Tanzania. Most respondents saw PASADA as operating under the umbrella of the Catholic Church, however, just what it meant to be under the umbrella of the Catholic Church was less clear. Respondents, for example, saw PASADA as belonging to the Catholic Church, or as an instrument or expression of the church:

It is a church institution, the church owns PASADA. So it is the church which I can say is the owner of the organization (PASADA employee, respondent #27).

PASADA is like an arm, an instrument of Catholics for giving services to the needy. Because the church, the Catholic Church in Dar es Salaam watches closely what is happening in PASADA (PASADA employee, respondent #20).

According to respondents, as a result of 'belonging to' or being 'an arm of' the Church, the organization had to operate under the regulations and ethics of the Church. As a result, PASADA is expected to follow TEC's HIV/AIDS Policy, which according to the policy "supersedes all other HIV/AIDS secular policies in matters of ethics and morality" (TEC, 2004). With regards to HIV prevention, when asked what regulations, ethics, and teachings of the Roman Catholic Church employees were expected to operate under, the answer was always in relation to the promotion of condoms. A Catholic Church representative, for example, when asked what "in matters of ethics and morality" refers to in the TEC HIV/AIDS policy, explained:

That goes to condoms, actually it's mostly that. That means no institution can go and decide now we will make a program. There was one started about the three boats¹³, no, no, no, we have two boats, the third one is a sinking one (Catholic Church representative, respondent #46).

As a result of its restriction on condom promotion, respondents saw the Catholic Church as having direct influence over the services that the organization could provide. According to respondents, this influence translated into the power to shut down PASADA if it was found to

¹³ The three boats refers to a metaphor used in HIV/AIDS prevention – each boat corresponds to a letter in the ABC approach, Abstain, Be faithful, and use a Condom. People must choose which boat to get on board if they want to protect themselves from HIV/AIDS infection.

go against the Catholic Church's position on condoms, as exemplified by the following quotation:

If we want to survive we really need to stick to what the Church wants us to really talk about, especially.... It's only condoms where we have controversies. [...] The repercussions if we don't follow? I'm saying yes there could be a heavy blow on us. For example, if we include the issue of condoms that we encourage it, PASADA can be closed the next day, the following day. [...] PASADA being one of its agencies, one of its institutions has again to follow the Church's instructions on the issue of, only on this issue of condoms where the Church doesn't actually encourage condoms (PASADA employee, respondent # 15).

This view was further endorsed by representatives of the Catholic Church, as the following respondent explained when asked if there would be any repercussions if PASADA went against Catholic Church regulations:

Ya, the repercussions are that we have to bring it back to line, at any cost. [...] Because if you lose the goal, you can't just be happy winning the battles, if you lose the war. Important is the war. You get the war you win a few battles, but if you concentrate on just a few battles and divert from the war, I mean you, we have no reason to have PASADA; you better leave all the others to do their job (Catholic Church representative, respondent #46).

As demonstrated by the above quotations, according to the Church representative the purpose of PASADA was to respond to HIV/AIDS according to Catholic Church principles, and if it was found to go against these it would be brought back in line 'at any cost'. The Catholic Church, therefore, can be interpreted as having direct power over PASADA. This power was found to particularly be connected to matters relating to religious ethics and morality, which in the case of the above examples refers to the role of condoms within HIV/AIDS prevention.

In addition to the issue of condoms, the Church was viewed as having direct influence within PASADA due to its control over appointing the Executive Director and the members of the Advisory Board. The appointment of the Executive Director was seen as particularly important, as the Executive Director's vision for the organization can affect the organization's mission and the strategies used to achieve it. The appointment of an Executive Director who did not hold a religious title, such as a bishop, priest, or nun, was viewed as influential in bringing the organization to where it is today – in terms of, for example, its emphasis on professionalism, its donor base, and its achievements, which were viewed a result of the Executive Director's competence and vision for the organization. The appointment of a professional Executive Director within the organization, as opposed to a religious leader,

however, was credited to the religious leaders who had initially run PASADA, who saw it as out of their expertise to effectively respond to the needs of PLWHA; and the Bishop was seen to support this position. Respondents suggested that the Bishop, and therefore Catholic Church, within Tanzania was unique in this respect, referring to the history of the Catholic Church appointing people of faith to positions which required technical expertise, affecting the quality of many Catholic organizations. At the same time, despite the Executive Director being hired as a result of their professional expertise, they are still expected to comply with Church directives. The role of leadership within the organization was therefore an important factor within the overall policy process, as it could influence the direction the organization took.

As stated above under 'process', the power of the Catholic Church, through the Bishop, was seen to be in relation to organizational policies, as opposed to departmental policies. At this level, it was believed that the Bishop permitted PASADA a level of autonomy due to the skill and knowledge, or the technical expertise, of its employees. While some viewed this as a choice of the Bishop, to let PASADA continue with its work due to the competence of its employees, others saw the Bishop as having little influence due to the fact that the Catholic Church did not provide any financial resources to the organization. This theme of influence being directly related to provision of financial resources will be discussed below in relation to donors. For some respondents the relationship between PASADA and the Catholic Church (through the Bishop) was therefore seen as more of a partnership than an ownership as it did not involve financial resources.

In summary, the Catholic Church's relationship with PASADA is a complex one and there are different views regarding its influence within the organization. As PASADA is under the umbrella of the Catholic Church it must abide by Church regulations and ethics. The Catholic Church can therefore be seen as having direct power over PASADA at the organizational level, particularly in relation to religious matters, including but not limited to the role of condoms in HIV/AIDS prevention. The Catholic Church, through the Bishop, was also seen to have influence over the appointment of the Executive Director who was hired for their professional expertise, which affected the organization's objectives. At the departmental level, PASADA was seen to have more autonomy over the policy process, particularly in relation to technical matters. At the same time, some respondents saw the Catholic Church as having little influence within PASADA as it did not provide any financial resources.

5.5.2 Government Context

PASADA began providing HIV/AIDS services before the government's national HIV/AIDS response began. However, because it is a registered health facility under the MOHSW, it is expected by government to work within national HIV/AIDS guidelines. The government's national HIV/AIDS response, and the role of civil society within this response, was discussed in the previous chapter. Included within this response are various national HIV/AIDS policy documents, such as the National Multi-Sectoral Framework (NMSF). Although PASADA is expected to operate within this framework, within the NMSF the government does recognize that not all faith-based organizations will support all recommended strategies due to religious convictions and regulations. As stated above, in such cases organizations are allowed to select their own preferences but are asked to "refrain from contradicting other elements of the NMSF" (URT-PMO, 2007). This is particularly relevant with regards to the NMSF's inclusion of the promotion and distribution of condoms as one of its main prevention strategies, which the Catholic Church does not support. As discussed above, the Catholic Church's insistence that condoms cannot help control HIV, and suggestion that condoms increase the rate of HIV infection through promoting immoral behaviour, contradicts with government policy. However, this view did not appear to be shared or promoted by all respondents, and many respondents agreed with the government's position on condoms.

PASADA recognizes that it must work within the national HIV/AIDS response and the main policies used within PASADA are from the MOHSW. Because PASADA is a registered health facility under the MOHSW respondents reported sending regular reports to local government offices. In addition, PASADA obtains its ARTs through the government. Many respondents within the organization recognized the importance of following government policies as this ensured they were adhering to a set of standards and were part of a uniform national response to HIV/AIDS, a view that was shared by Catholic Church representatives. As explained by the Catholic Church representative, although the Catholic Church in Tanzania has its own HIV/AIDS policy, the Church and its representative organizations:

Use more the national one (HIV/AIDS policy). Because when there is the national one there is no reason to go too much on the diocesan one, so we took the national one, and the diocesan one kind of started as that. If the national is doing the same thing why invent the wheel so we are using that one (Catholic Church representative, respondent #46).

As demonstrated by the above quotation, the national HIV/AIDS policy was used in the development of the Catholic Church HIV/AIDS policy. As stated above, however, not all recommendations within the national policy are supported by the Catholic Church and therefore were seen to need to be changed. According to one respondent, for example:

You know our government is not faith-based. So sometimes they stand as a government, they create policy as a government. So it is up to implementers to check whether all the materials are really satisfied for their organization. If not, you can eliminate part of it (PASADA employee, respondent #25).

With regards to HIV/AIDS prevention, the national policy recommendation that was not supported and was subsequently eliminated from Church policy was in relation to condom promotion. According to respondents, they are exempted by government from promoting condoms, which is the only issue as all other recommendations or messages used by the organization were similar to those used by the government.

Overall respondents perceived PASADA to have a good relationship with government. According to respondents, for example, PASADA is invited to attend relevant meetings or workshops held by the government, and the government recognizes PASADA as a centre of excellence through which it sends visitors to showcase the HIV/AIDS work that is going on in the country, as exemplified by the following quotation:

PASADA is recognized by the Ministry of Health, by the National AIDS Control Programme, by TACAIDS, as a centre of excellence [...] with regards to HIV/AIDS services. [...] The government itself, when they have visitors from abroad, or in Tanzania itself, very often come to PASADA. Let's go and see what they're doing, as a good example of what you can do (PASADA employee, respondent #33).

As demonstrated by the above quotation, PASADA was perceived to be used by the government as an example of good practice within the country. Some respondents regarded this relationship to be the result of the government's inability or inadequacy to effectively respond to the HIV/AIDS epidemic, forcing it to turn to organizations like PASADA to supplement its HIV/AIDS services. One respondent even accused the government of using PASADA's achievements as their own. Others felt that PASADA's relationship with the government was limited to accessing ART supplies, and as the government did not provide any financial resources their influence was and should be minimal.

In summary, because PASADA is a registered health facility under the MOHSW it is expected to work within the national HIV/AIDS response and report to the government regarding its work. Many respondents saw the organization's relationship with the government as beneficial as it ensured PASADA was working within a recognized set of standards within a uniform national HIV/AIDS response – mainly through the provision of national HIV/AIDS policies and guidelines. At the same time, it was recognized that PASADA as a FBO would not be able to support all recommendations made within government policy, which were excluded from TEC's HIV/AIDS policy. Overall PASADA's relationship with the government was viewed as good, and respondents perceived that the government used PASADA as an example of good practice within the country.

5.5.3 Donor Context

PASADA is fully donor dependent; all of its services, programmes, equipment, salaries, and infrastructure are funded by donors. PASADA has approximately eleven international donors, although this number fluctuates. The United States Agency for International Development (USAID) is their primary financial supporter, providing around 70-80% of all funds. Each donor funds a particular activity or programme and its related expenses, and PASADA applies directly to donors. Each donor has specific key performance indicators, targets, or requirements related to the specific activity it funds, which PASADA has to meet in order to secure future funding, and each donor has its own reporting structures and timeframes.

According to respondents, donors are very influential within the organization, as they are seen to have the power to decide which activities PASADA should undertake, the level of spending that will be attached to each activity, and whether spending should be cut. On the whole the organization's relationship with donors was viewed as positive, due to the organization meeting its targets and reporting deadlines. Donors, however, are required to accept Catholic Church regulations, as exemplified by the following respondent:

Even if the donor wants something that the Roman Catholic is not accepting, we won't accept that donor, because we are operating under the policy of the Roman Catholic Church (PASADA employee, respondent #35).

This was not viewed as a problem, however, as donors were seen to be willing to work with the organization, despite it being under the Catholic Church. One respondent explained that

this was the result of donors' pragmatic approach to HIV/AIDS, compared to, for example, the Catholic Church:

Most of the donors are more practical than the church is, so the Elton John Foundation donates funds, plenty of funds in the past to PASADA, knowing that it is a Catholic organization, and Catholics are against everything Elton John as a person stands for, so they are more pragmatic on the ground, a pragmatic approach. Not everyone has to do everything, and if a clinic works as well as this one does, if they don't entirely agree 100% of their founding ethos, it's less important than the people served, the lives saved (PASADA employee, respondent #26).

Due to the organization's technical capacity, it was therefore able to attract international donors and its faith identity was not seen as an obstacle. As most of the organization's activities were not directly influenced by Catholic Church regulations, such as their position on condoms, despite the organization's overall ethos it is likely that donors would not view the majority of the organization's activities as contentious.

Many challenges were seen to be attached to being fully donor dependent. One major challenge was the number of donors the organization had, which was seen as placing added stress on the administrative staff due to donors' different reporting structures and timelines. According to respondents, the organization had to employ more people in order to meet this demand, which required additional resources, as exemplified by the following respondent:

Each donor has their own requirements for reporting, and accountability, so you might find the finance department is juggling with five or six different donors, and therefore five or six different formats for reporting, different reporting periods, it's costly also in terms of time and human resources and money (PASADA employee, respondent #33).

Another major challenge was the lack of sustainability this meant for the organization as a whole, as well as its specific programmes and activities. Many respondents worried that if donors decided or were forced to withdraw funding it would have a devastating impact on the organization and the people it serves, and without donors the organization and its services would cease to exist. This fact was particularly exemplified when PASADA stopped receiving money from a specific donor as a result of the economic recession, forcing their grandmothers' programme to be terminated. This programme provided necessary resources and medical assistance to grandmothers taking care of orphans and vulnerable children, which was

identified as a particular need within the community. At the time of data collection PASADA had yet to find another donor willing to fund this programme.

This lack of sustainability is also exemplified in the fact that PASADA is only able to provide short-term one year contracts to employees, which makes it difficult for the organization to retain employees, as exemplified by the following quotation:

We have short contracts, our employment contracts are always on a one year basis. So sometimes people get discouraged by this short term contract, and this is because we don't have assurance of being here in three years to come. Though, theoretically we can say yes, we have been here for seventeen years and maybe we will be here for another 15 years, but we are not so sure. When, if [a] donor today they decided to go away and leave us alone, I don't know how we are going to survive (PASADA employee, respondent #27).

It is therefore possible that these short-term contracts contributed to the higher turnover of staff within the organization, affecting its ability to implement its services. As a result of this lack of sustainability, at the time of data collection PASADA had begun to search for alternative independent sources of funding and had recently hired a person to take this forward.

With regards to policy and decision-making, a major challenge was the conditions attached to funds, which were seen to determine the direction that the organization's activities and programmes could take. There was a feeling among some respondents that HIV/AIDS prevention in particular received little to no funding as donors were more likely to fund care and treatment related activities. The fact that the Community Education department was the only department that did not have a direct donor funding its activities, and instead had to obtain funding from the other departments, is potentially evidence of this. This may also be the result of the Community Education department's focus on HIV prevention and the organization's position on condoms, which may have made it more difficult to obtain funding from international donors. Because funding is attached to a specific activity, for a specific period of time, some respondents felt that this forced them to do what the donors wanted instead of what was actually needed. If an additional activity required resources, approval would have to be first sought from the donor.

In summary, as PASADA is fully donor dependent, donors were seen to have a major influence within the organization. Respondents recognized that without donor funding the organization and its services would cease to exist. This funding, however, is often attached to specific

requirements or tangible performance indicators that the organization has to meet in order to secure future funding, and the organization is confined to doing activities approved by donors. At the same time, however, donors have to accept the stance of the Catholic Church if they are going to work with PASADA. PASADA is very successful at acquiring donor funding, which is partly due to the technical capacity of the staff. Respondents felt, however, that being fully donor dependent put the organization in a vulnerable position. If donors decide to shift funding to another organization or from HIV/AIDS to another cause, or if they are forced to withdraw funding due to lack of finances, it could have major consequences for the organization and the people it serves, as was exemplified with the grandmothers' programme.

5.5.4 Community & Cultural Context

PASADA's HIV/AIDS response is influenced by the community and cultural context in which it works. The evolution of PASADA's HIV/AIDS services, for example, developed as a response to the needs identified within the community and by the organization's clients. The evolution of PASADA's services is described above in the overview of the organization. The grandmothers' programme provides a good example of how the surrounding environment and needs of the community influence PASADA's HIV/AIDS response, as the following respondent explains:

We had a programme that was supporting grandmothers. I think what influenced PASADA to take on board the grandmothers, though other organizations are doing it, it's because PASADA realized that the grandmothers were in trouble and they needed help. [...] The environment is the one which really dictates whether, what PASADA takes on board (PASADA employee, respondent #28).

The grandmothers' programme was therefore created as a result of needs recognized within the community. As described above, the grandmothers' programme is also a good example of how donor interests and the economic climate can influence PASADA's HIV/AIDS response, as the programme was terminated when its donor pulled out and no other donor was found to take its place.

The surrounding environment and needs of the community appears to strongly influence the organization's activities, which includes its HIV/AIDS prevention activities. When developing community HIV/AIDS prevention messages for example, the Community Education department first identifies what it sees as local drivers and causes of the epidemic and shapes its messages accordingly. According to respondents, local drivers of the epidemic often

include specific cultural beliefs and practices that facilitate risky or unhealthy behaviour. The Community Education department then works with the community to help them to identify these beliefs and practices. As the following respondent explained:

Before going to the community, we normally do a, something like research, simple research, to see what is going on there in that particular community, what strengths, weaknesses which doesn't facilitate for healthy behaviour. So we have to see exactly what the problem is in that community and then we will set down and prepare messages (PASADA employee, respondent #21).

As demonstrated by the above quotation, community needs are an important determinant when developing HIV prevention messages, which are then targeted to specific communities.

Within HIV prevention, particular cultural practices were identified throughout the interviews as driving the epidemic in the community, and therefore needed to be addressed. These included: the use of traditional healers or witch doctors to cure HIV/AIDS; widow inheritance, where a woman is 'inherited' by a male member of her late husband's family; polygamy, specifically not testing for HIV before entering into a polygamous relationship; traditional night dances, which are seen to encourage risky sexual behaviour among youth; circumcision, where one knife is used to circumcise multiple boys or girls; and witchcraft, the beliefs of which were seen to hamper HIV/AIDS education. Another important cultural issue that was identified was gender inequality, particularly the status of women within Tanzania. It was believed that women were more infected than men by HIV/AIDS, as 75% of PASADA's clients at the time were female; however, this might be due to women being tested more frequently than men. Although the situation was said to be changing, respondents recognized the difficulty in encouraging men to test for HIV/AIDS, as well as encouraging them to participate in PMTCT. Respondents also highlighted women's lack of empowerment, their inability to negotiate for safer sex, and sexual abuse and violence as important issues fuelling the HIV/AIDS epidemic. Poverty was seen to be closely related to gender issues, particularly in relation to PASADA's clients, as it was seen to create increased dependency of women on men. In addition, poverty was seen to be an exacerbating factor in forcing both women and men into commercial sex work.

It was as a result of the surrounding environment, and through the identification of community needs, that PASADA decided to focus on MSM as a vulnerable group, as exemplified by the following respondent:

We have started to think to reach these people (MSM) because it's a problem in our community, it's a problem, really. So slowly we have now started to make intervention for, to meet these men who have sex with men. [...] We understand in the community there is a problem, a big problem for men sexing with men (PASADA employee, respondent #21).

As discussed above, MSM is a very sensitive issue, both within the Catholic Church and Tanzanian context. Despite this, however, it was recognized by respondents as an important need within the community that needed to be addressed. In this instance community needs took precedence over Catholic Church policy.

In summary, contextual factors played an important role in the HIV/AIDS policy process within PASADA. The contextual issues discussed above are not exhaustive and only provide a part of the picture of the overall context in which the organization works; they were however, identified to be prominent within the overall HIV/AIDS prevention policy process. PASADA's HIV/AIDS prevention policy process takes place within a complex matrix of often interconnected and sometimes conflicting factors through which the organization and its members must navigate. Because PASADA is situated under the umbrella of the Roman Catholic Church it must ensure its HIV/AIDS response abides by Church regulations. At the same time, however, PASADA is also a registered health facility under the MOHSW and must therefore ensure its HIV/AIDS response is situated within national HIV/AIDS response efforts. In addition, PASADA must ensure it meets donor targets and guidelines while addressing the issues and responding to the needs of the community in which it works. Each contextual factor assumes a different level of influence within the policy process depending on the issue, as exemplified by the organization's approach to MSM in which community needs took precedence over Catholic Church policy. In addition to context, actors also play an important role within the policy process. The following section explores the role of actors and actor-related factors in the organization's HIV/AIDS prevention policy process.

5.6 Actor Factors Influencing Policy Process

For the purposes of this study, actors were conceptualized to be those who have direct influence within the HIV/AIDS policy process at the organizational level, both internal and external to the organization. Because this study is exploring the HIV/AIDS policy process at the organizational level (i.e. not the national level), only those actors directly involved at this level were included. It is recognized that other actors have an effect on the policy process, such as the government and donors. However, as specific government or donor actors were not found

to be directly involved within the policy process, the influence of government and donors was included within the discussion of the context. This section explores the influence of different actors and actor-related factors on the HIV/AIDS prevention policy process within the organization. Only those factors that were found to have significant influence are included.

As this study is exploring the policy process at the organizational level, actors within the organization were the main point of enquiry as they are the ones that must navigate through the different factors influencing the organization's HIV/AIDS prevention policy process. A separation between external and internal actors is therefore made as external actors are viewed as an influencing factor on internal actors' decision-making processes. As a result, the actor-related factors discussed here only refer to internal actors. In the case of the Catholic organization internal actors include the organization's employees. The external actors found to have direct influence on the policy process were the Bishop and Advisory Board. The actor-related factors (the characteristics of actors) that were found to influence the policy process have been grouped into one overall theme – actors' understanding of HIV/AIDS.

5.6.1 External Actors – Bishop and Advisory Board

External actors are actors who are not located within the organization, but have direct involvement or influence in the policy process. The main external actors with direct involvement in the policy process at PASADA were the Bishop and the Advisory Board, a board of representatives appointed by the Bishop and PASADA's Executive Director to advise PASADA on policy and technical issues. The influence of the Catholic Church within PASADA is mediated through the Bishop and the Advisory Board, of which the head of the TEC health department is a member. Respondents, for example, identified the Bishop as the 'owner', 'overseer', or 'watchdog' of the Church and of PASADA, whereas the Bishop identified the Catholic Church as the 'owner' of PASADA, and himself as the 'overseer'. The Executive Director is accountable to the Bishop, and they appeared to have a close relationship where the Executive Director consulted with the Bishop on a regular basis. Issues taken to the Bishop in the past have included: problems with senior staff, potential donors, and support for programmes and services, such as targeting MSM.

Many respondents felt that the Bishop was very influential within PASADA, however, that influence appeared to be limited mainly to religious issues at the organizational level as opposed to PASADA's everyday HIV/AIDS work at the departmental level. As one respondent

explained when asked whether the Bishop has any decision-making power within the organization:

Not really, not really because the Bishop, for example, he is not an expert in HIV/AIDS, so he waits for our guidance. Yes, that's what we see, because that's not his area. [...] With regards to prevention messages, unless we make a mistake somewhere where he comes in, "what are you doing?" But given, because we know what we are suppose to give, so they have not actually come and said that what you are doing in not good (PASADA employee, respondent #15).

The latter part of the above quote, referring to the Bishop coming in when a mistake has been made, is in relation to a specific example when a woman whose husband was HIV positive came to PASADA and was told by a counsellor to use a condom, which was against Catholic Church regulations. As the above participant explained:

This lady went straight to the Bishop. That PASADA has changed, PASADA has changed. I thought that it is following Catholic instructions. So he said "what". This woman was crying, my husband is positive, I'm negative, I don't want to get into sexual relations with him anymore. But then again the counsellor in PASADA told her that you can use a condom. Oh, the Bishop was very, very furious. And he called the Executive Director, what's happening at PASADA, what are you doing, what information are you giving? So we had to again to reorient our counsellors so that to know their role in the issue of condoms (PASADA employee, respondent #15).

As the above quotation suggests, part of the Bishop's role is to ensure the organization is working according to Catholic Church regulations. In the example above the organization was made to "reorient" its staff to ensure they followed Church regulations in relation to condoms. The Bishop's main authority within the organization was found to be over religious issues. This authority was also exemplified by the Bishop's involvement with the MSM programme discussed in section 5.3.3. If the organization did not have the Bishop's support, for example, they would have been unable to continue working with this group.

The Advisory Board was only recently established, and at the time of data collection was about three years old. It was started by the Bishop who realized that as PASADA continued to grow it would need more than just one person to keep track of its activities. The Advisory Board is selected by the Bishop, with the help of the Executive Director, and includes people working professionally in the area of HIV/AIDS in Tanzania, such as doctors, the head of the TEC national health department, members of the MOHSW, the National AIDS Control Program

(NACP), as well as a legal advisors and a priest. Although the members of the Advisory Board are not employed by the Church, according to a representative from the Catholic Church, they are chosen for their service, spirit, or 'heart', and their professionalism. According to respondents, the Advisory Board does not hold decision-making power within PASADA, but advises the Executive Director if there are any issues or problems, and ensures PASADA keeps with the organization's original vision and plan, in addition to diocesan and TEC policy.

According to respondents, on most issues it is PASADA's decision whether to take the advice of the Advisory Board, however, if the Board's members felt strongly about an issue it would be taken to the Bishop. In the words of a Catholic Church representative, "it has a stick over the Director", who as a result, knows someone besides the Bishop is paying attention. At the time of data collection the Advisory Board had not advised PASADA on any religious, moral, or ethical issues, but instead on service provision, government support, technical advice, fundraising advice, and site expansion. A Catholic Church representative who also sits on the Advisory Board explained that PASADA would only be advised on religious, moral, or ethical issues if they became technical policy issues (for example, if an issue became rampant within the organization, like the distribution of condoms or the promotion of abortion). The same respondent also felt that it was appropriate for religious, moral, and ethical issues to be dealt with on an individual basis, and science used before religion when a person's life was at risk, which exemplified a more flexible approach towards HIV/AIDS than the Catholic Church.

5.6.2 Actor Related Factors - Actors' Understanding of HIV/AIDS

While all factors described above have been external to actors within the organization, there were also internal actor-related factors (characteristics of actors) that were found to influence actors' decision-making processes. This section explores the actor-related factors which were found to have the most influence on the HIV/AIDS prevention policy process within the organization. Such factors can be grouped into the theme – actors' understanding of HIV/AIDS, and include actors' professional and religious understanding of HIV/AIDS. As stated above, within the Catholic organization actors' professional understanding of HIV/AIDS were found to conflict with Catholic Church policy on the role of condoms in HIV/AIDS prevention. In the Anglican and Muslim organizations the same contention was not found. As a result of this tension, respondents found ways to mediate between the conflicting factors which were discussed above in section 5.3 – HIV/AIDS Prevention Approach. Actors, for example, would distinguish between condom education and promotion and emphasize individual choice. With

regards to HIV prevention, on the whole actors' understanding of HIV/AIDS and HIV/AIDS prevention were found to influence their opinions about and/or actions in response to community HIV/AIDS prevention, positive prevention, and prevention of HIV/AIDS among vulnerable groups.

As stated above, actors' understanding of HIV/AIDS, and therefore HIV/AIDS prevention, were found to be influenced by a number of factors, namely their profession and associated professional understanding about HIV/AIDS and/or their personal religious beliefs. Respondents, for example, repeatedly emphasized the importance of their profession throughout the policy process, as exemplified by the following two quotations:

You have people who are professional, have more professional people, and people who come because of the skills and education that they have (PASADA employee, respondent #15).

The everyday decision of someone in the lab [is up to them], I mean that's their profession. And each department head is quite autonomous, because they are professionals (PASADA employee, respondent #33).

As indicated by the above quotations, PASADA's employees are hired based on their professional expertise. In fact many respondents' motivation for working at PASADA was due to their professional experience. Many of the actors within PASADA were medical or public health professionals, and as a result held a certain bio-medical or public health understanding of HIV/AIDS and HIV/AIDS prevention. The following respondent, for example, when asked about what they consider when making decisions, explained:

You look at the ethics of your work. Those that can help you to make the decisions. [...] Ethics are based on, well they're medical ethics. They are known, we're trained in medical school. But no I haven't a book written on medical ethics, but we know the ethics of the profession (PASADA employee, respondent #41).

As the above quotation suggests, the respondent's medical professional background influenced their decision-making process within the organization. As a result of this training, the respondent had a particular ethical understanding of HIV/AIDS and HIV/AIDS prevention. For many of the respondents this included an understanding of a client's right to know and be educated about all types of HIV/AIDS prevention tools, including the use of condoms. When asked about what they do if the issue of condoms comes up in the community, for example, the following respondent explained:

They have to know, and you are there. You have to tell them as a medical personnel. Ok you cannot deny their right. But I always talk about it (PASADA employee, respondent #16).

As the above quotation suggests, respondents' professional bio-medical understanding of HIV/AIDS and HIV/AIDS prevention influenced their approach to HIV/AIDS prevention. These understandings corresponded to the national HIV/AIDS prevention approach, which includes the education and provision of condoms.

As will be discussed in relation to the other case studies, respondents' faith can also influence their understanding and approach to HIV/AIDS and HIV/AIDS prevention. Within PASADA, however, not only was respondents' faith less emphasized than their profession, but in some cases it was even rejected. According to the following two respondents, for example, because many of the decisions made at PASADA were not religious decisions, but were instead technical or professional decisions, an actor's faith had no place within the process:

No, I don't think it (faith) has influence because my work really follows documents, terms of reference, manuals, therefore it does not depend on my faith (PASADA employee, respondent #34).

What we normally keep on telling employees, your faith has nothing to do with our services. We are having you as an expert and we, according to your terms of reference and contract, this is what you are supposed to do, I accept, I don't accept, that's the end of it (PASADA employee, respondent #15).

As the above two quotations suggest, an actor's profession was valued above their faith, and it was expected that decisions would be based on actors' professional expertise as opposed to their religion. This appears to say something about the nature of the organization itself. Although it is a faith-based organization that is expected to follow the regulations of the Catholic Church, little emphasis is placed on the role of respondents' personal faith within the organization. This is not to suggest an actors' faith does not have an influence as, for example, some organizational policy documents had religious references. Therefore, while faith influences the policy process at the organizational level, it appears to have less influence at the individual level. Actors' professional beliefs, however, were not always found to match their personal religious beliefs; as one actor described it, there are two levels of beliefs – professional beliefs and individual beliefs. An actor, for example, might be bound to the beliefs of their profession or organization, regardless of their own individual beliefs. At the

same time, professional beliefs and organizational policy might not correspond, and an actor must find a way to mediate between the two, the process of which was discussed above.

In summary, both the Bishop and Advisory Board were found to have influence within the organization's policy process. While the Bishop held authority over religious matters at the organizational level, he was found to have less authority over technical matters. At the same time, the Advisory Board played a consultative role within the organization; however, it had the authority to report to the Bishop if needed. At the individual level, actors' understanding of HIV/AIDS was found to influence the policy process. This understanding was influenced by actors' profession, experience, and/or religion. Within the organization, respondents' approach to HIV/AIDS prevention was found to be predominately influenced by their professional understanding of HIV/AIDS. With regards to HIV/AIDS prevention, respondents' professional understanding of HIV/AIDS was often found to conflict with Church regulations. As discussed above, in such cases, respondents would find ways to mediate between the two to ensure their prevention approach was not only in line with their own understanding of HIV/AIDS, but it did not go against the position of the Catholic Church.

5.7 Key Findings

Although many factors were found to influence the HIV/AIDS prevention policy process within the organization, there are three key factors. Firstly, the Catholic Church has a clear position on the promotion of condoms, which is that condoms as a method of HIV prevention is not allowed. As an organization operating under the Catholic Church, PASADA is expected to hold the same position. This position is in contradiction to government policy, which encourages the promotion and distribution of condoms within HIV/AIDS prevention. Secondly, PASADA is a professional organization, meaning it hires people based on their professional qualifications and expertise as opposed to their religious beliefs. As a health facility many of the organization's employees are medical and public health professionals. As a result, most of the respondents held a professional bio-medical understanding of HIV/AIDS, which included the belief that condoms are an effective method of HIV prevention. Respondents' professional bio-medical understanding of HIV/AIDS therefore conflicted with the Catholic Church's, and therefore PASADA's, position on condoms.

Thirdly, as result of this clash, respondents would find ways to mediate between these conflicting factors in order to ensure that their HIV/AIDS prevention approach was not only in

line with their own understanding of HIV/AIDS, but it did not overtly go against the position of the Catholic Church. Respondents, for example, distinguished between condom education and promotion in order to talk about condoms within the community, emphasized individual choice in order to leave the decision to use condoms up to the client, or framed issues in a way that circumvented religious issues in order to ensure vulnerable groups within the organization were targeted. As a result, while organizational HIV/AIDS prevention policy was technically in line with Catholic Church regulations, actors' practice led to a discrepancy between policy and practice within the organization.

5.8 Chapter Summary

The HIV/AIDS prevention policy process within PASADA is influenced by many factors. The factors presented were deemed to be the most influential within the policy process but are by no means exhaustive. Factors were identified and explored under four main themes – context, actors, process, and content. Contextual factors which affect the HIV/AIDS prevention policy process include the Catholic Church, government, donor, and community and cultural contexts. Actor factors which affect the process include both the influence of external actors and actor-related factors such as actors' understanding of HIV/AIDS. Process factors included the structures that facilitated, shaped, and/or confined the overall policy process, such as, for example, the Bishop's authority over religious matters. These factors inter-related to form policy content, in terms of written and unwritten policy and practice.

Within the overall process, Church policy on condoms was found to conflict with actors' professional bio-medical understanding of HIV/AIDS. As a result, actors would find ways to mediate between these conflicting factors in order to ensure their approach to HIV/AIDS prevention was in line with their own understanding of HIV/AIDS, while at the same time not overtly going against Church regulations. Actors mediated between these conflicting factors by distinguishing between condom education and promotion, emphasizing individual choice, and framing issues in a way that circumvented religious values or ethics. As a result, a discrepancy was found between organizational policy and practice. In addition to the Catholic organization, the factors influencing the HIV/AIDS prevention policy process of faith-based NGOs were also explored within an Anglican and Muslim NGO. The following chapter discusses the findings from the Anglican organization.

Chapter 6 – Policy Processes within the Anglican Organization

6.1 Introduction

This chapter explores the factors influencing the HIV/AIDS prevention policy process within the Anglican NGO. As with the previous chapter, the factors are presented in relation to the conceptual framework, according to the process, context, and actor factors that inter-relate to form HIV/AIDS prevention content, in terms of written and unwritten policy and practice. The role of faith will be explored within each factor where applicable. The factors presented are not exhaustive, but are those that were identified to be most influential within the organization's HIV/AIDS prevention policy process. As stated in chapter 5, although government and donors can be considered actors, within the chapter they are discussed within context as no immediate government or donor actors were found to directly influence the policy process, only aspects of each, such as policies or guidelines. The quotations used are based on interviews with respondents from the Anglican organization, unless otherwise indicated. While the key factors are similar to the Catholic organization, such as the religious, government, donor, community and cultural context, and actors' understanding of HIV/AIDS, how these factors influence the overall policy process differs from the Catholic organization. While these differences are highlighted within the chapter, they will be further explored in Chapter 8 when the findings from all three organizations are compared. The chapter begins with a description of the Anglican organization, followed by an overview of the organization's HIV/AIDS prevention approach. The findings are then presented according to the key process, context, actor, and actor-related factors. How these factors inter-relate to form content in terms of policy and practice is discussed throughout the chapter. The chapter concludes with a summary of the main findings.

6.2 Overview of Organization

The Anglican organization is a registered non-governmental organization (NGO) operating under the Anglican Diocese of Dar es Salaam. Similar to the Catholic organization, it can be described as a faith-based professional organization: an organization that self-identifies itself as faith-based and is formally affiliated with a religious body, while employing staff based on their professional qualifications as opposed to their faith. The organization's relationship with the Anglican Church is mediated through the Anglican Bishop and Board of Directors, each of

which is discussed below under 'actors'. At the time of data collection the organization had been in operation for a few years. According to its constitution its purpose is:

to help Tanzanians and their communities improve their Health, Education and [...] Sustainable Development, and also to provide safe drinking water, and better sanitation services in order to improve the well being of families and communities especially the poor and needy living in Dar es Salaam and its suburbs, including coast regions (Anglican organization, 2006: 4).

The above purpose was created at the organization's inception. At the same time, its website states that the organization's mission is to focus on the health and social situation of women and children, concentrating on infant and maternal mortality, HIV/AIDS education and prevention, and malaria eradication. It is therefore not clear what the overall strategic vision of the organization is as there is no consistency between what is written on its website and within its constitution, what respondents said during data collection, and the activities in practice. At the time of data collection, for example, its activities focused predominately on HIV/AIDS prevention and mitigation and malaria eradication.

The organization works in predominately Muslim areas of Tanzania. Since its inception it has worked on a number of projects, including: Nets-for-Life, distributing mosquito nets and health education literature; HIV/AIDS voluntary counselling and testing (VCT); outreach and microfinance loans to over 200 commercial sex workers (CSW); peer support and microfinance loans to about 100 people living with HIV/AIDS (PLWHA); an AIDS orphan program providing emergency aid, healthcare and education to around 150 AIDS orphans; an AIDS treatment program; and a home-based care (HBC) program. In addition, according to organizational literature the organization works in partnership with a local health centre in order to implement its VCT and AIDS treatment programs, treat opportunistic infections, and decrease maternal and newborn deaths. It is unclear exactly what this partnership entails besides referring people for VCT and treatment of opportunistic infections, as people within the organization did not work within the health centre, and it was rarely mentioned within interviews. The organization is fully donor dependent and most of the above programs are implemented through short-term grants. Projects have operated on a one year basis, such as the microfinance loans to PLWHA and CSWs, implemented in 2008; a two year basis, such as the peer support for PLWHA, HBC, and treatment for HIV/AIDS opportunistic infections, implemented from 2008-2010; or a four year basis, such as the Nets-for-Life program (*ibid.*).

According to respondents, the organization is considered to be a subsidiary of the Anglican Church in Tanzania, and was created by the Anglican Bishop, who also sits on the Board of Directors, to whom the organization is accountable. According to its website, however, which was not in operation at the time of data collection, the organization was created under the leadership of two American doctors. It is unclear what the exact involvement of the American doctors is, as their role rarely came up during the interviews, and it was only near the end of data collection that one respondent explained there was a missionary doctor who worked with the organization. Throughout this interview reference was made to an American who helped with fundraising efforts who may have also been this missionary doctor. The organization's website appears to be updated by the American doctors and their colleagues. According to the website, the doctors visit Tanzania and the organization about four times a year, and are currently in the process of applying for more funding for the organization. A newsletter about each visit is posted on the website.

At the time of data collection the organization had 22 employees, in addition to up to 300 volunteers within the villages. Four of these employees sat on the management team, which was made up of the Director, the Finance Manager, and two Community Health Coordinators. As discussed below under 'process', the management team is responsible for supervising and overseeing different aspects of the organization. As the following quotation demonstrates, employees within the organization are recruited from all religious backgrounds:

In spite of the fact that it is a religious organization, when the organization is recruiting people they don't choose, I mean they don't choose only Anglicans; they just take anybody regardless of their religious beliefs. Their main goal is not to spread the religion but to help people in the community. Even here there are Christians who are not Anglicans, there are also Muslims, so they are mixed (Anglican organization, respondent #65).

Similar to the Catholic organization, as the above quotation suggests, employees are recruited on the basis of their professional qualifications and expertise, as opposed to, for example, their religion. The organization's multi-religious environment appeared to be valued by respondents, who saw it as enabling them to create a multi-religious network within the communities in which they worked.

The organization is located on a small compound, which it had recently moved to at the time of data collection. On the compound are two small buildings, one with approximately four

offices for the management team, the other with two rooms used for staff meetings and morning prayers. Upon entry to the compound there is no indication that the organization is a faith-based organization (FBO), and even upon entering the buildings there are no religious objects or artefacts. It is unclear if this is because the organization just moved to this location, or it wanted to distance itself from the Church and its Anglican identity. The organization had one main truck which it used to reach the communities where it worked, however, during data collection it was out of commission awaiting repair.

Within the organization prayers took place every morning at around 8:00am. Although voluntary, they were done in conjunction with informal daily staff meetings and were therefore attended by most staff. According to respondents, the prayers were conducted in an inclusive way, where people were encouraged to pray according to their own religion. Overall respondents had different explanations for why there were morning prayers within the organization. According to some respondents, for example, they pray in the morning because the organization is under the Anglican Church, and the organization's activities are guided by the Church. According to other respondents, the decision to pray in the morning was made by the employees, independent from the Church. The importance of prayer was found to vary and is perhaps connected to the spirituality of the respondent. Some respondents, for example, described morning prayers as being very important, while others found them to have little importance within the organization.

Although the organization is a subsidiary of the Anglican Church, according to respondents it was purposively created to be separate from the Church in order to expand the scope of the Church's service provision in terms of the communities it is able to reach. According to the Bishop, for example, it can be difficult for the Church to work with non-Christian communities. The Anglican NGO was therefore created as a way to reach non-Christian communities in terms of service provision. In addition to reaching out to different religious communities, according to respondents, the organization's identity as an NGO separate from the Church enables it to be more flexible in its approach to HIV/AIDS than the Anglican Church. As one respondent explained:

Because we are registered as a non-governmental organization, we are like [...], it's like a private organization dealing with community issues. So, we are working for the community and not, we have another role in the society. [...] We are an Anglican organization, and the stakeholder is the Anglican Church,

and that's why, I would call it a private company now, which has more roles than the Anglican ones (Anglican organization, respondent #59).

As the above quotation suggests, although under the Anglican Church, respondents interpreted the organization's identity as an NGO to mean they were independent from the Church, and as a result could engage in activities and be more flexible in its approach than the Church.

At the same time, however, while some respondents saw the organization as being separate from the Anglican Church, others emphasized the importance of the organization's faith-based identity and their relationship with the Anglican Church. As one respondent explained:

The most important thing is that they (the community) should know that this is a religious institution. When we are introducing ourselves to the community we tell them this is a religious organization. But also the community members they ask us, which kind of organization is this, so we tell them. From my experience people are more, they like working with religious organizations because they know they are more serious, they follow up issues (Anglican organization, respondent # 64).

As the above quotation demonstrates, respondents felt that the organization's faith-based identity was important due to community perceptions of FBOs. According to respondents, compared to secular organizations FBOs were seen to be more trustworthy and accountable within the community. The organization's identity as a faith-based NGO was therefore important as it appeared to allow the organization to remain flexible in its approach to HIV/AIDS through its distance from the Anglican Church, while maintaining the faith element that set it apart from other secular organizations. At the same time, however, these different views regarding the organization's identity may be a result of the organization's lack of external and internal policy direction, which will be discussed in greater detail below. The following section describes the organization's approach to HIV/AIDS prevention, followed by an exploration into the process, context, and actor factors that shape content, in terms of policy and practice.

6.3 HIV/AIDS Prevention Approach

As described above, the organization has multiple programs in addition to their HIV/AIDS services. With regards to its HIV/AIDS work, the organization is involved in both prevention and mitigation; however, their mitigation work, such as VCT, is mainly done through partnership with the hospital. The organization itself does not carry out the testing or provide

anti-retroviral treatment (ART) to PLWHA, but sends people to the hospital or other health facilities. Similar to the Catholic organization, the organization's preventative services can be divided into three categories: (1) HIV/AIDS prevention at the community level, (2) positive prevention, and (3) HIV/AIDS prevention among vulnerable groups, particularly commercial sex workers. The organization's work with commercial sex workers was a one year program that had completed at the time of data collection, as such it is not discussed here. The organization's involvement within the first two categories is discussed below. At the time of data collection the organization had no formal HIV/AIDS policies; as a result, the organization's HIV/AIDS prevention approach has been deduced from the data.

6.3.1 Community HIV/AIDS Prevention

Community HIV/AIDS prevention involves sensitizing people within the community about HIV/AIDS with the aim of preventing new HIV/AIDS infections. The organization's HIV/AIDS prevention work is carried out in conjunction with their other services. As one respondent explained:

Our programs are piggy-backing on each other, when we go to talk about malaria, we also talk about AIDS. We distribute flyers and brochures talking about AIDS, you should have safe sex, and all these other symptoms of AIDS. Don't stigmatize people with AIDS, you don't get AIDS by touching, these kind of things (Anglican organization, respondent #59).

HIV/AIDS prevention messages are structured around educating the community about what HIV/AIDS is, how it is spread, ways in which one can prevent themselves from contracting HIV, and the importance of HIV testing and knowing one's status. Other messages include ways in which one cannot contract HIV (such as touching someone who is HIV positive, through insects, or sharing clothes etc.), what to do if found infected, taking care of those who are HIV positive, and what the process of HIV testing involves (Anglican organization, undated-a, undated-b).

As stated above, no formal HIV/AIDS policies were found within the organization. When asked about the HIV/AIDS prevention messages used within the community respondents had conflicting answers. While all respondents explained how they promoted both abstinence and faithfulness, for example, their responses regarding condom promotion were mixed. According to some respondents, as an Anglican organization under the Anglican Church they were not permitted to promote condoms:

As a Church [organization], we can't say use condom, because it's Church regulations, we cannot promote condoms (Anglican organization, respondent #62).

Because it's (the organization) under the Church, we try very much to avoid that, promoting condom use, because we want to follow what the Church does, what the Church says. So we really avoid telling people about condom use, to promote condom use in the community (Anglican organization, respondent #66).

According to the above two respondents, the Anglican Church does not allow the promotion of condoms. This position was corroborated by the Anglican Bishop who stated that the Anglican Church does not support condom use within HIV/AIDS prevention as it contradicted Christian values and was not 100% effective. According to the Bishop, the Anglican Church promotes abstinence and faithfulness, and preaches against the use of condoms as they are perceived to promote promiscuity. The role of condoms within HIV/AIDS prevention has created controversy within the Anglican community in Tanzania in the past. An example was given by the Bishop of another Anglican Bishop in northern Tanzania who in 2001 had told his congregation to use condoms to protect themselves from HIV/AIDS infection. This position received a lot of resistance within the country, and according to the media was rejected by the wider Church and dissident congregations (Conger, 2011). According to the media, the schism created by this "division over the morality of using condoms to prevent the spread of HIV/AIDs" was only settled after years of mediation and the Bishop backing away from his previous position (Conger, 2010).

Despite the position of the Anglican Church on condoms, according to respondents the organization has been given no direction regarding HIV/AIDS prevention and condom promotion from the Anglican Church, which instead has chosen to remain silent on the issue:

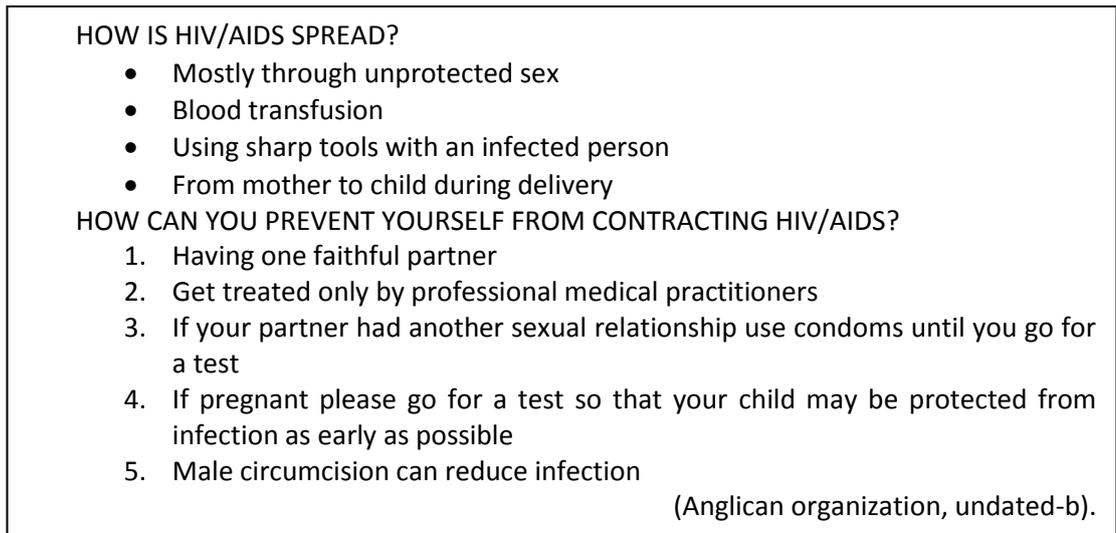
Regarding condom use the Anglican Church does not give direction whether to, does not guide us or tell us not to tell people about condom use, or that condoms cannot, we should not promote condoms, the Church does not tell us anything on that (Anglican organization, respondent #63).

The Anglican Church has not really made it a point, like the Roman Catholic Church, to say don't use condoms (Anglican organization, respondent #60).

This position was also corroborated by the Bishop who stated that the organization had not been told that it must work according to Church directives, and no meeting had taken place about what the organization should or should not promote. As will be further discussed

below, some respondents interpreted the Anglican Church's silence as tacit permission to promote condoms within the community. The organization's educational literature, for example, includes directions to use condoms if a person is uncertain about their partner's status. Figure 13 shows an excerpt from a pamphlet about HIV/AIDS produced by the organization, which identifies how HIV/AIDS is spread and the ways to prevent HIV infection:

Figure 13 – Anglican Organization HIV/AIDS Pamphlet



As evidenced by the above example, despite the different approaches to HIV/AIDS prevention discussed above, the organization actively promotes the use of condoms.

In summary, although the Anglican Church is against the promotion of condoms in HIV/AIDS prevention, respondents within the organization received no direction from the organization or Anglican Church regarding how they were to approach HIV/AIDS prevention, particularly with regards to condom promotion. This lack of direction translated into different approaches being used by respondents within the organization. For example, while some respondents would not promote condoms because they believed it was not allowed by the Church, others interpreted the Church's silence as tacit permission to promote condoms within the community. As evidenced by the organization's educational literature, however, the organization actively promotes condoms.

6.3.2 Positive Prevention

Positive prevention is prevention of HIV/AIDS among couples where one is HIV positive and one is negative or the prevention of re-infection where both are HIV/AIDS positive. Within the

organization positive prevention referred almost exclusively to married couples. Similar to community HIV/AIDS prevention, responses regarding the use of condoms with discordant couples were mixed – some respondents believed that condoms should be promoted in such situations while others believed they should not. Because the organization does not deal with VCT directly, but through their partnership with the health centre, many of the examples given were in reference to the health centre.

Within the organization itself a few respondents stated that if they were presented with the situation of a discordant couple, they were either unsure of whether they would promote the use of condoms, or they would not advise the couple to use condoms. When asked whether they would suggest the use of condoms to a discordant couple, for example, respondents stated:

I don't know, because... when you use condoms sometimes you forget [to use] it. Someone can forget (Anglican organization, respondent #62).

We cannot, because we are also not sure that a condom can really protect someone from contracting HIV/AIDS, so we don't advise them on that (Anglican organization, respondent #64).

According to the above respondents, they were unsure of whether they would, or knew they would not, promote condoms within discordant couples due to the possibility of the uninfected partner becoming infected.

At the same time, according to other respondents, when presented with a discordant couple, the couple would be advised to use condoms. According to one respondent, for example:

For such kind of couples, because now if they are married you cannot tell them, because one is infected now that is the end of their marriage, since they will still be together and they'll practice sex. So we educate, especially this one who is not, who is infected not to infect the other one, by advising them just to stop those things which will make this one partner pass the disease to another one. So we will advise them to use condoms yes, but also to teach them how to use condoms (Anglican organization, respondent #65).

As the above quotation suggests, some respondents within the organization would actively promote condoms to discordant couples in order to prevent the uninfected partner from becoming infected.

In summary, there were no clear guidelines from either the organization or the Anglican Church regarding discordant couples. As a result, respondents had different views, and therefore responses, towards discordant couples. While some respondents would not promote condoms within discordant couples because they were uncertain of their effectiveness, others would promote condoms within discordant couples to ensure the uninfected partner remained uninfected. Similar to community HIV/AIDS prevention, these respondents interpreted the Anglican Church's silence regarding HIV/AIDS prevention, as well as the organization's separation from the Church as tacit permission to promote condoms. The factors influencing respondents' different approaches to HIV prevention can be better understood by looking in greater detail at the processes of policymaking, the context in which the organization works, and the actors who are working within the overall process. The remainder of the chapter explores these factors.

6.4 Structures and Processes of Policymaking

The following discusses the process of policymaking within the organization. It explores the structures that facilitate, shape, and confine this process. As with the Catholic organization, the policymaking structures discussed have been derived from the data. They are formal in that they are habitual and well established within the organization. These structures are important as they influence who has decision-making power within the organization, what type of power they have, and where they can use that power. Similar to the Catholic organization, overall these processes were found to be both participative and authoritarian, and based within a hierarchical system of decision-making.

According to respondents, decision-making within the organization is a collaborative process through which decisions are made as a team. Informal discussions or 'staff meetings' are held after morning prayers and are used to discuss the activities that occurred the day before. Mondays are specifically used to discuss the previous week's activities and challenges, and were initially used for more formal discussions; however, this now occurs during a monthly staff meeting held at the end of the month. According to respondents, different issues are discussed at the monthly staff meeting, such as issues relating to staff, administration, or the programs they are running. The importance of involving all employees within the decision-making process was emphasized, particularly those who work on the front line within the community. As the following respondent explains, for example:

We are the ones who go out to the community, and we know better what the community needs are and what can be done there, unlike the management team who most of the time are in the office. So they don't know much about what is happening there in the community. So it's important that we sit together (Anglican organization, respondent #66).

As demonstrated by the above quotation, respondents felt that it was important for everyone within the organization to sit together, particularly those who implemented the organization's activities. Respondents thought this was important as their experiences within the community would be used to inform the overall decision-making process.

The management team meets every Friday and as needed to discuss issues at the organizational level. According to respondents, however, this meeting remains flexible depending on availability. Despite the perception of most respondents that the decision-making process was collaborative, according to respondents at the management level the process is hierarchical in that the Director has final say in the overall decision-making process within the organization. At the same time, the Director of the organization sits on the Board of Directors, which is chaired by the Bishop. According to respondents regular reports are sent to the Board of Directors, whose role is to approve organizational activities, as discussed by the following respondent:

At the end of the day they (reports) will go to the Board. Where of course the Board is chaired by the Bishop of Dar es Salaam diocese. [...] When we make write-ups, we have also to inform the Board that we are doing this, so that we don't delay from what we would expect. Because we may be looking for money, and the way we look for money is not the way our Church wants us to do it. So you have to, have to get confirmation from the Board (Anglican organization, respondent #60).

As the above quotations suggests, the organization is accountable to the Board of Directors, and if the Board did not approve an activity it would delay the overall process. As will be discussed below, at the time of data collection the Board had met only a limited number of times since the organization's inception. Therefore, their exact influence or role within the organization is unclear. At the same time, the Bishop does remain in regular contact with the organization and, as the chair of the Board, appears to hold a lot of influence within the organization. The role of the Bishop and Board of Directors will be discussed in greater detail below under 'actors'.

In summary, processes of policymaking are important as they influence who has decision-making power within the organization, what type of power they have, and where they can use that power. Overall no formal HIV/AIDS organizational policies were found within the organization; as a result the processes were derived from the data. The policy structures within the organization, however, appear to be formal in that they are habitual and well established within the organization. Similar to the Catholic organization these structures appeared to be based on a hierarchical system and were both collaborative and authoritarian. It was collaborative as employees met informally on a daily basis with a weekly meeting as well as a formal staff meeting once a month. The process was authoritarian in that, according to respondents, the Director had final say in the decision-making process within the organization. In addition, regular reports were sent to the Board of Directors, chaired by the Bishop, whose role was to approve organizational activities. The organization was therefore accountable to the Bishop and Board of Directors; however, the influence of the Board of Directors appears to be limited. While process factors influence who has decision-making power and where they use that power within the organization, other factors, such as context and actor-related factors influence how they use that power. The following therefore discusses the context and actor factors which influence the overall policy process within the organization.

6.5 Contextual Factors influencing Policy Process

Similar to the Catholic organization, the contextual factors presented refer to factors that are external to the organization, which include the overall local, national, and international context in which the organization and its policy processes are situated. The contextual factors relate to the Tanzanian context that was discussed in Chapter 4, as well as the international context that was discussed in Chapter 2. The contextual factors below are not exhaustive, but are those which were identified throughout the data collection and analysis process as being most influential in the HIV/AIDS prevention policy process of the organization, and include the religious, government, donor, and community and cultural context.

6.5.1 Anglican Church Context

The organization is an Anglican faith-based NGO operating under the Anglican Diocese of Dar es Salaam. The organization's relationship with the Anglican Church is mediated through the Bishop and the Board of Directors, which consists almost entirely of people from the Anglican Church and is chaired by the Bishop. Although the organization is accountable to the Bishop and Board of Directors, according to respondents, at the time of data collection they had given

no direction regarding the organization's HIV/AIDS prevention response. Instead, the Anglican Church, through the Bishop and Board of Directors, chose to remain silent regarding HIV/AIDS prevention.

When asked about the organization's relationship with the Anglican Church, respondents held mixed opinions. Some respondents, for example, believed the Anglican Church held a lot of influence within the organization, controlling the organization's activities and formulating all policies within the organization, as exemplified by the following quotations:

As we said a faith-based, our policies will come from the top, from the Church. And mainly know the doctrines and following the commandments of God (Anglican organization, respondent #60).

Because it is within the Anglican Church, and even most of the rules, most of the organization is also based in the Church, might say Church coordinated, almost everything is within the Church, because even the organization itself, [...] and even if you look on its constitution, most of the things there are based on the Church perception (Anglican organization, respondent #61).

As the above quotations suggest, these respondents believed the Anglican Church held a lot of influence within the organization, directing their policies and activities. At the same time, however, other respondents felt the Church did not have any influence in their day to day activities, as exemplified by the following quotations:

I don't see the influence of the Church in the activities we're doing (Anglican organization, respondent #63).

The Church, the Church is like a mother body, a mother organ, umbrella. And they are aware that the organization exists, but regarding the activities, what we should tell people, what we should do, the Church does not have influence (Anglican organization, respondent #65).

As the above quotations suggest these respondents did not view the Church as an active player within the organization's policy process. It is clear from the above examples that there were mixed views within the organization regarding the role and influence of the Anglican Church. While most respondents viewed the organization as being under the umbrella of the Anglican Church, what this meant was not clear. The influence of the Anglican Church was often made in reference to the role of the Board of Directors consisting mainly of members from the Church and chaired by the Bishop. Therefore, according to respondents, it was the Board of Directors, not the Church that had the power to control the organization's activities.

According to a representative from the Anglican Church, the organization was purposively registered as an NGO in order to separate it from the Church and Church doctrine. It was created as a place for the Church to work outside of its constituency with those who may not feel comfortable working directly with the Anglican Church. This separation from the Church may have contributed to the organization's lack of direction from the Church, diverse opinions regarding the role of the Church within the organization, and respondents' different approaches to HIV prevention, as discussed above. If the organization was created to be separate from, and, according to respondents, more flexible than the Church, it is unlikely that the organization would be constitutionally required to follow the Anglican Church's position on condoms. If this is the case, then the lack of direction or policy within the organization itself would be the main contributor to the diverse approaches to HIV/AIDS prevention found within the organization.

In summary, respondents had diverse opinions regarding the role of the Anglican Church in relation to the organization. For example, while some respondents believed the Church held influence, others saw it as having little influence within the organization. Although the organization is considered to be under the umbrella of the Anglican Church, according to respondents it was formed to be separate from the Church. Respondents believed that this separation allowed the organization to remain more flexible with regards to HIV/AIDS, particularly with regards to the role of condoms in HIV/AIDS prevention since at the time of data collection the organization had received no direction from the Church regarding HIV/AIDS prevention. At the same time, however, some respondents believed they were not permitted to promote condoms as they were part of an Anglican organization. As discussed above, while these differing views are likely the result of a lack of direction from both the Anglican Church and the organization itself, if the organization was purposively created to be separate from and more flexible than the Church, the diverse approaches to HIV/AIDS prevention within the organization are most likely the result of a lack of organizational direction or policy.

6.5.2 Government Context

The organization is certified by the Tanzanian government to operate as an NGO under the Anglican Diocese of Dar es Salaam (Anglican organization, 2010-2011). Apart from the initial registration, it appears that the government has a very limited relationship with the organization. One respondent, for example, stated that the organization's relationship with

the government is mediated through its partnering hospital, which uses Government HIV/AIDS policies and sends reports to the Ministry of Health. At the same time, however, when asked about the government's HIV/AIDS policies, some respondents did indicate that National HIV/AIDS policies were used within the organization, as exemplified by the following respondent:

For most of the current health activities that we are doing, they are coming from the National AIDS Control Program, TACAIDS. And we look on those, HIV strategic plans (Anglican organization, respondent #61).

Despite the above reference to government policy when questioned further respondents often referred to another person or location as to where these policy documents were located, such as the Director or the hospital. It is likely, therefore, that the actual use of government policy within the organization itself is minimal. According to respondents, the organization sends reports to the government, such as the Ministry of Health or the National Malaria Control Program, who then provide direct feedback, including improvements that could be made. In addition, respondents explained how the government has invited members of the organization to nationwide planning meetings in the past.

For respondents who mainly worked within the community, when asked about the organization's relationship with the government, they either indicated that it had no influence at all over the work that they did, or referred to the influence of local government officials whose support they sought within the community, as demonstrated by the following quotation:

The government has influence, because when we go to the community, before we start talking to people we first consult with the local government, the street leaders, or the government leaders. And they are giving us very good support so far (Anglican organization, respondent #64).

For these respondents, therefore, the government had most influence at the local level. At the same time, FBO respondents felt that the government at the national level was aware of the organization's existence and was supportive of their work, particularly in geographical areas where the government fails to reach. One respondent, for example, emphasized the time they received specific recognition from government officials who came to the organization to thank them for their work (Anglican organization, respondent #62).

In summary, respondents had diverse responses regarding the role of government within the organization. While respondents indicated that they used government HIV/AIDS policies, their actual use of these policies appeared to be limited. Respondents also explained that reports were sent to the government regarding their work, in which feedback was received. On the whole, respondents felt that the government was very supportive and emphasized the time government officials visited the organization to thank them for their work, particularly in relation to geographical areas that the government has been unable to reach.

6.5.3 Donor Context

The organization is fully donor dependent. At the time of data collection the organization had approximately five international donors, the majority of whom were Christian or Anglican organizations. Many respondents perceived donors as having a lot of influence within the organization, as demonstrated by the following quotation:

They (donors) have a very big influence because they are the ones who enable us to reach our goals, to implement the activities at the end of the day (Anglican organization, respondent #67).

As the above quotation suggests, respondents felt that donors' influence was attached to their provision of funding, without which the organization would not be able to implement its activities. At the point of implementation, however, respondents recognized that donors' influence was limited, as the funds had already been allocated. The impact of donors' influence was therefore seen to be mainly at the point of planning, when donors received proposals. It is at this point, for example, that donors would provide stipulations on how the organization is to use the resources. According to respondents, if the proposals are approved, the organization is then restricted to doing what was agreed upon within the proposal. Regular reporting is a main stipulation of donors and each year the organization sends four progress reports to each donor, in addition to an annual report.

Being fully donor funded was perceived as a challenge by some respondents due to the lack of sustainability, particularly in light of the global financial crisis. As a result, respondents alluded to the possibility of obtaining more sustainable funding sources in the future. A particular challenge was the short-term nature of donor funding as it meant that long-term programs had to be implemented within a short time frame, as discussed by the following respondent:

We have a one year budget, which normally donors give [...], when you talk about programs, which should have taken say three, five years, but you do it in one year and then it comes to an end. Then you will look for another program because you are just looking at, ok can we get a program to assist the people. So you have a program which is unfinished. [...] You cannot talk about with confidence that we have covered a certain area, which was intended for three years, according to the program, and had only one year to do (Anglican organization, respondent #60).

As the above quotation suggests, donors' restrictions on funding were seen to be detrimental to the long-term HIV/AIDS prevention and mitigation efforts of the organization. According to respondents, by only implementing short-term projects they could not be certain that their efforts were effective, especially as many projects had to end before they were fully completed. In addition to the above, not having enough resources to implement programs fully or realize the organization's vision was viewed as a challenge.

In summary, respondents had mixed opinions regarding the role of donors within the organization. On the one hand, donors were regarded as having a strong influence, as without their contribution activities could not be implemented. Donors' influence, however, appeared to be restricted to the planning phase when projects were being prepared and proposals written. Once a proposal was approved, the organization was restricted to what was agreed upon within the proposal. On the other hand, the organization's reliance on external funding was viewed as a challenge, as was donors' tendency to fund short-term projects. It was felt that this was not only unsustainable, but it did not allow for any real lasting change within the communities in which the organization worked. Lack of resources to fully implement programs was also viewed as a challenge.

6.5.4 Community & Cultural Context

The community and cultural context appeared to be very important within the organization's HIV/AIDS prevention policy process. Many respondents stated that community needs were an important factor in their decision-making process and respondents' motivation for working with the organization was often based on the chance to work with and respond to the needs of the community. According to the following respondent, for example, when creating programmes and HIV/AIDS sensitization messages, the main objective was to meet people's needs:

The objective is to meet the needs of the people, to support the needs of the people, that's number one (Anglican organization, respondent #59).

For many respondents, the importance of meeting the needs of the community appeared to be placed ahead of promoting religious values or messages. It became apparent, for example, that in the community respondents attempted to separate themselves from the organization's faith identity, as illustrated by the following quotations:

Our main goal is not to spread the religion but to help people in the community (Anglican organization, respondent #65).

When you go to the community, we usually don't talk much about the Christian issues there. [...] We introduce ourselves, we are from the Anglican Church, but we don't promote this, we don't promote much of the Church values there. We really take community as community, regardless of whether they are Christians or they are Muslims (Anglican organization, respondent #61).

While many respondents' main objective appeared to be to meet the needs of the community, as suggested by the above quotations, it is possible that respondents attempted to separate themselves from the Church as the organization worked predominately in Muslim areas, which might have not responded well if the organization pushed their Anglican beliefs. While this might be the case, it is clear from the above examples that the needs of the community influenced respondents' approach to HIV/AIDS prevention.

Respondents adapted their approach to HIV/AIDS prevention according to the type of community and the cultural or other type of practices the community engaged in. According to the following respondents, for example, the decision whether or not to include condoms in their prevention messages would depend on the community:

It will depend on the community, the message, or decision to tell people to use condoms or not will depend on the community (Anglican organization, respondent #63).

Most of the community, villages, sometimes we work with villages where the majority of them are Muslims. Yes we tell them about HIV/AIDS, about prevention, even the condom use, because they do what other people are doing. The fact that they are Muslim, they are also engaging in practices which could lead to the transmission of HIV/AIDS (Anglican organization, respondent #63).

According to the above examples, whether or not condoms would be promoted depended on if it was something that the community wanted or needed. In addition to condom use, respondents also referred to other cultural practices which could lead to HIV transmission that the community engaged in. Such practices included: circumcision, where unsterilized equipment is used, and not testing potential spouses for HIV/AIDS, particularly in polygamous marriages. HIV/AIDS prevention messages would include information about these practices if they were seen within the community. In addition to identifying community needs and practices, respondents also recognized many challenges in working with the community. These challenges included, for example: extreme poverty; lack of infrastructure, especially within the rural areas; ignorance of community members with regards to health, particularly malaria and HIV/AIDS; and HIV-related stigma, which was particularly a problem in identifying PLWHA in need of home-based care.

In summary, the community and cultural context were very important within the organization's HIV/AIDS prevention policy process. With regards to HIV/AIDS prevention, many respondents regarded responding to community needs as their top priority. At the same time, respondents' HIV/AIDS prevention approach depended on the type of community in which it worked and the cultural or other types of practices the community engaged in, such as circumcision or polygamy. According to respondents, their HIV/AIDS prevention messages would only include such practices if they were seen within the community. Respondents also identified a number of challenges within the community such as poverty, lack of infrastructure, ignorance, and stigma.

Contextual factors such as the Anglican Church's position on HIV prevention, government policies, donor regulations, community needs, and cultural practices played an important role in the HIV/AIDS prevention policy process within the organization. Contextual factors were found to influence the process both through their presence or absence. For example, respondents' HIV/AIDS prevention approach was influenced by community needs in addition to the lack of direction from the Anglican Church and absence of government policies. This, combined with a lack of direction or policy within the organization itself, and, as will be discussed below, respondents' different understanding of HIV/AIDS, appears to have contributed to the different approaches to HIV/AIDS prevention found within the organization. The following section explores the role of external actors and actor-related factors within this process.

6.6 Actor Factors Influencing Policy Process

This section explores the influence of different actors and actor-related factors on the HIV/AIDS prevention policy process within the organization. Only those factors that were found to have most influence are included. As discussed in the previous chapter, actors within the organization were the main point of inquiry as they are the ones that must navigate through the different factors influencing the organization's HIV/AIDS prevention policy process. As a result, a separation between external and internal actors is made as external actors are viewed as an influencing factor on internal actors' decision-making process. The actor-related factors discussed here therefore only refer to internal actors. In the case of the Anglican organization internal actors include the organization's employees. The external actors found to have direct influence on the policy process were the Bishop and Board of Directors. Similar to the Catholic organization, actor-related factors (the characteristics of actors) that were found to influence the policy process have been grouped into one overall theme – actors' understanding of HIV/AIDS.

6.6.1 External Actors – Bishop and Board of Directors

During data collection and analysis the Bishop and the Board of Directors were identified as the most prominent external actors which have direct influence over the HIV/AIDS policy process. The organization's relationship with the Anglican Church was mediated through the Bishop and the Board of Directors, which, except for the Director of the organization, was made up entirely of representatives of the Anglican Church. The role of the Bishop was almost always explained in relation to the Board of Directors, of which he was the chairman. According to the Bishop, the Board of Directors was set up to ensure the organization operated according to the organizational vision that was developed during its inception, and the organization would be "put back on track" by the Bishop and Board of Directors if it was found to be doing something that was not in accordance with this vision.

According to respondents, the organization sends reports to the Board for approval, including their proposed budget, organizational plans, activities, achievements, and challenges. The Board of Directors consists of approximately six people – the Bishop, the US missionaries described above, the Director of the organization, and one or two lay people. According to one respondent, the Board was purposively kept small to ensure it remained manageable. At the time of data collection the Board had met once or twice in the past with plans to meet up to four times a year. As the organization had already been running for a few years at the time

of data collection, the small number of Board meetings suggests that their involvement and influence within the organization is much more limited than described by the respondents. However, as mentioned above, the Bishop was almost always referred to in relation to the Board of Directors. As the Board had rarely met at the time of data collection, it is possible that the influence of the Board was actually the influence of the Bishop, and it is the Bishop that the organization is predominately accountable to. The role of the US missionaries that were discussed above was unclear as they were not discussed within the organization. The only reference made to them was by the Bishop, and it was in relation to fundraising activities.

As discussed above, different approaches to HIV/AIDS prevention, particularly condom promotion, were found within the organization. It is clear from the above discussion that the Anglican Church, and therefore the Bishop and Board of Directors, have chosen not to give the organization direction regarding HIV/AIDS prevention by remaining silent on the issue, despite the Anglican Church being against condoms. According to one respondent, the Bishop understands that actors within the organization sometimes talked about and promoted condom use within the community. According to the Bishop, however, he has not checked to see if the organization is promoting condoms, and he believed that the organization would raise it as an issue if it was a concern. As discussed above, the Anglican Church's (and therefore Bishop's) silence regarding HIV/AIDS prevention, in addition to the organization's separation from the Church, has been interpreted by many respondents as tacit permission to promote condoms within the organization. As the Anglican Church has not told the organization that it should not promote condoms, such a position could be interpreted as approval.

6.6.2 Actor-Related Factors – Actors' Understanding of HIV/AIDS

While all factors described above have been external to actors within the organization, there are also internal actor-related factors (characteristics of actors) that were found to influence actors' decision-making process. As stated above, these have been grouped into one overall theme – actors' understanding of HIV/AIDS. Similar to the Catholic organization actors' understanding of HIV/AIDS was influenced by their professional understanding of HIV/AIDS and/or their personal religious beliefs, which were found to direct respondents' HIV/AIDS prevention approach. Unlike the Catholic organization, however, where there was a conflict between actors' understanding of HIV/AIDS and organizational policy, due to the policy vacuum within the Anglican organization, no conflict was found between these two factors.

According to respondents, staff within the organization were employed due to their profession and expertise. Similar to the Catholic organization, many respondents explained how they were attracted to the organization as it gave them an opportunity to use their professional skills to help people within the community. Many of the respondents within the organization were identified as medical or public health professionals. As a result, it became apparent that many held a bio-medical or public health understanding of HIV/AIDS and HIV/AIDS prevention, such as the belief that condoms were an effective HIV prevention strategy, which they would use to justify their HIV/AIDS prevention response. According to the following two respondents, as health professionals they would talk about and promote condoms when necessary:

We've got doctors with us on the programme who are free to talk about [condoms], and that's where you find it's a bit [tricky]... We are [an FBO] doing the programme, but also we've got doctors who are implementing the program. For example the one doing home-based care, she's a nurse by profession. And she's attached to the programme, and it's where she'll talk about it (condoms) (Anglican organization, respondent #59).

In fact we've been talking about condoms, depending on the environment. [...] I know yes we sometimes go against what they (the Anglican Church) want, but with my profession, and the health centres profession, people and their profession, sometimes we meet with people, whom ourselves we think, telling this guy that you have to wait until marriage, it sometimes becomes very difficult for you (Anglican organization, respondent #61).

It is clear from the above quotations that respondents' approach to HIV/AIDS prevention was influenced by their profession and professional understanding of HIV/AIDS. As discussed above, compared to the Catholic organization, where actors' professional understanding of HIV/AIDS was at odds with the Catholic Church position and organizational policy on HIV/AIDS, the lack of Church direction regarding HIV/AIDS was regarded by some respondents as tacit permission to use their profession in their HIV/AIDS response, as exemplified by the following quotation:

Ya there's no precedent (within the Church) that you should not really promote condoms, should just say this and this and this. So for use we are happy because they are giving us the room so that we can use our profession as well (Anglican organization, respondent #61).

As the above quotation suggests, respondents saw the use of their profession to mean the inclusion of condoms in their HIV/AIDS prevention approach, which was often seen to be in contradiction to religious directives.

In addition to respondents' professional understanding of HIV/AIDS their HIV/AIDS response, respondents' religious understanding of HIV/AIDS also appeared to play a role. For example, in the following two quotations the respondents discuss how the promotion of condoms within HIV/AIDS prevention is the equivalent to promoting sexual intercourse and encouraging adultery, beliefs that are commonly associated with religious understanding of HIV/AIDS and HIV/AIDS prevention:

When you promote condoms it means you promote sexual intercourse (Anglican organization, respondent #62).

I don't see the need or the importance of telling people to use condoms. Because people have different understandings, some of them will think, will take it as you've allowed them to commit adultery. [...] So for me I wouldn't promote condoms (Anglican organization, respondent #64).

It is clear from the above quotations that these respondents did not believe condoms should be promoted within HIV/AIDS prevention, despite their professional roles within the organization. As a result of these beliefs, the respondents chose not to promote condoms. It is unclear why respondents' religious understanding of HIV/AIDS within the Anglican organization took precedence over their professional understanding, while this did not appear to happen within the Catholic organization.

Due to the contentious nature of condoms within the Anglican community, it is possible that the Church's lack of direction and the organization's lack of formal policy is a way of ensuring that the organization is able to maintain a professional bio-medical approach to HIV/AIDS without creating controversy. If the Church was to tell the organization to promote condoms, for example, it is likely there would be resistance within the Anglican community, as was experienced in northern Tanzania. However, if the Anglican Church was to tell the organization not to promote condoms, it would restrict staff's use of their professional bio-medical understanding of HIV/AIDS within the organization's overall HIV/AIDS approach. If this is the case, this approach can be contrasted with the Catholic Church's overt resistance to condom promotion which is encouraged within their subsidiary organizations and restricts staff's approach to HIV/AIDS. The lack of organizational policy, however, has also meant that

not all actors are promoting a bio-medical perspective within the organization, instead promoting their religious understanding of HIV/AIDS. As a result, there are conflicting approaches to HIV/AIDS prevention within the organization.

In summary, actors and actor-related factors play an important role within the policy process. The organization's relationship with the Anglican Church is mediated through the Bishop and Board of Directors, whose role is to oversee the running of the organization and ensure it works according to their vision. At the same time, however, the organization was specifically created to be separate from the Anglican Church, and the Bishop and Board of Directors actively chose not to tell the organization how it was to respond to HIV/AIDS. For many respondents this was interpreted as tacit permission to promote a bio-medical understanding of HIV/AIDS, as opposed to a religious one. Despite the organization's separation and lack of direction from the Church, other respondents believed their role as an Anglican faith-based NGO was to promote a religious understanding of HIV/AIDS. These beliefs appeared to be based on actors' perception of the Anglican Church's position on HIV/AIDS, such as whether they regarded the Church's silence as tacit permission to promote condoms. The absence of both external and organizational policy therefore meant that actors decided how they were going to respond to HIV/AIDS prevention, and how much of this response would be influenced by their professional and/or religious understanding of HIV/AIDS. As a result, conflicting approaches to HIV/AIDS prevention were found within the organization.

6.7 Key Findings

Although many factors were found to influence the HIV/AIDS prevention policy process within the organization, three key factors were found. Firstly, despite the Anglican Church's position against condoms, it appears that the Anglican Church has actively chosen to remain silent regarding this issue. The organization, for example, has not been told how it must respond to the HIV/AIDS epidemic and what it should or should not promote. At the same time, there is evidence to suggest that the organization was specifically created to remain separate from the Church, allowing it to maintain a more flexible professional approach to HIV/AIDS prevention, which may be why the organization has not received direction from the Church. This may be evidence of the Anglican Church being more flexible towards issues of sexuality, wanting to promote a professional bio-medical understanding of HIV/AIDS without creating controversy within the Anglican community. At the same time, it may also be evidence of the role faith-based NGOs play within overall faith-based HIV/AIDS response efforts. Although faith-based

NGOs are affiliated to churches, for example, their identity as an NGO may allow them to maintain a degree of independence and flexibility in their overall approach. Within this study there is evidence to suggest that the Anglican NGO was specifically created to circumvent religious directives that restrict the Church's HIV/AIDS response; however, as this was not the case with the Catholic organization, this is an area that requires further exploration.

Secondly, in addition to the lack of direction from the Anglican Church discussed above, there was no policy within the organization outlining how actors were to respond to HIV/AIDS. While the lack of policy may be seen as a strategy to maintain a professional bio-medical approach to HIV/AIDS without creating controversy, it also meant the organization lacked a clear strategic direction and HIV/AIDS response. As a result, contrasting approaches to HIV/AIDS prevention were being implemented within the organization. And thirdly, as a result of a lack of external and internal policy direction, actors' professional and/or religious understanding of HIV/AIDS, accompanied by their perception of the Anglican Church's stance on condoms, played a large role in their HIV/AIDS prevention approach. Some respondents, for example, interpreted the Anglican Church's silence as tacit permission to use a professional approach to HIV/AIDS that included the promotion of condoms. While others believed that because the Anglican Church was against condom promotion, as an Anglican faith-based NGO they should not promote condoms. The lack of policy within the organization itself meant that both positions were neither confirmed nor opposed, leading to contrasting approaches to HIV/AIDS prevention.

6.8 Chapter Summary

There are multiple factors influencing the policy process within the organization. The factors presented were found to be most prominent, and included the processes and structures of policymaking within the organization; the religious, government, donor, and community and cultural context in which the organization works; external actors such as the Bishop and Board of Directors with direct influence on the policy process; and actors' professional and religious understanding of HIV/AIDS. The organization's HIV/AIDS prevention policy content is influenced by the interaction between these factors. Policy content is the output of the policy process, and includes both written and unwritten policy as well as practice. Within the organization no external or internal formal HIV/AIDS policies were found. No external or internal HIV/AIDS prevention policy meant that there was a policy vacuum within the organization. As a result, respondents' approaches to HIV/AIDS prevention were influenced by

their professional and/or religious understanding of HIV/AIDS, resulting in contrasting approaches to HIV/AIDS prevention within the organization. In addition to the Catholic and Anglican organizations, the factors influencing the HIV/AIDS prevention policy process of faith-based NGOs were also explored within a Muslim NGO, the findings of which are discussed in the following chapter. The findings from each of the three organizations are compared in Chapter 8.

Chapter 7 – Policy Processes within the Muslim Organization

7.1 Introduction

This chapter explores the factors influencing the HIV/AIDS prevention policy process within the Muslim NGO. As with the previous two chapters, the factors are presented in relation to the conceptual framework, according to process, context, and actors, and how these inter-relate to form content, in terms of policy and practice. The role of faith will be explored within each factor where applicable. As stated previously, although government and donors can be considered actors, within the chapter they are discussed within context as no immediate government or donor actors were found to directly influence the policy process, only aspects of each, such as policies or guidelines. While the key factors, such as the religious, government, donor, community and cultural context, and actors' understanding of HIV/AIDS, are similar to the Catholic and Anglican organizations, how these factors influence the overall policy process differs. These differences are highlighted within the chapter, and will be further explored in Chapter 8 when the findings from all three organizations are compared.

The process, context, and actor factors below are not exhaustive, but are those which were identified as most influential within the organization's HIV/AIDS prevention policy process. The quotations are based on interviews with respondents from the Muslim organization, unless otherwise indicated. The chapter begins by providing an overview of the organization and its HIV/AIDS prevention approach, followed by a discussion of the structures and processes of policymaking within the organization, and the context and actor-related factors important to the policy process. How these factors inter-relate to form the content in terms of written and unwritten policy and practice is discussed throughout the chapter. The chapter concludes with a summary of the main findings.

7.2 Overview of Organization

The United Muslim Fighters Against AIDS (UMFAA) is a non-governmental Islamic organization. UMFAA began its activities in 2000, and was officially registered in 2001 under RITA (Registration, Insolvency, and Trusteeship Agency) in Dar es Salaam. UMFAA can be described as a faith-based non-professional volunteer organization: an organization that self-identifies itself as faith-based and is made up of non-professional volunteers within the community. According to respondents, UMFAA was the first Islamic organization working in the area of

HIV/AIDS to be registered in Tanzania and was formed in response to the Muslim community's sparse knowledge of HIV/AIDS. At its inception, four sheikhs (religious official or leader) jointly approached UNICEF, who subsequently sponsored a project on life skills for sheikhs. The sheikhs then approached Imams (male prayer leaders in mosques) and madrasa (schools for teaching Islamic theology) teachers to join the organization. According to respondents, UMFAA's main aim is to fight the HIV/AIDS pandemic by empowering Muslim communities and individuals to fight against HIV/AIDS through promoting Islamic values, as explained by the following respondent:

United Muslim Fighters against HIV/AIDS is an institution, [a] non-governmental institution. It deals with fighting against HIV/AIDS to the Muslim and non-Muslim people in Tanzania. And we are working regarding the government seculars (government policy) and Muslim regulations so that we are trying to empower people to fight against HIV/AIDS (UMFAA respondent #45).

The organization's constitution lists 11 objectives, which include educating people about HIV/AIDS, receiving and distributing aid, preparing seminars and publishing material on HIV/AIDS, and promoting Islamic culture. Figure 14 provides a list of UMFAA's objectives as listed in its constitution:

Figure 14 – Objectives of UMFAA

1. To educate children (students) and adults about AIDS through MASJID, MADRASA, DAY CARE CENTRES, P/SCHOOLS, SECONDARY SCHOOLS, UNIVERSITIES, AND FUNERAL CELEBRATIONS, and also to establish, manage, maintain and develop DAY CARE CENTRES for children affected by HIV and AIDS.
2. To receive grants, donation[s], aid, Swadaka, and Zakaht from organization[s], governments or individual[s] inside and outside the country [...].
3. To receive and distribute all humanitarian aid.
4. To print and/or publish newspapers, magazines, books or any other kinds of literature for the purpose of disseminating Islamic knowledge in fighting against AIDS.
5. To impart Islamic knowledge to Muslims especially youth which can create [a] conducive environment for them to adopt in practice the Islamic way of life.
6. To engage in or undertake any business or venture falling and/not prohibited under Islamic SHARIA for the purposes of generating funds for finances of UMFAA.
7. To own or acquire movable or immovable properties adequate and necessary for facilitating [and] carrying out object[ives].
8. To prepare SEMINAR WORKSHOP and to print or publish newspapers, magazines, books, or any other kind of education regarding AIDS.
9. Facilitate contact and communication between Muslim and non-Muslim leaders and promote harmony, mutual respect and peaceful co-existence between followers of various religions and/or philosophies in order to unite together and fight against AIDS and other disease[s].
10. Enable and/or encourage Muslim and non-Muslims to acquire higher academic qualifications and become more aware[] about [the] disease (HIV/AIDS).
11. Promote Islamic culture and/or social activities and enable and/or encourage Muslim[s] [and] non-Muslim[s] to lead a healthier and more enjoyable life.

(Source: UMFAA, 2001)

Although most of UMFAA's objectives relate to HIV/AIDS, they include a diverse and ambitious number of activities, many of which the organization was not involved in at the time of data collection due to limited capacity.

According to respondents, from 2001 to 2008 UMFAA worked with UNICEF, UNAIDS, Global Fund, TACAIDS, the Ministry of Health, Family Health International, and USAID on specific

projects. The organization's activities included: life skills training for Muslim leaders (2001), Community Mapping and Theatre Against HIV/AIDS (COMATAA) (2002-2006), formulation of and participation in Council Multicultural AIDS Committees (CMAC) (2003), training of trainers for Muslim Family Health Life Education (MFHLE) (2006), stigma and discrimination education to sheikhs, madrasa teachers, and the Muslim community (ongoing), and home-based care (HBC) support (ongoing). At the time of data collection many of the above projects had been completed and UMFAA was relying solely on members' contributions with no external donor support. In addition, the organization's main activities included support for PLWHA through home-based care, and ad hoc HIV/AIDS prevention education, as exemplified by the following quotation:

UMFAA is an Islamic organization and is working on HIV/AIDS prevention. What we are doing is to give education, especially on how to take care of a person who is HIV positive. And this education is divided into groups. The first one is to educate people especially on stigmatization and what Islam is talking about stigmatization. And the second one is to provide services to people who are suffering from HIV/AIDS (UMFAA, respondent #49).

UMFAA's head office is located in Dar es Salaam. Since its inception it has expanded to include up to eight branches throughout Tanzania. Data collection took place at two of UMFAA's branches: the national branch in Dar es Salaam (denoted here as branch one), which functions as the head office for the remaining eight branches, and a branch in a town in Northern Tanzania (denoted here as branch two). Branch one operates out of a small office in a mosque within Dar es Salaam, while branch two operates out of a donated building within the town. As a whole, UMFAA is not accountable to any coordinating body or structure. According to respondents, however, each branch sends yearly activity reports to the head office (branch one) in Dar es Salaam, which in turn disseminates information to the branches to ensure they are kept informed about UMFAA's activities. The branches access their own financial support and decide which activities to implement. However, according to respondents, the head office has the power to prevent the branches from working if necessary. The branches can therefore be described as semi-autonomous. As a result, UMFAA's activities are not uniform throughout the country. Membership is voluntary, with each member paying a small registration fee and filling out an application form. The number of members varies between branches depending on the size of the community, with the largest reaching up to 100 members. Branch one, for example, had approximately 100 members, while branch two had approximately 25 members. As stated above, all members are non-professional volunteers, meaning they are not paid health or management professionals, such as within the other two organizations.

Although the branches are semi-autonomous, branch two had expected to receive financial or technical support from the head office at the time of inception. According to respondents, however, they have only received limited support from the head office, as exemplified by the following quotation:

I thought that being the headquarters, they might have been ahead of us in many things, but in terms of support we don't get any support, maybe only advice. Because we thought maybe they are ahead of us, they could even support us to secure sponsors, but it's the opposite (UMFAA, respondent #50).

As the above quotation suggests, the head office has limited capacity to support the other branches in their activities. A lack of capacity to secure donors and implement activities was found within each branch. Despite this lack of capacity, branch two appeared to be much more active than branch one, the reasons for which are discussed below. Both branches, however, reported losing members since their inception due to lack of funds and subsequent activities.

According to the constitution, each branch must maintain the core structure of UMFAA by appointing a chairman, secretary general, and treasurer. Other branch roles include: assistant secretary-general, deputy chairman, training coordinator, and planning coordinator. Members are elected into these positions, which make up the branches' management teams. At the two branches, the majority of members on the management team were religious leaders within the community, such as Imams or madrasa teachers. According to the constitution, the role of the chairman is to be the spokesperson and general overseer of UMFAA, preside over all meetings of UMFAA, and submit a policy report to their branch's general meeting. The role of the secretary is to be the chief executive of UMFAA, be the accounting officer regarding UMFAA's funds, and prepare and submit a progress report to the organization's Board of Trustees. The role of the treasurer is to keep a financial record of UMFAA, prepare a balance sheet statement for auditing purposes, and be part of the management of UMFAA (UMFAA, 2001). The roles of the other posts are determined as needed by the individual branches. As will be discussed below, the management team meets separately from the members to discuss organizational activities and complete the above activities. The organization's constitution does not say how long members are to hold the positions of chairman, secretary general, or treasurer within each branch, and at the time of data collection, no election had been held to elect new members into these positions at either of the two branches.

According to respondents, UMFAA has a Board of Trustees made up of the chairman, secretary, administrator, treasurer, and assistant secretary from branch one, each of whom are founding members of UMFAA. According to the constitution, the role of the Board of Trustees is to supervise and manage the organization in good faith, formulate policy guidelines and make rules regarding the administration and operation of UMFAA, prepare progress reports, and meet no less than four times a year. At the time of data collection, however, the Board appeared to be inactive. Throughout the interviews the Board of Trustees was mainly mentioned in relation to the management team, as they were made up of the same members. The Board of Trustees acts on behalf of all branches. According to the constitution, each board member shall hold the office for a term of five years, after which there will be an election. At the time of data collection, however, the members of the Board of Trustees had been the same since UMFAA's inception (minus one member who had passed away).

The following section describes the organization's approach to HIV/AIDS prevention, in terms of policy and practice, followed by an exploration into the process, context, and actor-related factors that shape this approach. As the unit of analysis is UMFAA as a faith-based NGO, and the branches maintain a similar structure and decision-making process, for the most part the branches are not distinguished within the discussion. The branches are identified where differences existed that are important for the study.

7.3 HIV/AIDS Prevention Approach

Since its inception UMFAA has been involved in a variety of HIV/AIDS prevention and mitigation activities. As this study is exploring the factors influencing the organization's HIV/AIDS prevention policy process, only those activities related to HIV/AIDS prevention will be discussed. The following describes UMFAA's approach to HIV/AIDS prevention, which is divided into two categories: (1) community HIV/AIDS prevention, and (2) positive prevention. At the time of data collection UMFAA was not involved in HIV/AIDS prevention among vulnerable groups, although an individual member had worked with commercial sex workers outside of the organization. At the time of data collection the organization had no formal HIV/AIDS policies; as a result, the organization's HIV/AIDS prevention approach has been derived from the data.

7.3.1 Community HIV/AIDS Prevention

Community HIV/AIDS prevention involves educating people at the community level about HIV/AIDS prevention. According to respondents, UMFAA has been involved in a number of HIV/AIDS prevention activities, such as the promotion of life skills, Muslim Family Health Life Education, and community HIV/AIDS education within madrasas, mosques, and at particular life events like funerals and weddings. UMFAA's HIV/AIDS prevention messages mainly revolve around how individuals can protect themselves from being infected by HIV/AIDS, such as by not committing *zinaa* (sinful practices such as pre-marital sex or adultery), the importance of testing before marriage, and life skills. Throughout the interviews, respondents often used the word 'adultery' to depict both pre-marital and extra-marital sexual relations.

UMFAA does not have a formal HIV/AIDS policy. In addition, there was little evidence that external policies, such as government HIV/AIDS policies and BAKWATA's HIV/AIDS policy, were used within UMFAA¹⁴. According to respondents, UMFAA's HIV/AIDS education is taught according to Islamic principles and regulations, which originate mainly from the Quran, as exemplified by the following quotation:

We give people messages on AIDS, and we use books, it's not from our heads [...], and we also use the Quran, what the Quran says about AIDS. The source of AIDS is mainly sexual contact between a man and a woman. We go back to the Quran and tell people about these verses, where God talks about adultery and what people should not do (UMFAA, respondent #55).

The main cause of AIDS transmission is adultery, sex. But then when you go back to the Quran, it restricts people from engaging, from practicing adultery. So we look at what the Islamic religion says about AIDS, and apart from adultery look at other means which could cause HIV/AIDS transmission (UMFAA, respondent #57).

As the above quotations suggest, respondents referred to the Quran to formulate their HIV/AIDS prevention messages. As respondents saw the main cause of HIV/AIDS to be adultery (pre-marital and extra-marital sexual relations), verses and teachings from the Quran about adultery were used. As a result, HIV/AIDS prevention education within UMFAA predominately revolved around messages of abstinence for those who were not married and fidelity for those who were. Respondents saw this approach as a long-term solution to

¹⁴ As discussed in Chapter 4, BAKWATA is the National Muslim Council of Tanzania, and is the official apex organization of all Muslims in the country. Its HIV/AIDS policy guide is meant to help coordinate and streamline the Islamic HIV/AIDS response in Tanzania by acting as a guide to direct the Muslim community and its believers within their HIV/AIDS response efforts.

HIV/AIDS, compared to, for example, 'the short way' advocated by the government, which involved condom promotion messages. According to one respondent, although each approach was recognized as having the same aim – to prevent Tanzanians from acquiring HIV/AIDS – the problem of HIV/AIDS would be solved if the government used the same approach towards HIV/AIDS as UMFAA or Islam, as condoms were seen to encourage promiscuity and adultery, as discussed below.

Compared to the Catholic and Anglican organizations, the approach towards condoms within UMFAA was fairly consistent. Like general HIV/AIDS messages, the issue of condoms was taught according to Islamic principles and regulations, as exemplified by the following quotation:

Because Islam, or the Quran, does not allow [people] to engage in adultery, practising adultery, we don't promote condom use, because once you tell people to use condoms, you give them a go ahead that they should go and practice adultery. Because that has been restricted, that people should stay away from adultery, they should not come even close to adultery, so once you tell people to do that, it's like you're now encouraging them to practice adultery, which has been restricted by the holy Quran (UMFAA, respondent #57).

As the above quotation suggests, respondents associated condoms with adultery. As the Quran forbids adultery, condoms were not permitted within the organization. The above respondent was referring predominately to people who were not married. According to many respondents, condoms are permitted in particular circumstances within Islamic regulations, such as with married couples who want to space births, or where one or both are HIV positive. The following respondent, for example, explains how condoms are permitted only within marriage:

When we are talking about condoms, in our regulation, as a Muslim, the condom is permitted, but not to the people who are not in marriage. In marriage is permitted, but out of marriage is not permitted, because when you say everyone can use this you mean, you authorize them to have sex without marriage (UMFAA, respondent #45).

Because condoms are permitted only within certain circumstances, as the above quotation demonstrates, according to respondents there is often misunderstanding and conflict within the Muslim community. One respondent explained, for example, how they had previously believed Islamic regulations did not permit condoms, and it was only after attending a seminar

that they learned Islam permitted condoms in particular circumstances. According to the same respondent, there is still the common belief in Tanzania that condoms are not allowed within Islam, which was exemplified by an incident in 2009 where the retired President of Tanzania, Ali Hassan Mwinyi, was slapped in the face by a Muslim during a speech promoting condom use. As a result of this belief, respondents were careful when bring up the issue of condoms within the Muslim community.

In summary, UMFAA does not have a formal HIV/AIDS policy. Respondents' approach to community HIV/AIDS prevention was influenced predominately by Islamic teachings and regulations, which originate mainly from the Quran. As respondents saw the main cause of HIV/AIDS to be adultery (pre-marital and extra-marital sexual relations), verses and teachings from the Quran about adultery were used. As condoms were seen to promote adultery, community HIV/AIDS prevention predominately revolved around messages of abstinence for those who were not married and fidelity for those who were. Compared to the Catholic and Anglican organizations the approach towards condoms within UMFAA was fairly consistent, meaning no discrepancy between organizational (informal) policy and practice, or diverse practices on the ground, was found. Like general HIV/AIDS messages, the issue of condoms was taught according to Islamic principles and regulations, which do not permit condoms outside of marriage. Because condoms are permitted only within certain circumstances, according to respondents there is often misunderstanding and conflict within the Muslim community regarding condoms. As a result, respondents were careful when bringing up the issue of condoms within the Muslim community.

7.3.2 Positive Prevention

Positive prevention refers to prevention of HIV/AIDS among discordant couples, where one is HIV positive and one is HIV negative, or among couples where both are HIV positive. Similar to community HIV/AIDS prevention, respondents' approach to positive prevention was predominately influenced by Islamic regulations. As discussed above, within Islam condoms were permitted within certain circumstances, such as within marriage for birth spacing or positive prevention, as exemplified by the following quotation:

The Quran accepts the use of condoms, but only in some cases, like when these people are married, I mean the couples who are legally married, but then they are HIV positive, so they are allowed to use condoms. In such circumstances they are allowed to use the condom so as to prevent themselves from infecting each other. And then in the case where people are not married, they are only

using to protect maybe AIDS or pregnancy, Quran doesn't allow that, but for married couples it is allowed (UMFAA, respondent #51).

As the above quotation suggests, as married couples were permitted to use condoms within Islam, respondents would promote condoms in such circumstances. When asked why discordant couples were permitted to use condoms within Islam, and therefore why UMFAA was permitted to promote condom use in such circumstances, respondents explained how it has been inferred from the Quran and other Islamic teachings. According to respondents, for example, although condoms are not specifically mentioned within the Quran, certain passages or teachings have been interpreted to extend to the use of condoms, such as those referring to family planning or medicine. As the following respondents explained:

In the Quran there is nowhere where condom use is mentioned, it is mentioned nowhere in the whole book. But what we know is whenever there is a disease, medicine or a cure can be used. We think that the condom can be used as a cure, to prevent these two married partners from re-infecting each other (UMFAA, respondent #55).

In a case where one partner is infected and one is not, because in Islam there is something that is called barula, which in English it's an emergency, so in such situations it's now the rule, it can be used (UMFAA, respondent #57).

As suggested by the above quotations, within Islam religious texts have been interpreted so as to permit the use of condoms in particular circumstances. These circumstances, however, did not extend to PLWHA who were not married. Because UMFAA's approach to HIV/AIDS is influenced by Islamic principles and regulations, within the organization positive prevention included the promotion of condoms, but only to individuals who were married. In comparison to the Catholic organization, the issue of discordant couples was not a contentious issue. Within the Catholic organization, for example, due to a clash between respondents' understanding of HIV/AIDS and Church policy it created tension at the point of implementation. As the Anglican Church did not have an HIV/AIDS policy, the issue of discordant couples was not contentious within the Anglican organization. At the same time, however, while respondents within the Catholic and Anglican organizations appeared to educate or promote condoms within the community to people who were both married and unmarried, due to Islamic regulations respondents within the Muslim organization would not promote condoms within the community, or would only discuss them in relation to marriage.

In addition to the above, it is important to recognize the potential influence of religious and/or cultural views about gender and gender roles on UMFAA's HIV/AIDS prevention approach. Unlike the Catholic and Anglican organization, HIV/AIDS prevention messages within UMFAA often included explicit messages relating to gender and gender roles, as exemplified in the following quotations:

Because sometimes you find maybe this man still loves his wife, and if that is the case then if they have unprotected sex it means this woman will also be infected and there will be no one to take care of him. So it's to protect this one partner, and to protect the marriage (the use of condoms) (UMFAA, respondent #49).

And we also tell people how to live, for example the dress code, if you are not dressed properly, if a woman is not dressed properly, maybe it can cause men to [commit zinaa] (UMFAA, respondent #55).

In the first quotation, there is the perception that condoms are permitted within a discordant couple in Islam in order to ensure a man will continue to have someone to look after him, while the second quotation appears to place the responsibility of HIV/AIDS prevention on women by dictating how they should dress to not bring unwanted attention. It is important to recognize the influence of such views, as they can disproportionately affect women by re-enforcing certain gender norms and/or blaming women for what is seen as immoral behaviour that spreads HIV infection. As the above quotations suggest, religious views on gender and gender roles played a role in UMFAA's approach to HIV/AIDS prevention.

In summary, no formal HIV/AIDS policies existed within UMFAA. In spite of there being no formal policies within the organization, there was a uniform approach towards HIV/AIDS prevention compared to the Catholic and Anglican organizations. Similar to community HIV/AIDS prevention, respondents' approach to positive prevention was predominately influenced by Islamic regulations. As Islam permits condoms within marriage, respondents would promote condoms in such circumstances. Compared to the Catholic organization, as condoms were permitted within married discordant couples this was not a contentious issue within the organization. However, compared to the Catholic and Anglican organizations, UMFAA did not educate or promote condoms to PLWHA who were not married. Cultural and religious views on gender also appeared to play a role within UMFAA's HIV/AIDS prevention approach. The remainder of the chapter explores the factors that influence UMFAA's HIV/AIDS prevention policy process and approach.

7.4 Structures and Processes of Policy Making

The following discusses the process of policymaking, or decision-making within the policy process, within the organization. The structures described are derived from interviews within the two branches of UMFAA where data collection took place. Overall the structures appeared to be informal, in that they were not regular or well-established, although the extent of this differed between the two branches. As all branches have a similar structure – a chairman, secretary, and treasurer – it is possible that the processes within the branches not included within the study are similar. However, as will be described, the processes between the two branches differed slightly due to a number of factors, such as location, membership base, and number and frequency of activities. As stated previously, these structures are important as they influence who has decision-making power within the organization, what type of power they have, and where they can use that power. Within the organization, the structures and processes of decision-making were predominately participative, involving input from members where possible.

The structures of decision-making at each branch included management meetings, members' meetings and, according to the constitution, a yearly general meeting (UMFAA, 2001). However, the frequency and regularity of the meetings varied between branches, as did the involvement of members in the decision-making process. Within branch one, according to respondents the management team had met previously once a month, and sometimes weekly when there were many activities. After most of the activities stopped due to lack of resources, the management team met less frequently, and at the time of data collection it appeared there were no regular meetings. One respondent commented on how difficult it was for the management team to meet due to outside commitments. During these meetings decisions would be made about which programmes the organization was to be involved in and how they were to be implemented. According to respondents, if members needed to be informed of something a letter was written or telephone call was made.

According to respondents, within branch one member's meetings were held three times a year, with the last meeting held a few months prior to data collection. However, as stated above there appeared to be no regular meetings at the time of data collection. According to one respondent, at the last meeting the discussion revolved around the organization's need for funding. The management team was the main group involved in decision-making within

this branch. At the same time, according to respondents, the members played a large role in the decision-making process, as discussed by the following respondents:

As an individual it's difficult to have a voice, or to have a decision, as an individual. But as members, yes we have power to talk about something and decide (UMFAA, respondent #57).

Yes members have an influence because it is our right. We are the ones who decide which activities, to agree with what the management is saying. [...] The management cannot amend what the members agree. The leaders are not there just to dictate, they also have to involve the members, and together we agree what to be done or not. So the members have that power (UMFAA, respondent #58).

As demonstrated above, the management team and members all had a role within the decision and policymaking process in branch one. According to respondents, the management team, however, had greater influence, which is likely due to the large size of the branch and frequency of the different meetings. Due to the branch's location within a large city and the large number of members, for example, the management team appears to play a more predominant role in the decision-making process compared to the other branch, which is discussed below.

Within branch one some respondents expressed concern over the way the organization was run. One respondent explained how members outside the management team found it difficult to believe that the organization lacked resources, and there was suspicion from the members that the management were hiding something. Another respondent expressed concern over the fact that elections had not been held for the key positions on the management team since the organization's inception. This same respondent described what they saw as a lack of unity in the management team, which they believed had possibly led to their inability to organize themselves to apply for and receive funding. This may, however, be the result of poor communication within the branch itself, as according to respondents up to three funding proposals had been written by the management team which proved to be unsuccessful.

Similar to branch one, branch two held management and members' meetings; however, these appeared to be more regular. According to respondents, in the past both management and members' meetings were held regularly twice a month, which had recently been reduced to once a month. Additional meetings were held as needed, such as when there was an increase of people within the community that needed help. In addition to the three key positions,

within this branch the positions of deputy chairman and planning coordinator were created, who sit on the management team, along with a representative from the members. According to respondents, the management team first meets together to discuss issues, which are then brought to the members. Respondents explained how during these meetings, discussions are held about the organization's upcoming activities, achievements, organizational challenges, possible improvements, future plans, as well as the needs of PLWHA.

Branch two's decision-making process appeared to involve both the management team and members equally, which is likely due to its small number of members and location, which made it easier for members to attend meetings. According to respondents, decisions about what services and programmes to provide, in addition to what HIV/AIDS messages to tell people, were decided as a group:

We meet together, there is no particular person who makes the decision, but normally we sit together and agree on what to do and what not to do, it's not one person's responsibility to decide. The leaders are just there as leaders, but when it comes to decisions it's all of us, we sit together (UMFAA, respondent #51).

The meetings, we sit, it's where we (members) agree what to do. And also what follows, after we decide what to do then the resources, where we will get the resources. And then once we get everything we now embark to the training or to those services (UMFAA, respondent #52).

As the above quotations demonstrate, the decision-making process within this branch was participative, involving all members within the process. According to respondents, all issues were taken to the members for discussion, who would decide as a group what to do. Compared to branch one, members in branch two appeared to much more involved in the decision-making process.

As discussed above, the differences between the decision-making process within the two branches, such as the frequency of meetings and collaborative nature of the process, appeared to be the result of a number of factors. The branch location, for example, whether in a large city or small town, appeared to influence members' ability to meet, in addition to how easy it was for members to travel to the organization's main office and the number of members within each branch. This would then influence the number and frequency of the organizations' activities, which is also influenced by how much members were involved in activities outside the organization. The leadership structure also appeared to contribute to the differences in

the decision-making process between the two branches. How effectively the management team worked together, for example, whether members' trusted the decisions and actions of the management team, and how effectively the management communicated and involved the members all appeared to influence the process.

In summary, compared to the Catholic and Anglican organizations, the policy and decision-making process within UMFAA was much more informal and collaborative. While branches had a uniform management structure and management and members' meetings, differences existed between the two branches' structures and processes of policymaking. These included the frequency of meetings and collaborative nature of the overall process, which appeared to be the result of differences in branch location, number of members, and leadership structures. Despite these differences, the overall process within each branch was similar in its informal and collaborative nature. In addition to the process factors described above, contextual factors were also found to influence the HIV/AIDS prevention policy process, which are discussed in the following section.

7.5 Contextual Factors Influencing Policy Process

Similar to the Catholic and Anglican organizations, the contextual factors presented refer to factors that are external to the organization, which include the overall local, national, and international context in which the organization is situated. The contextual factors relate to the Tanzanian context that was discussed in Chapter 4, as well as the international context that was discussed in Chapter 2. The factors below are not exhaustive, but are those which were identified as being most influential in the HIV/AIDS prevention policy process of the organization, and include the religious, government, donor, and community and cultural context. While these factors are similar to the Catholic and Anglican organizations, they differ in how they influence the organization's policy process.

7.5.1 Religious Context

Unlike the Catholic and Anglican organizations, UMFAA is not a subsidiary of a larger religious organization. UMFAA is therefore not accountable to a Muslim organization in the same way that PASADA is accountable to the Catholic Church or the Anglican organization is accountable to the Anglican Church. However, as a faith-based organization, UMFAA is part of a wider religious context or structure. Part of this structure includes the Islamic context within Tanzania. For reasons discussed in Chapter 4, the Muslim community within Tanzania is much

less involved in health and HIV/AIDS than the Christian community. According to respondents, UMFAA was the first Islamic organization in Tanzania to work on HIV/AIDS. BAKWATA, the National Muslim Council of Tanzania, which is the official apex organization of all Muslims in the country, soon followed suit with the launch of a national HIV/AIDS program known as BAKWATA National HIV/AIDS Program (BAK-AIDS). In addition, BAKWATA developed a policy guide, *Islam and AIDS: AIDS Policy Guide*, which is meant to provide “a rational approach to the fight against HIV/AIDS according to Muslim principles” (BAKWATA, 2007: 4), and guide the Muslim community and its believers in their HIV/AIDS response efforts. Although UMFAA is not accountable to BAKWATA, according to respondents, BAKWATA’s policy is used within the organization. For a summary of BAKWATA’s HIV/AIDS policy see section 4.7.2 in Chapter 4. However, while respondents reported using this policy, there was little evidence of its actual use with the organization.

Compared to the Catholic and Anglican organizations, which are bound together by a coordinating institution (as well as their profession), UMFAA and its members appeared to be bound together by their interest in HIV/AIDS and mutual faith – Islam. Within Islam, the Quran (as well as other religious texts such as the Hadith) is used as a guiding principle, in which codes of conduct are derived. Within the Quran, codes of conduct refer to all aspects of life, from which HIV/AIDS is no exception. Within the Muslim community, for example, quotations are often used from the Quran and the Hadith to educate and guide people on how to live in relation to HIV/AIDS, which include codes of conduct relating to sexual behaviour and gender roles. Although there is no specific passage about HIV/AIDS in the Quran, respondents described how HIV/AIDS was predicted through passages describing how Allah would bring disasters and diseases and hide the cure if people continued to commit adultery and other sins. According to respondents, people could prevent HIV infection if they followed the codes of conduct described in the Quran and Hadith, such as staying away from *zinaa* (pre-marital sex and adultery). As the following quotations demonstrate, UMFAA’s HIV/AIDS prevention approach was influenced by Islamic teachings:

[We] educate people on the religious teachings, what does the Quran say [on] these issues. HIV/AIDS is increasing, the cases are increasing, because people are engaging into, they are committing adultery. So we are teaching people not to commit adultery and to follow the teachings (UMFAA, respondent #49).

So many people have written about HIV/AIDS. But us as UMFAA, or myself as a religious teacher, I use the Quran because the Quran has talked a lot about HIV/AIDS or any diseases. It’s talked about the diseases, any diseases that will

come. So we use the Quran and Prophet Muhammad's teachings, what he's saying about HIV/AIDS. Although we sometimes refer to these other books from other writers, for us as UMFAA it's basically the Quran (UMFAA, respondent #58).

It is clear from the above quotations that Islamic teachings, derived predominately from the Quran, play an important role within UMFAA's HIV/AIDS education, informing respondents' understanding of and approach to HIV/AIDS. As explained in the second quotation above, although other books about HIV/AIDS are also used, the Quran is the predominant source for information about HIV/AIDS prevention.

The role and influence of Islam in UMFAA's approach to HIV/AIDS is evidenced in Figure 15, which provides the text from a brochure on AIDS and Islam distributed by the organization. The brochure describes how *zinaa* is seen as the cause of HIV/AIDS, and by staying away from *zinaa* people can prevent HIV infection:

Figure 15 – UMFAA Brochure – AIDS and Islam

AIDS and Islam (*translated from Kiswahili*)

THANK GOD MOST GRACIOUS, MOST MERCIFUL

AIDS has become a chronic issue that could not have been predicted by people on earth. In Islam we are aware of the issue and are busy looking at where we fell instead of what made us fall in order to not treat the wrong thing.

Ways to protect ourselves from AIDS

God *Subhanah Wataala* (glorified and exalted be He) has warned us not to commit *zinaa* in the Quran line 32 Suratul Israa by saying: "Do not commit *zinaa* because *zinaa* is dirty and it is going against God's will'.

What does committing *zinaa* mean?

Committing *zinaa* includes using your body parts by looking, listening or touching a person of different sex and hence letting the emotions and feelings lead to committing the act. *Zinaa* is committed by many people including young people and older people. Therefore it is important that every person use their capacity to be able to protect themselves and distance themselves from committing *zinaa*. This will help in controlling the infection of sexually transmitted diseases including HIV/AIDS. [...]

How to deal with temptations

Where there is God, there are good and positive benefits for those who follow him and his teachings and avoiding all the issues that he has condemned through His Prophet Muhammad (SAW), by doing so Satan cannot get into a good Muslim. Remember that if you are together and conform to Gods' teachings and those of his prophet you will be saved from all tragedies including HIV/AIDS.

What we see in our community

As Muslims we are required to follow the commandments of God and His Prophet Muhammad (SAW). HIV/AIDS is a message from God to us his followers that we can see. The prophet said there will be five tragedies, among them is *zinaa* which is going to kill a lot of people in the world. In reality nobody can object to the widespread of *zinaa* in the world in general. Imagine all the night clubs leading to such behaviours [...] while technology is affecting how people dress. Like Prophet Muhammad (SAW) said, *zinaa* will cause a lot of deaths. Many tragedies are happening in the world that are associated with *zinaa*. AIDS has killed and is continuing to kill and leaving others in painful circumstances, children left behind suffering alone with no parents to take care of them. Therefore they lack their basic rights like education. A death caused by AIDS alone reduces productivity.

This situation proves that *zinaa* has a lot of negative effects in the community. Prophet Mohammed said that it is because of *zinaa* we are witnessing all the sad deaths. In the past decades there was no one disease that did not have treatment for such a long time like AIDS. Therefore as Muslims this is a lesson from God, so we need to bow before him and change our behaviours. Let's stop committing *zinaa*.

If we believe this is a lesson from God we must keep in mind the following:

1. Let's grow with prophet Muhammad's (SAW) teachings
2. Teachings about the rights of the God's followers
3. Wear Muslim style clothes that reduce the urge to get involved in *zinaa*
4. We must be firm in our faith
5. We should fear the day when people will be paid according to their actions
6. To remove/eliminate unnecessary gatherings of both sexes, male and female

REMEMBER MUSLIMS

IT IS NOT ALLOWED FOR YOUNG PEOPLE TO COMMIT ZINAA BEFORE OR AFTER MARRIAGE.

(UMFAA, undated)

As the brochure demonstrates, Islam plays a large role in UMFAA's approach to HIV/AIDS. Normative religious discourse is used throughout the brochure, which espouses the view that HIV/AIDS is a lesson from God for committing sinful acts known as *zinaa*, and the only way to prevent HIV infection is to not commit *zinaa* by resisting temptation. It also emphasizes the role of religious teachings and faith within HIV/AIDS prevention. The brochure is therefore evidence of the influence of religious discourse within UMFAA's HIV/AIDS prevention approach, which was found to be much greater than within the Catholic and Anglican organizations.

Due to the belief that HIV/AIDS is caused by adultery and other sins, it is common within Islam for HIV/AIDS to be viewed as a punishment from God. This view, however, was only overtly expressed by one respondent who, instead of seeing it as a way to condemn PLWHA, saw it as a reason why PLWHA should be supported and encouraged:

As Muslims we encourage those people, those who are suffering from AIDS, we encourage them. I mean the main thing is to encourage them, it's a disease like any other but it could be because of the deeds that somebody did. It's like a punishment from God. So the more important thing is to encourage this person who is suffering from AIDS to persevere, not to give up, not to lose hope. To just depend on God, because it can be a punishment from God, that's why somebody got AIDS (UMFAA, respondent #57).

As the above quotation demonstrates, this respondent viewed HIV/AIDS as a punishment from God. Despite not using this belief as a justification to condemn PLWHA, which has been common among FBOs in the past, this belief has been proven to perpetuate stigma within the literature by blaming the individual for their HIV/AIDS status, which was discussed in Chapter 2. While it is not known whether this view is held by other members within the organization, it is possible that due to the emphasis placed on the Quran within the organization, and the Quran's statements that Allah would bring disease if people continued to commit *zinaa*, this view is more common within the organization than has been suggested. It is possible that the organization is perpetuating stigma through the use of religious principles and regulations; however, this in an area that would require further exploration.

In summary, while UMFAA is not a subsidiary of a larger religious organization, it is situated within a wider religious context. Part of this structure includes the Islamic context within Tanzania, which includes the role BAKWATA, the official apex organization of all Muslims in the country. Respondents reported using BAKWATA's HIV/AIDS policy as a guide within the organization, although there was little evidence of its actual use. Unlike the Catholic and Anglican organizations, which are bound together by a co-ordinating institution, UMFAA and its members appeared to be bound together by their interest in HIV/AIDS and shared faith – Islam – through which the Quran is used as a guiding principle. The organization's HIV/AIDS prevention approach is therefore influenced by Islamic regulations and teachings, and is similar to the approach advocated within BAKWATA's HIV/AIDS policy. Within the organization, for example, quotations are often used from Islamic texts to educate and guide people on how to live in relation to HIV/AIDS, which include codes of conduct relating to sexual behaviour and gender roles. Compared to the Catholic and Anglican organizations, the influence of religious discourse on the HIV/AIDS prevention decision-making and policy process was much greater.

7.5.2 Government Context

UMFAA appears to have a very limited relationship with the government in Tanzania, despite the government, according to respondents, having “opened its doors” to faith-based

organizations in the fight against HIV/AIDS. According to one respondent, for example, when the government was developing its national HIV/AIDS policy UMFAA was invited to a consultation meeting to gather religious leaders' opinions about the policy. Respondents also discussed how organizational reports were sent to the district level, and within branch two local government leaders were used to publicise UMFAA events and gather people together. At the same time, respondents explained how they had on numerous occasions applied for funding from TACAIDS, but received no response or feedback, despite having worked with TACAIDS on two projects in the past.

Each branch reported how it worked within the frame of the national HIV/AIDS policies; however, there was no evidence of the physical policy documents. According to some respondents it was mandatory for UMFAA, as an organization working on HIV/AIDS, to use national HIV/AIDS policies (despite there being no evidence that such policies were used within the organization). Many respondents viewed the government's approach to HIV/AIDS as similar to UMFAA's approach, as the aim of each approach was regarded as the same – to save the lives of Tanzanians. According to respondents, the main difference between the two approaches was in relation to the role of condoms, as exemplified by the following quotation:

What differs is what the Quran says about HIV/AIDS. Most of those things which are in the national health policy, they are also in the Quran. [...]. They differ on the use of condoms, because the Quran doesn't say directly, people should use condoms, while in the policy it's there. The difference is that the Quran allows the use of condoms, but only in particular instances (UMFAA, respondent #49).

As the quotation above suggests, while the government advocates for the use of condoms in all situations, the Quran only permits condoms in certain circumstances, as was discussed above.

According to respondents, although both the government and UMFAA have the same ultimate aim, the government's approach is not a viable long-term solution to the epidemic. As discussed above, some respondents viewed the government's approach to HIV/AIDS as the 'short way', and UMFAA's approach as the 'long way'. One respondent even condemned the government's approach as fuelling the epidemic, mainly through the advertising of condoms and by allowing alcohol in bars. Within the organization it was argued that if the government were to adapt UMFAA's approach, the problem of HIV/AIDS would be solved.

In summary, although the government was seen to be welcoming and supportive of faith-based organizations working in the area of HIV/AIDS, the government's relationship with UMFAA was limited. Respondents explained how reports were sent to the district level; however, beyond this the government appeared to have little influence in the organization. In addition, respondents complained how, despite having worked with UMFAA on a number of projects, TACAIDS gave no response or feedback to funding proposals. The main difference between the government and UMFAA's approach to HIV prevention was the role of condoms, which were only permitted within marriage within Islam. According to respondents, UMFAA worked within the framework of the national HIV/AIDS policies, and the ultimate aim of both approaches was seen as the same. At the same time, however, many respondents criticized the government's approach as it was not seen as a long-term solution to the HIV/AIDS epidemic. According to respondents, if HIV/AIDS was to be effectively addressed, an Islamic approach was needed.

7.5.3 Donor Context

At the time of data collection UMFAA did not have any external donors and relied solely on contributions from individual members. At its inception in 2001, UMFAA was sponsored by UNICEF, the United Nations Children's Fund, to undertake the training of sheikhs on HIV/AIDS. UNICEF also sponsored members of UMFAA to travel to Thailand to learn how leaders there were working with HIV/AIDS. Since this time, UMFAA has collaborated with other organizations, such as BAKWATA, TACAIDS, and Family Health International, however these organizations did not provide funding. According to respondents, although UMFAA has submitted funding proposals to various organizations, it has been unable to secure funds since UNICEF's support. According to a respondent at UNICEF, since 2001 the funding structure at UNICEF has changed. Instead of funding organizations directly, UNICEF now contributes to the Rapid Funding Envelope (RFE). The RFE is a basket-fund established in 2002 by TACAIDS and nine donor partners, the aim of which is to allow civil society institutions to participate in the national multi-sectoral HIV/AIDS response (RFE, 2006). According to this respondent, individual organizations must now apply directly to the RFE for funding, instead of UNICEF. It is therefore possible that this new funding structure has contributed to UMFAA's inability to access funding due to their limited capacity as a non-professional membership organization, which is discussed below.

Many respondents viewed the organization's inability to access funding as a challenge. As mentioned above under government context, according to respondents funding bodies do not reply to proposals, meaning respondents were unaware why they failed to secure support. One respondent queried whether the organization has had difficulty obtaining funding due to its name – the United Muslim Fighters Against AIDS, as it was wondered whether after 9/11 international donors were worried about sponsoring an organization with 'Muslim fighters' in the title. Another respondent questioned whether donors were favouring other religions; while another thought it might be because there were so many NGOs working in the area of HIV/AIDS in Tanzania. Other reasons included the lack of people to write funding proposals in the organization and a lack of unity among the management team. Although many reasons were given as to why UMFAA was unable to acquire financial support, a lack of capacity amongst its members to compete within the structure and requirements of the aid industry appeared to be an important factor, such as the ability to speak and write in English.

According to respondents, the lack of financial support meant that UMFAA was unable to do as much as they would like and were restricted to activities that require little to no funding. According to respondents, this led to negative perceptions from the community about UMFAA, who did not believe that it had no financial support and were instead giving out a fraction of what they received from donors, as exemplified by the following quotation:

Some of the challenges that we face, especially these people who are living with AIDS, when we invite them for training or something, these people they don't believe UMFAA [is] just doing that voluntarily, that we don't have any support. So for them they think maybe UMFAA gets money or support from somewhere, but then what we give them is just very little compared to what we get from maybe the support of donors. That's a problem. Very few of them believe that UMFAA is working on a voluntary basis, we just depend on our own contributions. The majority will think that UMFAA has a lot of money and maybe their resources, they don't want to distribute them (UMFAA, respondent #51).

Within branch one, members also held suspicions that the management team were withholding funds from its members. As the above quotations suggests, these suspicions appeared to be grounded in the belief that there is a lot of easily accessible money in the area of HIV/AIDS and NGOs working in this area have a lot of money. Due to this lack of financial support, the organization relied on contributions from its members, which went mainly to care and support of PLWHA (buying food and other supplies), as well as running the office. Both branches reported losing members due to a lack of financial support and activities.

In summary, at the time of data collection UMFAA did not have any external donors and relied solely on members' contributions, which were used mainly to support PLWHA and run the office. At its time of inception, UMFAA was supported by UNICEF, but has since been unable to acquire additional funds. According to respondents, UMFAA's activities are limited due to its lack of financial support, which has led to a loss in membership. Various reasons were given as to why UMFAA was unable to acquire funds; however, the organization's lack of capacity to compete within the structure and requirements of the aid industry appeared to be an important factor. According to respondents, UMFAA's inability to acquire funds led to suspicions within the community and amongst its members that UMFAA was withholding funds.

7.5.4 Community & Cultural Context

The role of the community within UMFAA was predominately discussed in relation to the Muslim community, although one or two respondents mentioned working with people from other faiths. A motivation for starting UMFAA was the recognition that while HIV existed in Muslim communities, the community did not understand or know anything about HIV. Respondents discussed how, at the time of data collection, a lot of education about HIV/AIDS was still needed within the Muslim community, and in some villages people were reluctant to attend HIV training due to lack of knowledge and understanding. According to respondents, a particular challenge within the Muslim community was the association of HIV/AIDS with the promotion and use of condoms. According to one respondent, such misunderstandings meant that people often assumed talking about HIV/AIDS meant that one had to entertain the use of condoms. Another respondent described the threat of violence from the community itself as a concern when talking about HIV/AIDS and condom use, and the example of the former president being slapped by a Muslim after mentioning condoms (as mentioned above) was given by a number of respondents. As a result, although condoms were permitted within marriage, whether respondents discussed condoms often depended on whether the environment was viewed as conducive.

As discussed above, decision-making within the organization is predominately collaborative, meaning members decide as a group what their HIV/AIDS activities and messages will be. According to respondents, in addition to available resources, decisions are based on members' experiences within the community. At one branch, for example, a program on stigma and discrimination was started as it was recognized as a particular problem within the Muslim

community. At both branches respondents discussed how HIV/AIDS prevention messages were often based on “bad cultures” or practices within the community that could lead to HIV infection. Such cultures that were identified included: the cleansing of dead bodies through sexual intercourse, female genital mutilation, gender violence, widow inheritance, and the use of witch doctors to cure HIV/AIDS. It was unclear whether these practices were regional or particular to the Muslim community. As the following quotation demonstrates, respondents viewed such practices as problems that needed to be prevented:

As UMFAA we teach the community, we talk to the community about those practices, [like] widow inheritance. Because we see that it is a problem, in one way it also speeds up the spread of HIV/AIDS. The majority of the people within the community they need this education just to know that these practices are not good and they should be stopped or dropped (UMFAA, respondent #51).

As the above quotation suggests, respondents’ HIV/AIDS prevention messages were influenced by their experiences within the community and the unsafe practices that the community engaged in. The community and cultural context played a large role in respondents’ HIV/AIDS prevention approach.

In addition, promoting HIV testing before marriage was viewed as an important issue within UMFAA, particularly as polygamy is practiced within Islam. As men are permitted to marry up to four wives, if a new wife was HIV positive, the other wives would be put at risk. While the promotion of faithfulness and trust within such relationships (in order to prevent adultery) was also viewed as an important issue, within such cases abstinence, fidelity, and condom use would be inappropriate HIV/AIDS prevention messages. Therefore, within the organization HIV testing before marriage was seen as a particularly important HIV/AIDS prevention message within the Muslim community.

In summary, the community and cultural context was important within UMFAA, as it informed the organization’s HIV/AIDS activities and messages. Working within the Muslim community was viewed as a challenge by some respondents due to the lack of education and understanding about HIV/AIDS, and perceptions or misunderstandings about the relationship between HIV/AIDS and condoms. Within the organization, many respondents’ decisions were based on their experiences within the community, which included the identification of cultural practices that were seen to spread HIV infection; the issue of testing before marriage was particularly important, as within Islam men are permitted to marry up to four wives.

Contextual factors play an important role in the overall HIV/AIDS policy process within UMFAA. The role of Islam, for example, played a large role in shaping respondents' understanding of and approach to HIV/AIDS, which will be discussed in greater detail below. Respondents reported using both BAKWATA's and the government's HIV/AIDS policies. At the same time, however, respondents did not support the inclusion of condom promotion in HIV/AIDS prevention to unmarried couples, and regarded the Islamic approach to HIV/AIDS as the only long-term solution. The role of donors within the organization was more notable due its absence rather than its presence. Although UMFAA has submitted multiple funding proposals, it has been unable to secure external financial support since its inception, which appeared to be mainly due to its limited capacity to compete for scarce resources. The lack of financial support has limited the organization's HIV/AIDS activities and has appeared to create tensions both within the community and the organization itself. The community and cultural context was particularly important within the HIV/AIDS prevention policy and decision-making process as it played a large role in informing UMFAA's HIV/AIDS activities and messages. In addition to these contextual factors, and the process factors described above, actor-related factors also play an important role in the organization's HIV/AIDS policy process. The following section explores the role of actor-related factors within UMFAA's HIV/AIDS prevention policy process.

7.6 Actor Factors Influencing Policy Process

This section explores the influence of different actors and actor-related factors on the HIV/AIDS prevention policy process within the organization. Only those factors that were found to have most influence are included. Unlike the Catholic and Anglican organization, no external actors with direct influence on UMFAA's HIV/AIDS policy process were found as UMFAA was not subsidiary to a larger organization. This section therefore explores the actor-related factors associated with internal actors, including the management team and members of the organization. Similar to the Catholic and Anglican organizations, the actor-related factors that were found to influence the policy process have been grouped into one overall theme – actors' understanding of HIV/AIDS.

7.6.1 Actor-Related Factors - Actors' Understanding of HIV/AIDS

Actor-related factors are the characteristics of actors found to influence actors' decision-making within the policy process. Actor-related factors are important as they can influence how an actor responds to HIV/AIDS prevention, especially in relation to the other factors discussed above. Compared to the Catholic and Anglican organizations, however, actors'

understanding was found to be predominately influenced by their personal religious beliefs, which appeared to be the result of the organization's identity as a non-professional volunteer organization. Unlike the Catholic and Anglican organizations, members were not medical or public health professionals and therefore lacked the same bio-medical education and understanding of HIV/AIDS as actors within the other two organizations. Members were instead volunteers from the community with an interest in Islam and HIV/AIDS prevention and mitigation.

Many respondents came from a low socio-economic status, which would affect both their ability to receive bio-medical or other types of education, as well as their ability to volunteer, for example due to the amount of time available to volunteer. In the absence of bio-medical education, another source will be used to understand HIV/AIDS and HIV/AIDS prevention, which in this case was religion. Within the organization, for example, Islamic education appeared to be highly valued, and many respondents had a lot of knowledge regarding the Quran and other Islamic texts. A number of respondents, for example, particularly those on the management team, were either Imams or madrasa teachers. As the organization's activities focused on Islam and HIV/AIDS, knowledge of Islam in relation to HIV/AIDS was particularly valued.

Most respondents' decision to join UMFAA was religiously motivated and, because UMFAA focused on Islam and HIV/AIDS in particular, respondents shared Islam as a religion. Some respondents, for example, described how they were interested in joining UMFAA as it focused on HIV/AIDS in the context of Islam. Other respondents described how they saw fighting HIV/AIDS as a religious duty, how they wanted to publicize Islam through the organization and guide people to live a good life, or how they wanted to understand HIV/AIDS better, particularly what Islam says about HIV/AIDS. Respondents' religious motivations for joining UMFAA are exemplified in the following quotations:

I decided to volunteer with UMFAA because I wanted to know much about HIV/AIDS, and thought that if I am outside I won't know, but if I join an institution like this one, I'll be in a better position to understand AIDS. Because AIDS is real, and people are suffering of AIDS. I also wanted to understand better what the Quran says, what the religious teachings are saying regarding AIDS (UMFAA, respondent #51).

Based on my faith, helping the sick, regardless of who they are is one of the basic things in our religion. So when I saw, when I knew about UMFAA and what they do I was interested (UMFAA, respondent #52).

As suggested by the above quotations, respondents' faith was an important factor in their decision to join UMFAA and educate people about Islam and HIV/AIDS. It is clear from the above discussion that Islam influences respondents' understanding of HIV/AIDS, which in turn influences their decision-making process. As discussed above under religious context, respondents used Islamic principles and regulations to guide their HIV/AIDS prevention approach, which resulted in a common understanding among respondents about HIV/AIDS and HIV/AIDS prevention. Because this understanding corresponded to the organization's overall approach, a uniform approach to HIV/AIDS was found within the organization, particularly in relation to condoms.

In summary, respondents' understanding of HIV/AIDS played an important role in the organization's HIV/AIDS prevention policy and decision-making process. As UMFAA was an Islamic non-professional volunteer organization, members were not medical or public health professionals and lacked the same bio-medical education and understanding of HIV/AIDS as respondents from the Catholic and Anglican organizations. At the same time, due to the organization's focus on Islam and HIV/AIDS most respondents' decision to join was religiously motivated, resulting in respondents sharing Islam as a religion. Respondents therefore shared a common understanding of HIV/AIDS and HIV/AIDS prevention. As this understanding corresponded to the organization's overall approach, there was a uniform approach to HIV/AIDS prevention within the organization.

7.7 Key Findings

Many factors were found to influence the HIV/AIDS prevention policy process within UMFAA. It is how these factors inter-relate that forms the organization's HIV/AIDS prevention content, in terms of both policy and practice. The following describes the key factors that were found to inter-relate to form the organization's HIV/AIDS prevention content.

Firstly, as UMFAA is a non-professional volunteer organization, and respondents lacked bio-medical education, respondents did not have the same bio-medical understanding of HIV/AIDS that was found to conflict with Church policy and/or inform respondents' HIV/AIDS prevention approaches within the Catholic and Anglican organizations. Secondly, despite lacking a

coordinating body or structure, like the Catholic and Anglican organizations, the organization itself maintains a strong statement of faith. Although many organizational objectives existed, what was common throughout the policy process was the overall objective of responding to HIV/AIDS through Islam, which in itself has a strong position regarding HIV/AIDS. Compared to the Catholic and Anglican organizations, respondents' decisions to join the organization were religiously motivated, as opposed to professionally, and respondents had a similar understanding about HIV/AIDS based on their shared religion. Thirdly, as a result of the above, despite having no formal policy the organization had a uniform approach to HIV/AIDS based on Islamic principles and regulations. This uniform approach to HIV/AIDS was not only the result of respondents' similar understanding of HIV/AIDS, but the fact that this understanding corresponded with the organization's overall HIV/AIDS prevention approach.

7.8 Chapter Summary

As discussed above, there are multiple factors which influence the organization's overall HIV/AIDS prevention policy process, such as the organization's structures and processes of policymaking, the religious, government, donor, and community and cultural contexts in which the organization works, and actors' understanding of HIV/AIDS. The factors discussed were identified as being the most prominent throughout data collection and analysis. The content of organization's HIV/AIDS prevention approach is influenced by the interaction between these factors.

Within the organization no external or internal formal HIV/AIDS policies were found. At the same time, however, the organization was found to have a uniform approach to HIV/AIDS prevention. This uniform approach was the result of respondents' lack of bio-medical education and understanding of HIV/AIDS, the strong statement of faith within the organization, and respondents' shared religious understanding of HIV/AIDS that corresponded to the organization's overall approach. In comparison, within the Catholic organization respondents' professional understanding of HIV/AIDS was found to conflict with Church policy, while in the Anglican organization the lack of external or internal policy, coupled with respondents different understanding of HIV/AIDS, led to diverse approaches to HIV/AIDS prevention. These comparisons are further explored in the following chapter, which compares the findings discussed in chapters 5-7.

Chapter 8 – Discussion & Conclusions

8.1 Introduction

The last three chapters explored the findings in relation to the three organizations included in the study. Within each chapter the factors influencing the HIV/AIDS prevention policy process were explored in relation to the conceptual framework outlined in Chapter 2. The conceptual framework was developed using Walt and Gilson's (1994) health policy framework, which differentiated between context, actors, process, and content. Within this study, context, actors, and process factors were explored in relation to how they interacted to shape content in terms of policy and practice. In addition, the study explored how faith is reflected in, and interacts with, other factors within this process. This chapter aims to present the study's main findings by comparing and analysing the key factors found to influence the HIV/AIDS prevention policy process within the three case studies. It will do so by addressing three key areas: the influence of faith structure on the HIV/AIDS prevention policy process of faith-based NGOs, government and faith-based NGO HIV/AIDS prevention policies, and the influence of actor-level responses on the HIV/AIDS prevention policy process. The implications of the findings on the original conceptual framework will then be presented with a revised conceptual framework. Finally the chapter will end with a discussion of the implications of the findings for research, policy, and practice.

8.2 Key Findings

The aim of this study was to develop a better understanding of the faith-based HIV/AIDS response by gathering new evidence and gaining further theoretical understanding of the factors influencing the HIV/AIDS prevention policy process, and how faith is reflected in and interacts with these factors, within faith-based NGOs of different faiths. I utilized a comparative case study approach to explore and compare the processes that influence the organizations' HIV/AIDS prevention content, or response. I hope that by understanding these processes, more appropriate policies or responses can be developed and implemented, in terms of their suitability within their local and national contexts. The objectives were to identify and assess what factors influence the HIV/AIDS prevention policy process of faith-based NGOs in relation to process, context, actors, and content; identify and assess the role of faith within the HIV/AIDS prevention policy process of faith-based NGOs; and, identify how the key context, actor, and process factors inter-relate to form HIV/AIDS prevention policy

content, in terms of policy and practice, within each faith-based NGO. Table 7 presents a summary of the key findings that were identified within each organization in relation to the above objectives. It summarizes the key context, actor, and process factors, as well as content in terms of policy and practice. The role of faith is discussed in relation to each factor where applicable. The findings from the three organizations are compared within the final column. As discussed in the methodology chapter, data collection and analysis were influenced by researcher bias. The data were explored, for example, according to my own discipline and belief system. I recognize that if the research was conducted or the data were to be explored from a different perspective, such as by someone from a religious background, the findings and interpretation of the findings may have been different. An avenue for future research would therefore be to approach the study and/or interpret the findings from an alternative perspective. Exploring the HIV/AIDS policy processes within faith-based NGOs from a theological perspective, for example, would uncover many of the theological influences within the policy process that this study may have missed. The key findings from this study are summarized in Table 7 below.

Table 7 – Summary of Key Findings

	Catholic Organization	Anglican Organization	Muslim organization	Main Conclusions
Content	<p>Policy Top-down organizational policy related to Catholic Church position:</p> <ul style="list-style-type: none"> • Promotion of abstinence and faithfulness • Not permitted to promote condom use <p>Practice Discrepancy between organizational policy and practice.</p> <p>Strategies used by staff to mediate between conflicting factors in order to ensure that their HIV/AIDS prevention approach (particularly in relation to condoms) was not only in line with their own professional understanding of HIV/AIDS, but it did not overtly go against the position of the Catholic Church.</p>	<p>Policy No external Anglican Church or internal organizational HIV/AIDS formal policies, despite the Anglican Church being against condom promotion.</p> <p>Church’s silence interpreted as permission to have a professional approach to HIV/AIDS.</p> <p>Practice Diverse practices on the ground – some staff reporting only promoting abstinence and fidelity, while others also reported promoting condoms, in addition to abstinence and fidelity.</p> <p>Actors based HIV/AIDS prevention decisions on individual professional or religious understanding of HIV/AIDS.</p>	<p>Policy No formal organization policy.</p> <p>Organizational objective was to respond to HIV/AIDS through Islam.</p> <p>Practice Use of Islamic principles and values from Quran and other religious texts for HIV/AIDS prevention.</p> <p>Uniform and consistent approach to HIV/AIDS prevention (promotion of abstinence outside of marriage and fidelity within marriage, promotion of condoms only within marriage).</p>	<p>Organizations’ HIV/AIDS policy processes are influenced by interaction between multiple factors, namely faith structure, presence or absence of an organizational formal or informal HIV/AIDS policy, professional or non-professional nature of the organization and its actors, and whether these factors conflicted.</p> <p>All three organizations have policy differences from that of government but these manifest in different ways.</p> <p>Catholic organization policy conflicts with government policy in terms of condom promotion.</p> <p>Anglican organization’s lack of external and internal policy leaves opportunity for organization to work according to government policy; however, organization’s response is not consistent with national response efforts.</p> <p>Muslim organization policy conflicts with government policy regarding condom promotion outside of marriage.</p>

	Catholic Organization	Anglican Organization	Muslim organization	Main Conclusions
Context	<p>Religious Context Subsidiary organization within controlling, hierarchical, non-flexible faith structure with top-down faith directives. Faith directives supersede all secular policies in matters of ethics and morality, which mainly relates to condoms.</p> <p>Government Context Perceives itself as working within National Multi-Sectoral HIV/AIDS Framework; using national policies. Organizational policy conflicts with government policy in relation to condoms.</p> <p>Donor Context 100% donor-funded; majority of donors secular; sustainability of organization and activities relies on donor funding.</p> <p>Community & Cultural Context HIV/AIDS prevention messages appear to be shaped around community needs and cultural</p>	<p>Religious Context Subsidiary organization within flexible, ‘silent’ faith structure (no faith directives given) – organization considered separate from Church, unrestricted by faith directives.</p> <p>Government Context No evidence of working within NMSF/ using government policies. Due to diverse practices, approach conflicts with government policy in some instances.</p> <p>Donor Context 100% donor funded; majority of donors Anglican; donor funding short-term, influencing sustainability of programmes.</p> <p>Community & Cultural Context HIV/AIDS prevention messages shaped around community needs and cultural drivers of epidemic.</p>	<p>Religious Context Not accountable to larger religious body or structure. Independent organization within permeating faith structure that regulates most aspects of life.</p> <p>Reference to religious principles and values from religious texts within HIV/AIDS prevention messages.</p> <p>Government Context No evidence of working within NMSF/ using government policies. Approach conflicts with government policy in relation to condoms outside of marriage.</p> <p>Donor Context No external funding, dependent on member contributions, which restricts activities; lacks capacity to work within donor structure/ funding restrictions.</p>	<p>Religious Context Faith structure influences organizations in varying ways, depending on other factors influencing policy process.</p> <p>Catholic faith structure is controlling, hierarchical and non-flexible, compared to Anglican faith structure, which is hierarchical but flexible. Muslim organization operates within a permeating faith structure that regulates most aspects of life.</p> <p>Government Context Organizations’ policy and/or practice conflicts with government policy in different ways.</p> <p>Catholic organization perceives itself as working within National Multi-Sectoral HIV/AIDS Framework and using government policies. No evidence of Anglican and Muslim organizations working within national framework and using government policies.</p> <p>Donor Context Organizations’ capacity to access funding influences extent of HIV/AIDS prevention</p>

	Catholic Organization	Anglican Organization	Muslim organization	Main Conclusions
	drivers of epidemic. Actors' circumventing religious directives to address community concerns.		<p>Community & Cultural Context HIV/AIDS prevention messages shaped around community needs and cultural drivers of epidemic.</p> <p>HIV/AIDS prevention messages tailored to gender, influenced by religious values and beliefs.</p>	<p>and mitigation activities. Organizations' capacity related to type of organization (professional or non-professional), and ability to work according to structure of aid industry.</p> <p>Community & Cultural Context Organizations' HIV/AIDS prevention policy process influenced by community needs and local cultural drivers of the epidemic.</p>
Actors	<p>External Organization's relationship with Catholic Church mediated through Bishop, who has decision-making power over moral and ethical issues at organizational level.</p> <p>Advisory Board held consultative role.</p> <p>Internal Professional organization that employs professionals; diverse religions among staff. Executive Director a professional.</p>	<p>External Bishop and Board of Directors oversee running of organization, but silent on issues relating to sexuality and HIV prevention; have not told organization that it belongs to Church or must work according to Church's standards.</p> <p>Internal Professional organization that employs professionals. Executive Director a professional.</p> <p>Diverse religions among staff.</p> <p>Due to lack of organizational policy or faith directive, staff</p>	<p>External No external actors with immediate influence over policy process.</p> <p>Internal Non-professional volunteer organization. Chairmen of organization are religious leaders.</p> <p>Shared religion among members.</p> <p>Members lacked professional experience, expertise or education related to health or HIV/AIDS.</p>	<p>External Role of external actors different within organizations.</p> <p>External actors have a strong influence within Christian organizations; in particular they control the organization's overall direction.</p> <p>External actors predominately influence religious matters as opposed to technical matters.</p> <p>No external actors found to influence Muslim organization, likely the result of it not being subsidiary to wider religious body.</p>

	Catholic Organization	Anglican Organization	Muslim organization	Main Conclusions
	Clash between religious and professional understanding of HIV/AIDS led to competing frames being used within organization (religious and professional) and actors employing strategies to circumvent religious directives.	made decisions based on professional or religious understanding of HIV/AIDS.	Decisions based on religious understanding of HIV/AIDS. Common understanding of HIV/AIDS among members.	Internal Organizational type (professional or non-professional) related to staff/members' understanding of HIV/AIDS. Within professional organizations, staff's professional understanding of HIV/AIDS influenced policy process; within non-professional organization, members' religious understanding of HIV/AIDS influenced policy process.
Process	Hierarchical, rule-bound environment. Religious directives instigated top-down. 'Street level bureaucracy' at implementation – as a result of conflicting frames relating to HIV prevention, actors re-defined policy directives and employed strategies to circumvent faith directives at implementation.	Organization given flexibility within decision-making process; religious directives not instigated top-down. Formal decision-making structure but no resultant clear policy on HIV/AIDS. Lack of organizational policy meant staff retained discretion in their relations with clients, shaping organizational practice on individual professional or religious understanding of effective HIV/AIDS prevention strategies.	Independent self-governing body with no outside religious body instigating top-down religious directives. Organization retains large degree of discretion regarding HIV prevention response. Members elected into positions of authority; accountable to members. Decision-making structure perceived to be informal, bottom-up, and collaborative.	The processes of policy and decision-making differed between the three organizations. Catholic organization's HIV/AIDS prevention policy conflicts with government policy. Due to professional nature of organization, staff implemented strategies to circumvent religious directives. Due to lack of explicit policy within Anglican organization, some staff interpreted Anglican Church's silence as permission to promote condoms, while others operated according to their religious understanding of HIV/AIDS.

	Catholic Organization	Anglican Organization	Muslim organization	Main Conclusions
		Lack of conflicting frames within organization meant actors did not have to re-define organizational objectives or employ implementation strategies to circumvent organizational policy.	Uniform frames within organization meant actors did not have to define or re-define organizational objectives or employ implementation strategies to circumvent organizational policy.	<p>Within Muslim organization, members' religious understanding of HIV/AIDS corresponds with organizational policy, creating uniform approach to HIV/AIDS prevention.</p> <p>Lack of competing frames within Anglican and Muslim organizations meant actors did not have to define or re-define organizational objectives or employ implementation strategies to circumvent organizational policy.</p>

In relation to the overall aim and objectives of the study, three main conclusions have emerged from the above findings. Firstly, faith has a varying influence on the HIV/AIDS prevention policy process within faith-based NGOs, depending on the faith structure that the organization is a part of, and how the other factors interact with this structure. Secondly, there is a discrepancy between government and faith-based NGOs' HIV/AIDS prevention policy, which not only affects the policy processes within faith-based NGOs, but overall HIV/AIDS prevention response efforts. And thirdly, actors' individual response to HIV/AIDS prevention within faith-based NGOs depends on what factors influence the overall process, whether these factors create tensions within this process, and how actors deal with these tensions. Each of these conclusions is discussed below in relation to the above findings.

8.2.1 Influence of Faith Structure on the Policy Process

The role of faith within faith-based NGOs' HIV/AIDS prevention policy process varies depending on the faith structure that the organization is a part of, and how the other factors within the policy process interact with this structure. Organizations' HIV/AIDS prevention content, in terms of policy and practice, can be described as the product of the interaction between these factors. Each organization was found to work within a specific faith structure, which influences its HIV/AIDS prevention policy process. The faith structures that the organizations work within can be described as controlling, flexible, or permeating. The faith structures are presented in Table 7 under 'religious context'.

The Catholic organization works within what is described here as a controlling faith structure with clear delineations of authority through which top-down policy directives are employed. Subsidiary organizations are expected to follow the position and policies of the Roman Catholic Church – a structure which spans across the local, national, and international level. The Catholic organization, for example, was expected to follow the Catholic Church's position on HIV/AIDS prevention, which was outlined in the TEC HIV/AIDS policy described in Chapter 4. The organization's official HIV/AIDS prevention policy was therefore that of the Catholic Church – to promote abstinence and fidelity as primary HIV/AIDS prevention strategies, and not promote condoms. This structure is similar to those reported in other studies, particularly in relation to the organization's position on condoms (Denis, 2009; Ferrari, 2011; Joshua, 2011; Rankin, et al., 2008). The Catholic Church therefore has a uniform approach to HIV/AIDS prevention from the top-down; however, as will be discussed below, this does not always correspond to the practice of individual actors.

In comparison, the Anglican organization works within what is described here as a flexible faith structure. The structure is flexible in that by choosing to remain silent on issues of sexuality and HIV prevention, and allowing the organization a degree of separation from the Church, the organization is not restricted by religious directives. At the time of data collection, for example, there was no HIV/AIDS policy within the Anglican Church and, according to respondents, the Church had chosen to remain silent and not direct the organization in its HIV/AIDS prevention approach. At the same time, within the Anglican organization there was no internal HIV/AIDS policy or uniform understanding of the organization's relationship with the Anglican Church. Compared to the Catholic organization, top-down faith directives were therefore not employed within the organization.

It is likely that the lack of a single policy directive within the Anglican organization may be the result of the diversity in HIV prevention approaches found throughout the Anglican Church as a whole, which are reported within the literature. Many Anglican leaders are often described, for example, as having a more flexible approach to HIV/AIDS prevention compared to other Church leaders, such as those within the Catholic Church. The approach is described as more flexible as it does not directly reject the role of condoms within overall HIV/AIDS prevention approaches. According to Levy et al. (2005), for example, the Anglican Archbishop Desmond Tutu has a positive stance on the role of condoms within HIV/AIDS prevention. In addition, the Anglican Bishop Tilewa of The Gambia has also been reported as having a positive stance on the role of condoms. According to Bishop Tilewa, for example: "in a world where not everybody is holy and for some people abstinence or one partner is not a viable proposition, [...] the only sensible and responsible line of action is a use of condoms" (Trinitapoli, 2009: 200). According to Trinitapoli (*ibid*) these approaches are not supported by the entire Anglican community and have therefore created controversy. The Anglican Church in Uganda, for example, has been described as emphasizing abstinence and fidelity, while rejecting condom use (Liebowitz, 2002).

As stated in Chapter 6, the Anglican Church as a whole in Tanzania is against condom promotion, and controversy has surrounded the issue of condoms within the Anglican community in the past. It is therefore possible that the silence from the Anglican Church is due to the fact that Anglican leaders wanted to take a flexible approach to HIV/AIDS without creating the controversy that a policy encouraging condom promotion would generate. Along the same lines, it is also possible that the Anglican organization itself did not want to create a

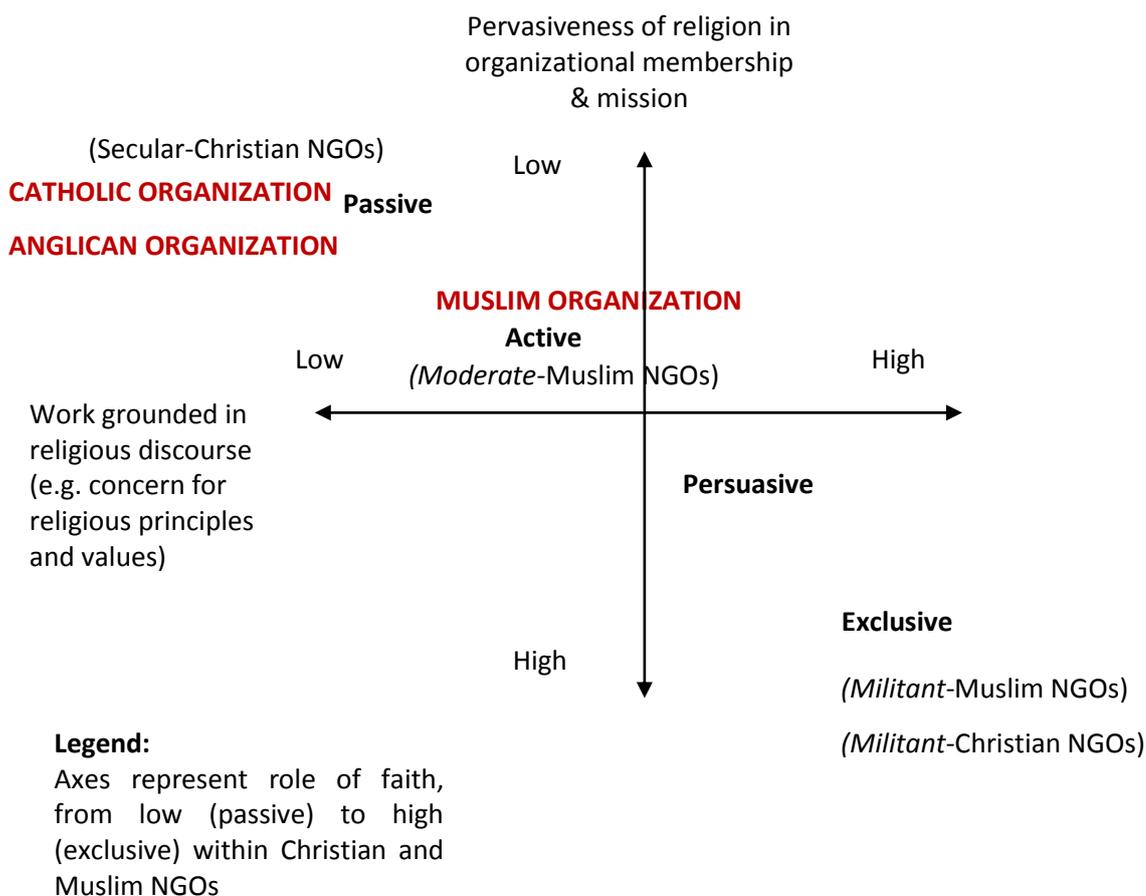
policy in case, in the absence of a wider Church policy, this resulted in a perceived need at the Church level for such a policy, or created the same controversy surrounding condom promotion that was witnessed in northern Tanzania, as stated in section 6.3.1. Not having an HIV/AIDS policy might therefore be a pragmatic solution to HIV/AIDS prevention within the Anglican Church and organization.

The Muslim organization, in comparison, works within what is described here as a permeating faith structure. Although the organization is not a subsidiary of a larger religious organization like the above two organizations, it is still part of a larger religious context or structure. The structure is permeating in that, in the words of Balogun (2011: 459), "Islam is not only a religion but also a way of life which can regulate most aspects of an adherent's life – political, economic or social activities, and personal, inter-personal or inter-group relations". Islam, therefore, can be seen as 'permeating' all aspects of life. The normative Islamic discourses used within the organization were interpreted from the Quran and other Islamic texts. These discourses are similar to those reported within the literature, which included beliefs about the cause of HIV/AIDS being *zinaa* (adultery and fornication), adhering to Islamic teachings about abstinence outside of marriage and marital fidelity as being the only solutions to HIV prevention, HIV/AIDS being a punishment from God, and condoms being permitted only within marriage (Balogun, 2011; Hasnain, 2005; Maulana, et al., 2009; Rankin, et al., 2008; Tiendrebeogo & Buyckx, 2004a). The discourses therefore influenced and directed the HIV/AIDS prevention messages and practices within the organization.

The influence of these faith structures was found to depend on other factors within the policy process, in particular the presence or absence of a formal or informal organizational HIV/AIDS policy, the professional or non-professional nature of the organization and its actors, and whether the two corresponded. The organizations' HIV/AIDS policy content, in terms of both formal and informal policy and practice, was therefore influenced by the interaction between these factors, whether they created tensions within the organizations, and how actors would deal with these tensions. What the above discussion makes clear is that the religious approach to HIV/AIDS prevention is diverse, as FBOs operate within different faith structures, which influence their HIV/AIDS prevention policy process and response. The role of faith within these organizations depends upon the faith structure that the organization works within and its interaction with other factors. In reference to the role of faith within FBOs, Chapter 2 discussed Clarke's and Benedetti's faith utilization theories, and brought them together to

provide a framework for analysing the role of faith within and between faith-based NGOs of different faiths. The term “faith utilization theory” was developed as a result of this study, as no appropriate term was found to describe how faith is used by organizations or individuals. The three case study organizations have been mapped onto this framework (in red), as shown in Figure 16.

Figure 16 – Faith Utilization within Case Study Organizations



The above framework is useful as it illustrates how faith is utilized within the three faith-based NGOs within the study. It suggests that faith plays a more significant role within the Muslim organization’s HIV/AIDS policy process than within the Catholic and Anglican organizations. Chapter 2 discussed how Benedetti’s typology placed Christian and Muslim NGOs on separate continua due to the more significant use of faith within Muslim organizations, which is corroborated by this study’s findings. According to each typology, both the Catholic and Anglican organizations can be considered secular-Christian NGOs due to their passive use of faith. According to Clarke, the role of faith is passive when the teachings of the faith are

subsidiary to broader humanitarian principles as a motivation for action and in mobilizing staff and supporters, and play a secondary role to humanitarian considerations in identifying, helping or working with beneficiaries and partners (Clarke, 2008). Within the Christian organizations, Church policy played a secondary role to staff's professional understanding of HIV/AIDS in identifying, helping, and working with beneficiaries. In comparison, according to each typology, the Muslim organization can be considered a moderate-Muslim NGO due to its active use of faith. According to Clarke, the role of faith is active when it provides an important motivation for action and in mobilizing staff and supporters, and it plays a direct role in identifying, helping or working with beneficiaries and partners, although there is no overt discrimination against non-believers (*ibid.*). Within the Muslim organization, Islam provided an important motivation for action in mobilizing members and played a direct role in working with beneficiaries, while not discriminating against non-believers. It is important to recognize that the above framework is meant to provide an illustration of the role of faith within each organization; however, as findings from this study suggest, the role of faith is influenced by a number of inter-relating and sometimes conflicting factors. While this framework is helpful in comparing the role of faith within different organizations, it is an oversimplified representation of the role of faith, as faith is used by organizations in different ways depending on these other factors. It is therefore important that the above framework, in addition to both Clarke's and Benedetti's typologies, are not taken as exact representations of the role of faith within FBOs. As this study has shown, the role of faith is much more complex than the framework would suggest.

Due to the nature of faith-based NGOs that engage in HIV/AIDS prevention and mitigation efforts, and based on the study's findings, it is possible that most faith-based NGOs would fall within the top left hand side of the above framework. Clarke (2008), however, acknowledges that more work is needed to understand better the ways FBOs employ and utilize faith within their work. This study adds to the knowledge of how FBOs employ and utilize faith by showing how faith interacts with a multitude of different factors to influence actors' HIV/AIDS prevention approaches. Because the study only explored the role of faith within faith-based NGOs, it is recognized that more work is needed in order to understand the role of faith within different types of FBOs, such as local, national, and international faith-based NGOs, as well as churches and mosques, in addition to organizations from different faiths, such as Pentecostal faith-based NGOs.

It is important to recognize that faith was also found to influence the organizations' HIV/AIDS prevention approaches in distinctly positive ways. Within the Catholic organization, for example, the organization's holistic approach, which viewed HIV/AIDS as more than just a physical ailment, recognizing the psychological, social, physical, and spiritual problems of PLWHA, was viewed as a positive aspect of the organization's faith-based identity. The incorporation of spiritual counselling, which was also found within the Anglican and Muslim organizations, was seen as an advantage as respondents believed it gave PLWHA hope and the spiritual strength to know that being HIV positive was not the end. Spiritual counselling, which was often tailored to the recipient's own faith, was seen as a way to let PLWHA know that they are not alone and that God is by their side – it was therefore seen as a way to encourage PLWHA to continue to live. The provision of compassionate services was also seen as a distinct advantage within the organizations, as was the trust instilled in them by the community as a result of their faith-based identities. Within the more professional faith-based organizations, respondents reported, for example, that the community or PLWHA believed they would not only get the services promised to them but that the services would be the best. Whether or not this is true is out of the scope of this thesis, however, what is important is that it is a perceived characteristic of faith-based organizations. Being a faith-based organization was therefore seen by many respondents as a distinct advantage to their HIV/AIDS prevention and mitigation work.

8.2.2 Government and Faith-Based NGO HIV/AIDS Prevention Policy

The national HIV/AIDS response was discussed in Chapter 4. This response included the development of the National HIV/AIDS Policy and the 2008-2012 National Multi-Sectoral Framework (NMSF); the NMSF is currently the main response strategy. As stated in Chapter 4, the NSMF was set up to guide “the approaches, interventions and activities which will be undertaken by all actors in the country regardless of whether they are coming from the public or private sector, the civil society groups, the business communities or the bilateral and international partners of the government of Tanzania” (URT-PMO, 2007: vi). Its overall vision is to see “Tanzania united in its efforts to reduce the spread of HIV and to provide the best available care for those infected and affected by the virus within a human rights and empowerment framework” (*ibid.*: 29). Within the NMSF are four key thematic areas: enabling environment; prevention; care, treatment and support; and impact migration. Within the NSMF the government recognizes that the national response cannot be implemented by state actors alone, and requires the participation of society, including civil society organizations

(CSOs), of which FBOs are a part. At the same time, the NMSF acknowledges that the sheer number of CSOs makes coordination and control of quality of CSOs a challenge. The NSMF therefore calls for CSOs to integrate their activities better within national coordination and planning mechanisms.

According to the NSMF, all CSOs, including FBOs, have to operate within the NMSF. As stated in Chapter 4, however, the NSMF recognizes that FBOs in particular “may not wish to support all recommended strategies based on their own convictions and mandate” (*ibid.*: 86). The NMSF goes on to state that while such organizations may select their own preferences, they should refrain from contradicting other elements of the NMSF. The NSMF, however, is critical of FBOs, recognizing that some FBOs will “have values regarding HIV and AIDS that may be disabling”, particularly those that “have fairly strong views on commercial sex activities, condom promotion and other prevention activities” (*ibid.*: 86). According to the NMSF, advocacy work is needed with FBOs to help them understand the dynamics of the epidemic and promote evidence-based interventions that they may not agree with, such as the use of condoms in HIV/AIDS prevention (*ibid.*). The importance of evidence-based HIV/AIDS prevention interventions is well recognized within the literature (Coates, et al., 2008; Noar, 2008; Weller & Davis-Beaty, 2002). The NMSF recognizes that in order for the national HIV/AIDS prevention response to be effective, there must be a coordinated evidence-based response, and that any activities that contradict the framework will ultimately hinder national response efforts.

Despite the Catholic organization being the only organization within this study actively using the NMSF policy document as a guide, many of the HIV/AIDS prevention activities of each organization were in line with the NMSF. The area that was found to most contradict with the NMSF, and therefore evidence-based practice, was in relation to condom promotion. Consistent use of condoms has been found to result in an 80% reduction in heterosexual HIV incidence (Weller S.C. & Davis-Beaty K., 2002). It is important to recognize that condoms are only one part of HIV/AIDS prevention, and effective prevention efforts require the combination of biomedical, behavioural, and structural interventions, as discussed in Chapter 2. However, as it is the area where the faith-based response to HIV/AIDS most conflicts with national response efforts, and therefore has the potential to do the most damage to the

national response, it is important that the faith-based response to condoms is explored¹⁵. Rankin et al. refer to this conflict as the ‘condom divide’ – “the divergence of messages related to HIV prevention strategies that [are] transmitted by FBOs and the government” (2008: 599). They criticize this divide for creating confusion around HIV/AIDS prevention and argue that it diminishes FBOs’ ability to help in overall response efforts. This view is supported by those who criticize FBOs’ resistance to government-led secular HIV/AIDS prevention strategies for promoting unrealistic, unjust, and dangerous prevention strategies (Campbell, et al., 2005; Casale, et al., 2010; Denis, 2009).

As evidenced in Table 7, HIV/AIDS prevention policy and practice in relation to condoms differed between the three organizations within the study. The organizations, however, shared one similarity – not one consistently educated about or promoted condoms, and none distributed condoms. Due to organizational policy, staff within the Catholic organization, for example, were not permitted to promote condom use. Due to the professional nature of this organization, however, many respondents did not agree with the Catholic Church’s stance on condoms, and actively found ways to circumvent religious directives to ensure condoms remained an HIV/AIDS prevention option, particularly in relation to discordant couples. Such practices created a discrepancy between policy and practice. Within the Anglican organization, due to a lack of organizational policy there were diverse and inconsistent practices with regards to condom education and/or promotion. While some respondents’ HIV/AIDS prevention practices were in line with the NMSF, others were found to contradict it. Within the Muslim organization, condoms were only promoted within married discordant couples, creating a service gap among the unmarried population. The effect of these discrepancies on the health of the community, and overall national response efforts, is something that would require further exploration, particularly if we are to understand better the potential negative influences of FBOs’ HIV/AIDS prevention responses.

Each organization’s HIV/AIDS prevention response with regards to condoms was found to be inconsistent with the evidence-based practice recommended within the NMSF. As the NMSF rightly states, such inconsistent practices can be damaging to overall national response efforts. Within the NMSF the promotion and distribution of condoms is a specific HIV/AIDS prevention strategy. The NMSF, for example, recognizes that “[m]ale condoms are one of the most

¹⁵ As stated in Chapter 2, the faith-based response to HIV/AIDS prevention is not uniform. While many FBOs reject condom promotion and distribution, there are some FBOs whose strategies include condoms. As the organizations’ approach to condoms within this study was found to contradict with national response efforts, this contradiction is explored here.

effective and easy to use barriers preventing the transmission of HIV and other sexually transmitted infections” (URT-PMO, 2007: 50). And although the “number of condoms sold and distributed in the country has increased dramatically” from about 50 million in 2001 to 150 million in 2006, “their general acceptance and regular use is still very limited” (*ibid.*: 50). In addition to limited access in rural areas and women’s limited decision-making power in sexual issues, unbalanced messages regarding condom use and their effectiveness in the prevention of HIV infection are recognized as reasons contributing to a lack of their acceptance and use. Religious leaders and FBOs are recognized in particular as contributing to these unbalanced messages, particularly in relation to discordant couples where the only available HIV prevention method (besides abstinence) is condom use (*ibid.*). A specific strategy of the NMSF is therefore to “advocate with religious leaders who are opposed to condoms, to accept condom use, particularly in discordant couples” (*ibid.*: 51); however, the extent to which this advocacy has occurred is uncertain.

Due to a lack of government capacity to effectively respond to HIV/AIDS prevention at the national level, government and FBOs need to work together if HIV/AIDS prevention is to be effective within Tanzania. As evidence from this study suggests, however, FBOs are contributing to what the NMSF calls the unbalanced condom messages within the country, which leaves the “majority of prospective users in total confusion” (*ibid.*: 50). There is therefore a strong likelihood that FBO policy and practice is damaging HIV prevention response efforts within Tanzania; however, the detail of this damage is beyond this thesis and is something that requires further exploration. Despite calling for advocacy with FBOs who are opposed to condoms, the government appears to have little capacity to ensure FBOs respond to HIV/AIDS prevention according to the NMSF. The NMSF states that all CSOs, including FBOs, have to operate within the framework of the NMSF. However, by stating that organizations can select their own preferences according to their own convictions and mandate, the government has undermined their own policy response by effectively allowing FBOs to continue contributing to the confusion about condoms that, according to the NMSF, currently exists within the country.

In addition, the NMSF recognizes the importance of fighting stigma, denial, and discrimination in their overall HIV/AIDS response. The NMSF recognizes, for example, that while the

major mode of HIV transmission in Tanzania is through sexual intercourse [...] [i]n Tanzania, like in many African countries, sexual matters are largely taboo

subjects that are not normally discussed in public. People who contract the infection are assumed to have got it through promiscuous sexual behaviour which is frowned upon by the community. Subsequently they often are stigmatized and discriminated by the wider community (URT-PMO, 2007: 32).

As discussed in chapter 2, within the literature FBOs are often recognized as instigators and perpetrators of stigma and discrimination among PLWHA within the community due to the association of HIV/AIDS to sin (Campbell, et al., 2005; Campbell, et al., 2006; Ogden & Nyblade, 2005). While the association of HIV/AIDS to sin and the belief that HIV/AIDS was a punishment from God, both of which have been found to contribute to stigma and discrimination of PLWHA, were not directly found within the Catholic and Anglican organizations, there was evidence of such beliefs within the Muslim organization. Evidence from the literature and this study therefore suggest that through their HIV prevention messages FBOs are contributing to HIV/AIDS-related stigma within Tanzania and negatively influencing overall prevention efforts. The government is therefore in a position to provide guidelines for FBOs and work with them to address how religiously influenced HIV prevention messages and strategies can perpetuate HIV/AIDS-related stigma. If HIV/AIDS-related stigma, denial, and discrimination are to be effectively addressed within the national HIV/AIDS response, the government must engage FBOs within these efforts.

Although the government lacks the capacity to ensure FBOs respond to HIV/AIDS prevention according to the NMSF, the findings from this study contribute to an understanding of where and how FBOs' HIV/AIDS prevention policy and practice conflict with government policy. It has also drawn attention to the limited role national policy documents play within faith-based NGOs' HIV/AIDS prevention policy processes, and the fact that government needs to be clearer in their policy statements. Through this understanding, the government will be better able to identify how best to work with FBOs by identifying which areas the government can intervene in to meet their HIV/AIDS prevention targets, as outlined in the NMSF. As the focus of this study was on faith-based NGOs and their HIV/AIDS prevention policy processes, the views of government have been underrepresented, which is a limitation of this research. At the same time, however, a good picture of the government's response to HIV/AIDS can be drawn by looking at government HIV/AIDS policy documents, such as those discussed above. An important avenue for future research would therefore be to explore government attitudes towards FBO involvement in HIV/AIDS, as well as their capacity to ensure FBOs' response is in line with the national response.

8.2.3 Influence of Actor-Level Responses on the Policy Process

As stated above, the organizations' HIV/AIDS prevention content, in terms of both policy and practice, were influenced by the interaction between multiple factors, namely the religious structure within which the organization works, the presence or absence of a formal or informal HIV/AIDS policy within the organization, and the professional or non-professional nature of the organization and its actors. Whether these factors created tensions within the organizations, and how actors would deal with these tensions, were found to influence practice on the ground. The following section discusses the interactions between these factors, and how they influenced practice within each organization.

As we can see in Table 7 above, both the Catholic and Anglican organizations are professional organizations, meaning they employ staff based on their professional qualifications and expertise, as opposed to their faith or interest. Respondents within these organizations were mainly bio-medical or public health professionals, and therefore held a bio-medical understanding of HIV/AIDS and HIV/AIDS prevention. Other respondents were management and/or finance and administration professionals. Within the Catholic organization staff's bio-medical or public health understanding of HIV/AIDS conflicted with the organization's policy on condom promotion. This resulted in actors finding ways to mediate between these factors in order to ensure that their HIV/AIDS prevention approach was not only in line with their own understanding of HIV/AIDS, but that it also did not overtly go against the position of the Catholic Church. Such strategies included, for example, distinguishing between condom education and promotion, emphasizing individual choice, and framing issues in a way that circumvented religious moral or ethical arguments. The first two strategies were found particularly within community HIV/AIDS prevention and positive prevention, and were implemented to ensure condoms remained an option to prevent HIV/AIDS infection. The third strategy was used within the organization's HIV/AIDS prevention work with vulnerable groups, such as men who have sex with men, to ensure the organization could target these men without directly going against Church policy. As a result, a discrepancy between policy and practice was found with the organization.

In comparison, within the Anglican organization there were no clear guidelines from either the organization or the Anglican Church regarding HIV/AIDS prevention. The lack of Church direction was interpreted by some respondents as tacit permission to promote condoms, which corresponded with their own professional understanding of HIV/AIDS. At the same

time, despite the lack of direction from the Church, other respondents believed their role as an Anglican faith-based NGO was to promote a religious understanding of HIV/AIDS, which they interpreted as meaning the rejection of condom use. As there was no HIV/AIDS policy within the organization, respondents were given no direction on how they were to respond to HIV/AIDS prevention. The absence of both external and organizational policy therefore meant that actors decided how they were going to respond to HIV/AIDS prevention, and how much this response would be influenced by their professional and/or religious understanding of HIV/AIDS. As a result, conflicting HIV/AIDS prevention practices were found within the organization. As was discussed above, however, not having an HIV/AIDS policy may have been a pragmatic solution to HIV/AIDS prevention by both the Anglican Church and the organization.

Compared to the Catholic and Anglican organizations, the Muslim organization is a non-professional volunteer organization, meaning it is made up of non-professional volunteers within the community with an interest in HIV/AIDS. Respondents therefore did not have the same bio-medical or public health understanding of HIV/AIDS that was found to conflict with Church policy and/or inform respondents' HIV/AIDS prevention approaches within the Catholic and Anglican organizations. Possible reasons for respondents' lack of bio-medical knowledge were discussed in Chapter 7. At the same time, despite lacking a coordinating body or structure, like the Catholic and Anglican organizations, the organization itself maintained the overall objective of responding to HIV/AIDS through Islam, which in itself has a strong position regarding HIV/AIDS. Due to the organization's focus on Islam and HIV/AIDS, most respondents' decision to join was religiously motivated. Respondents therefore shared a common religious understanding of HIV/AIDS and HIV/AIDS prevention. As this understanding corresponded to the organization's overall approach, no conflict between factors was found and there was a uniform approach to HIV/AIDS prevention within the organization.

The nature of leadership within the organizations was also important within the overall policy process. In the Christian professional faith-based NGOs the directors of the organizations were professionals, with a professional understanding and approach towards HIV/AIDS. While in the Muslim volunteer faith-based NGO, the chairmen of each branch were not only volunteers but religious leaders within the community, with a religious understanding and approach towards HIV/AIDS. It is likely that the nature and position of the leaders influenced the organizations' objectives and overall approach to HIV/AIDS. If the leaders of the Christian organizations were

religious leaders they may have had a very different approach to HIV/AIDS. At the same time, it is also likely that the position of the external actors on HIV/AIDS prevention, namely the Bishops, also influences the organizations' HIV/AIDS policy process and approach.

Possible explanations for the differences between the three organizations are found within the literature. Within each organization, for example, respondents' HIV/AIDS prevention practices were found to be influenced by their professional and/or religious understanding of HIV/AIDS and HIV/AIDS prevention, and whether these corresponded with organizational policy. The reasons for why respondents' practices were based on this understanding were discussed above. Ferrari refers to such understandings as 'frames', which she defines as "templates that perceivers use to determine which information is important in a given situation and how to proceed with discourse on the topic" (2011: 86).

In the Catholic organization staff predominately drew upon professional bio-medical discourses or frames in their HIV/AIDS prevention response, ultimately circumventing religious directives regarding HIV/AIDS prevention. In the Anglican organization, in the absence of policy both professional bio-medical and religious discourses were drawn upon. In comparison, within the Muslim organization, members predominately drew upon religious discourses in their HIV/AIDS prevention response. According to Ferrari, religious and scientific (or in this case professional) frames "build competing visions of the AIDS crisis, and lead to quite different strategies for addressing the epidemic" (2011: 101). Ferrari's distinction between scientific and religious frames, and how they can lead to different response strategies, helps to explain the different prevention responses found within the case studies. As the findings from this study suggest, discrepancy or consistency between policy and practice will depend upon whether actors' frames, and therefore strategies, correspond to the organization's frame. As actors' frames within the Catholic organization did not correspond with the organization's frame, there was a discrepancy between policy and practice, while policy and practice within the Muslim organization was consistent due to a similarity of frames between actors' and the organization. Within the Anglican organization, as there was no organizational frame, actors employed their own individual frames within their HIV/AIDS prevention response, and different approaches to HIV/AIDS prevention were found.

It is important to recognize that health workers act within a broader context, which will ultimately influence their work at the implementation stage. This context includes their

personal religious or other beliefs. While there is ample literature about the influence of religious beliefs on preventative behaviours, HIV stigma, disclosure, and treatment attitudes (see: Browning, 2009; Gray, 2004; Maulana, et al., 2009; Zou, et al., 2009), there is less literature about the role of religious beliefs among health care providers. Dickinson and Buse (2008), in discussing the role of ideas, interests, and institutions in national HIV policy processes consider the role of implementers' ideas, values, and morals in determining the nature of policy at the service delivery level. According to Dickinson and Buse (*ibid.*), ideas, values, morals can stem from a religious, bio-medical, human rights, or other source, and can include the value or importance that service providers attach to scientific and medical knowledge or epidemiological evidence.

In a study about nurses' motivations in delivering anti-retroviral therapy in South Africa, Stein et al. (2007) illustrate how service providers appropriate different discourses during implementation, including religious discourse. Stein et al. found that nurses used religious metaphors alongside "medical notions of effective treatment and care to help them and their patients negotiate, and make sense of, the difficult terrain of HIV/AIDS and the possibilities offered by lifesaving ART treatment" (2007: 962). The use of different discourses were found to enable nurses to create and sustain hope both for patients and themselves when faced with the burden of HIV/AIDS and the constraints of the health system (*ibid.*). As the above study suggests, health service providers draw upon their own religious or other beliefs to help them navigate the difficulties associated with HIV/AIDS service delivery. The use of religious discourse to create and sustain hope was also found among the respondents within the three faith-based organizations in this study, as discussed above. The use of bio-medical discourse, alongside religious discourse, however, was found only in the professional faith-based NGOs. It therefore appears that whether respondents drew upon bio-medical or religious discourses, or both, was influenced by the type of organization and the respondents' background. As previously discussed, the discourses used at implementation influenced the organizations' overall HIV/AIDS prevention approach.

The notion of implementers' religious or bio-medical discourses influencing and affecting organizational policy at the service delivery level is an example of Lipsky's (1980) theory of street-level bureaucracy, which can be used to help explain the findings from the Catholic and Anglican organizations. Within the Catholic organization, for example, a discrepancy between policy and practice was found. This discrepancy was found to be the result of tension created

between conflicting factors within the overall policy process, namely Church policy and actors' understanding of HIV/AIDS. As discussed in Chapter 2, Lipsky (1980) coined the term 'street-level bureaucrats' to describe how at the point of implementation front-line staff would re-define and navigate around central policy directives, reshaping policy for their own ends (Buse, et al., 2005). Lipsky saw the implementation process, in particular, as an "interactive, political process characterized by largely inescapable negotiation and conflict between interests" (Buse, et al., 2005: 125). In the case of the Catholic organization, a conflict of interest was found between Church policy and respondents' professional understanding of HIV/AIDS. As a result, respondents would implement strategies to navigate around Church policy, reshaping this policy according to their own professional ends.

As street-level bureaucracy refers to actors shaping policy according to their own ends at the implementation stage, the diversity in practice found within the Anglican organization is also an example of Lipsky's theory of street-level bureaucracy. Because there was no external or internal HIV/AIDS policy within the organization, actors retained a degree of discretion in their relations with clients, shaping policy at the implementation stage according to their own professional or religious understanding of HIV/AIDS. While in the Catholic organization respondents were found to reshape policy at the point of implementation due to a clash between factors, within the Anglican organization respondents were found to shape policy at the point of implementation due to a lack of policy.

'Street-level bureaucracy' did not occur within the Muslim organization as it did within the Catholic and Anglican organizations. Decision-making within the organization was much more collaborative than in either of the two other organizations. As members within the Muslim organization shared the same religion and most lacked the same level of professional experience or expertise as actors within the other two organizations, competing bio-medical and religious discourses did not exist. As a result, actors' religious understanding of HIV/AIDS corresponded with organizational policy, creating a uniform approach to HIV/AIDS prevention within the organization. Unlike in the other organizations, respondents were therefore not found to shape or reshape policy directives at the implementation stage due to competing objectives or lack of organizational policy.

'Street-level bureaucracy' was therefore evident in environments with a hierarchical structure of policy-making where competing frames, or understandings of HIV/AIDS, existed within the

organization and actors were forced to negotiate between them, such as within the Catholic organization; or where there was a lack of direction within the organization, forcing actors to base decisions on their own understanding of HIV/AIDS, such as within the Anglican organization. This study suggests that where there is no hierarchical structure of policy-making, street-level bureaucracy becomes irrelevant, such as in the Muslim organization. This study has added to an understanding about the conditions when street-level bureaucracy does or does not take place within faith-based NGOs. It has also shown that in some circumstances FBOs' policy documents do not represent what is happening on the ground. Such an understanding is particularly important if FBOs are to be better coordinated into national HIV/AIDS response efforts.

In their book on non-governmental organizations and health in developing countries, Green and Matthias (1997) described a shift in NGOs from volunteer-driven organizations, like the Muslim organization within this study, to professional organizations, like the Catholic and Anglican organizations. According to Green and Matthias (*ibid.*), this shift has created a loyalty among staff to their professional objectives, as opposed to the emotional objectives common among volunteers, which has led to a tension in some organizations between staff and volunteers. Although the authors were referring to secular professional NGOs and objectives of individual actors, it is possible that this clash between objectives is a common feature of professional faith-based NGOs, like the Catholic and Anglican organizations within this study, and might be an explanation for the tensions found to exist within these two organizations. The tensions found within the Catholic and Anglican organizations were between the professional objectives of the staff and the 'emotional' religious objectives of the wider religious structure.

As discussed in Chapter 5, the Catholic organization shifted from a volunteer-driven to a professional organization, as described by Green and Matthias. Unlike secular NGOs, however, whose wider organizational objectives presumably also shift – from being emotionally to professionally driven – the Catholic organization's objectives continue to be influenced by its wider religious structure, and are therefore partly emotionally driven. The Anglican organization in comparison was created as a professional faith-based NGO; as a result, its objectives are also influenced by its wider religious structure, and are therefore also partly emotionally driven. It is possible that the nature of these organizations, as professional faith-based NGOs, means that the organizations' emotionally driven organizational objectives will

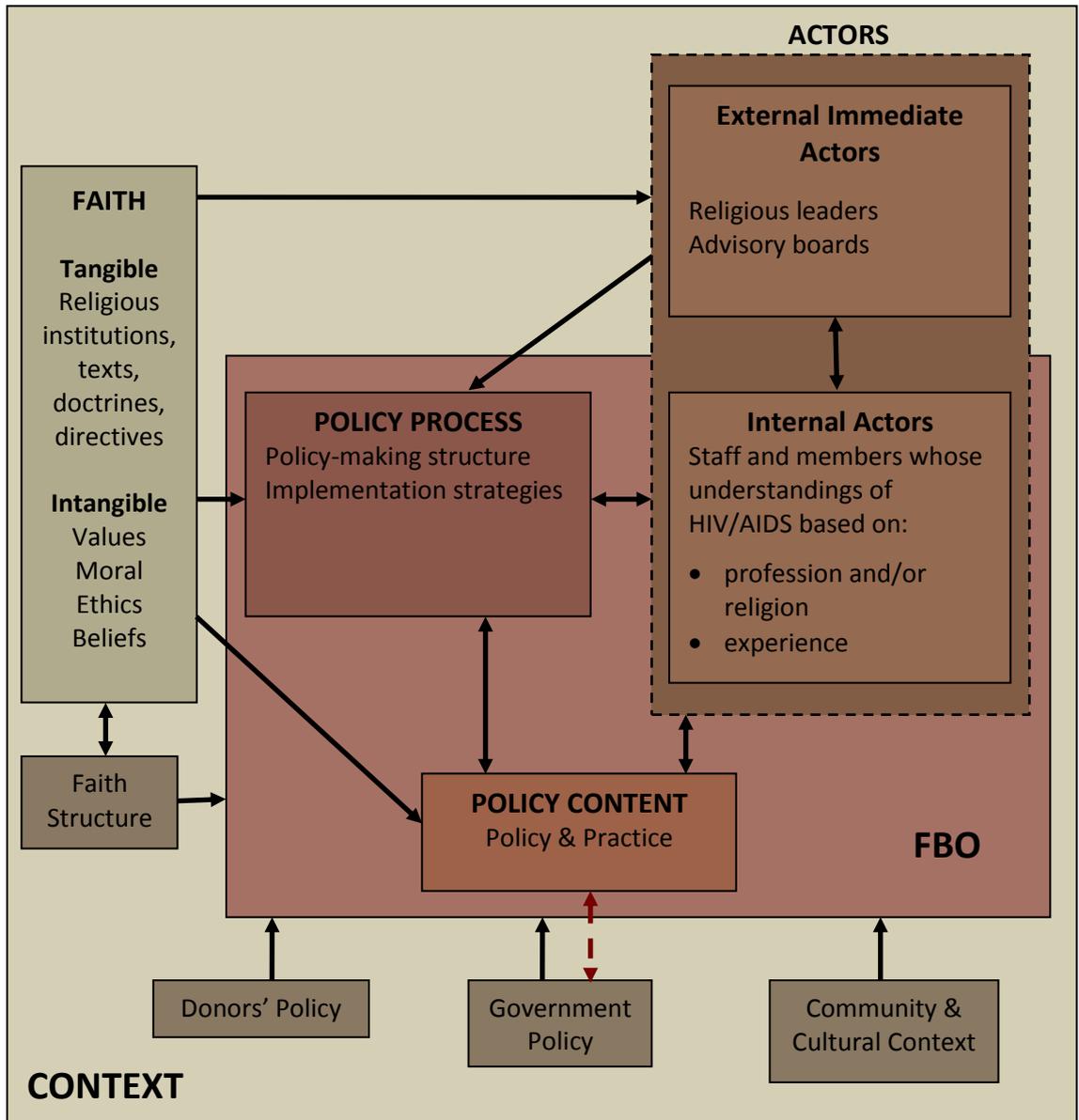
clash with the professional objectives of the staff, leading to tensions and discrepancies within the organizations. Whether this is a distinct characteristic of faith-based NGOs is uncertain, and is something that requires further exploration.

8.3 Revised Conceptual Framework

In the course of analysis it became clear that the original conceptual framework could be refined further. A revised conceptual framework based on the lessons learned from the study is presented in Figure 17 below. As stated in Chapter 2, a prominent health policy analysis framework – Walt and Gilson’s health policy framework – was used as the starting point for the conceptual framework. However, as the framework omits the role of values or beliefs, of which faith is a large part, the framework was expanded in order to represent the importance of faith within the work of faith-based NGOs. While Walt and Gilson’s framework was developed for policy analysis at the national level, it was used here to analyse policy at the organizational level, as the main factors appeared to have similar influence on the policy process at this level.

As a result of data collection and analysis, the conceptual framework was revised from the original framework presented in Chapter 2 to better reflect the study’s findings; the following section describes the revised conceptual framework. While the previous conceptual framework presented the four concepts as broad categories, the revised framework presents the key context, actor, and process factors that were identified under each category as influencing the HIV/AIDS prevention content, in terms of policy and practice. While the role of faith is situated within these factors, the framework also shows how it directly influences organizational HIV/AIDS prevention policy processes. Because this study is exploring the policy process at the organizational level, it is important that specific factors are identified in addition to broad thematic categories, in order to understand better how these factors interact to influence both policy and practice. The categorization of ideas in the original framework, which was separated into worldviews, principled beliefs, and causal beliefs, was taken out of the revised framework as it was found not only to be too analytically difficult to establish, but also proved to be unhelpful in that these concepts were too abstract and intangible to represent accurately. As a result, religious ideas and beliefs were explored as a general category, with regards to whether actors appeared to utilize them within their decision-making process within the overall policy process. The revised conceptual framework is presented in Figure 17.

Figure 17 – Revised Conceptual Framework – Factors influencing faith-based NGOs’ HIV/AIDS prevention policy processes



—————> Direction of influence

-----> Degree of consistency

Although for analytical purposes the factors within the conceptual framework are discussed separately, it is important to recognize that each factor is intertwined and linked with the others. Each of the categories within the framework and how they link with the other factors is discussed in more detail below.

Context: Includes systemic factors (both internal and external to the organization) which have an effect on the policy process. Important external contextual factors within this study include: wider religious context or structure, donor context, government context, including government HIV/AIDS policies, and the community and cultural context. The contextual issues were found to have a direct influence over the other factors within the organizations' HIV/AIDS prevention policy process. For example, top-down government, donor, and/or wider church policy were found to influence actors' decision-making within the overall process, ultimately influencing the organizations' HIV/AIDS prevention content, in terms of both organizational policy and practice.

Actors: Includes individuals and groups of individuals that have direct influence on the organizations' policy process. 'Actors' include both external actors outside the organizations, such as the Bishop and Advisory Board, and internal actors within the organization, such as employees, volunteers, and clients and their influence over or within the policy process. 'Actors' also includes actor-related factors, such as actors' personal religion and beliefs, experience, education, or expertise. How actors within the organization navigated through the policy process was found to influence the organizations' HIV/AIDS prevention policy content. In particular, whether actor-related factors corresponded to or contradicted with contextual factors and how actors mediated between the different factors when they conflicted was found to influence the overall policy-making process, particularly at implementation.

Process: The process in which policies are identified, initiated, formulated or developed, communicated, negotiated, implemented, and evaluated. Due to the nature of the policy process within the organizations, the process of policy identification, initiation, and formulation took place within the wider contexts outside of the organizations. For example, the organizations were found to be influenced by church, government, and/or donor policy that was developed outside of the organizations. Within the organizations themselves, the process of implementation was found to be most influential, as it was at this stage that actors

navigated through the different context and actor-related factors, particularly when the factors contradicted or there was a lack of formal written organizational policy.

Faith: A system of religious belief and practices. Faith includes both tangible aspects, such as religious institutions, texts, doctrines, and directives, and intangible aspects, such as values, morals, and ethics. Within the study, faith was found to include both a contextual component, namely the faith structure of the organization and its associated policies or mandates, and an actor component, namely the individual faith of the actors. These components were found to interact with each other and the other factors in different ways. For example, whether the faith structure in which the organization was a part of, corresponded to, or contradicted with the individual faith of the actors, or other actor-related factors such as professional or other beliefs, and how actors navigated between these factors was found to influence the organizations' HIV/AIDS prevention policy content, particularly at the implementation stage.

Content: The output of the policy process – the product of the different factors and how actors navigate through them. Content includes both written and unwritten policy within the organization as well as practice. Organizational policies can include: objectives, visions, decisions, strategies, targets, plans, guidelines, or directives, and may be formal or informal, implicit or explicit. Practice refers to actors' actions at the implementation level. When there was written policy content, such as within the Catholic organization, it was found to be influenced by the interrelationship between the other factors, particularly contextual factors, such as the religious context of which the organization was a part. When there was a lack of written policy content, or factors within the policy process were found to conflict, organizational practice was found to be most predominant in influencing the organizations' overall HIV/AIDS prevention policy. Organizational practice was influenced by the interaction between context, actors, process, and faith within the organizations.

The conceptual framework shows the interaction between context, actors (which have been divided into external and internal), process, and faith on HIV/AIDS prevention policy content – in terms of both policy and practice. It shows how the factors interact to produce policy content within the organization, which has direct influence over organizations' HIV/AIDS prevention response. The factors are separated into those that are internal and external to the organization. As stated previously, donors and government were included within context as no immediate actors within donor or government organizations were found to influence the

policy process. Instead, such things as donor and government policies, frameworks, and restrictions were found to influence this process. In addition, although there are different aspects of faith evident within each factor, faith is given its own category in order to show its overall influence. This study therefore adds to the understanding of how faith influences each part of the policy triangle (presented in Chapter 2) within faith-based NGOs. Within the policy literature there have been no known systematically planned studies exploring the factors influencing faith-based NGOs' HIV/AIDS prevention policy processes, and in particular the role of faith within this process. This study therefore significantly adds to the understanding of faith-based NGOs' HIV/AIDS prevention policy processes, both in terms of practice in Tanzania, and in terms of the development of a framework for analysis that can be extrapolated to other contexts.

The revised conceptual framework is helpful as it outlines the key factors which influenced the HIV/AIDS prevention policy process within the three organizations. This theoretical understanding is particularly important as FBOs provide up to 70% of health services in Africa, much of which includes HIV/AIDS prevention and mitigation. Within the literature there was, and continues to be, a gap in understanding about FBOs' HIV/AIDS or other health-related response; this study provides a framework for other studies to fill this gap. I hope that the framework can be extrapolated to other organizations within Tanzania and other countries, such as other faith-based organizations and secular NGOs. Secular NGOs, for example, share many of the characteristics of faith-based NGOs, such as wider social and humanitarian objectives and decision-making processes that are independent from government. In addition, many secular NGOs, while independent from government, are subsidiary to larger international organizations, similar to the Catholic and Anglican organizations within this study; and community-based organizations will be similar to the Muslim organization in that they are not subsidiary to larger organizations. Secular NGOs are also part of wider ideological structures that will most likely influence their decision and policy-making processes in ways that are similar to the faith structures found within this study. At the same time, it is important to recognize that in societies where faith is an important component of society and people's lives, where religious organizations and beliefs ultimately shape how people view health, disease, and sexuality, religious structures and beliefs have the potential to influence the HIV/AIDS prevention responses of all NGOs working within these contexts. As a result, the conceptual framework can be applied to other organizations and country contexts, particularly in identifying how ideology or belief influences organizations' policy processes.

8.4 Implications of Findings for Research, Policy and Practice

The following section explores the implications of the research findings for research, policy, and practice. The implications are discussed in relation to the main findings above. Implications for research are questions that emerged as a result of the study's findings, while implications for policy and practice are recommendations that emerged in relation to the FBOs' HIV/AIDS prevention responses. The research findings and implications will be disseminated to the relevant bodies in Tanzania where applicable and feasible. The implications are discussed in relation to three key areas: the diversity of FBOs' HIV/AIDS prevention response, the implementation of FBOs' HIV/AIDS prevention response, and FBOs' role in wider HIV/AIDS prevention response efforts.

8.4.1 Understanding the Diversity of FBOs' HIV/AIDS Prevention Response

FBOs are important actors within overall HIV/AIDS prevention response efforts; however, currently there is a lack of understanding of FBOs' HIV/AIDS prevention response. Many FBOs, for example, are depicted as either for or against condom use and promotion. In addition, FBOs' response to HIV/AIDS is either seen as supporting overall response efforts, through, for example, providing care and support for people living with or affected by HIV/AIDS; or as undermining response efforts through, for example, the perpetuation of HIV/AIDS-related stigma and the rejection of condoms as an effective prevention strategy. As demonstrated by this study, however, the HIV/AIDS prevention response of FBOs varies depending on a number of inter-relating and sometimes conflicting factors. This study showed, for example, how organizations' HIV/AIDS prevention policy process varies depending on the interaction between the faith structure that the organization is a part of, the presence or absence of organization policy, and the professional nature of the organization and its actors.

In order to move away from oversimplified notions of FBOs' prevention response, the diversity of FBOs needs to be represented and studied, both in terms of organizational type (e.g. local, national, and international NGOs; churches or mosques) and faith. In particular, more research needs to be conducted on the Muslim response to HIV/AIDS, an area that has only recently been given attention within the literature. In addition, Pentecostal and other charismatic FBOs are increasingly becoming involved in HIV/AIDS prevention, but little is known about their response efforts. At the time of data collection, for example, a Pentecostal NGO had recently been set up within Tanzania to respond to HIV/AIDS. If government and other organizations are to work effectively with FBOs in their HIV/AIDS prevention response

efforts, a greater understanding of the diversity of FBOs' HIV/AIDS prevention response is needed. As FBOs are actively working in the area of HIV/AIDS worldwide, future research could therefore draw upon the findings presented here in order to undertake similar studies and explore the diversity of FBOs' prevention response within other contexts.

8.4.2 Strengthening the Implementation of HIV/AIDS Prevention within FBOs

As evidenced by the findings, there are multiple inter-relating factors that influence the HIV/AIDS prevention policy process of faith-based NGOs. Although common factors were found across the three organizations, the influence of these factors at the implementation stage differed. As a result, the implementation of HIV/AIDS prevention within each organization can be strengthened in different ways. Within the Catholic organization, for example, bio-medical professional discourses were found to conflict with religious discourses, creating a discrepancy between organizational policy and practice where actors employed strategies to circumvent faith directives. This tension was created as a result of competing understandings of HIV/AIDS. Due to actors' professional experience and education, and their proximity to the problem and local situation, their understanding of HIV/AIDS and effective prevention techniques was different from the Catholic Church. As evidenced in Chapter 5, many respondents felt that HIV prevention was much more complex than the ABC (abstinence, faithfulness, and condom use) debate, and the Catholic Church was too rigid in its HIV/AIDS prevention response. This conflict therefore placed added tensions on professionals working within this organization, where a professional understanding of HIV/AIDS did not correspond with religious directives. It is unclear what effect this has on the professionals working within faith-based professional organizations, compared to professionals working in organizations without faith restrictions. Future avenues of research could explore these tensions and their effect on professionals within FBOs and overall prevention efforts in greater detail, in order to understand better how such tensions are impacting on HIV/AIDS prevention response efforts at the organizational and national levels.

It is also important for wider faith structures that employ restrictive religious directives, such as the Catholic Church, to understand the tensions placed on professionals working within professional FBOs. Such tensions create conflicting HIV/AIDS prevention messages that can negatively impact on intended HIV/AIDS prevention efforts. HIV/AIDS prevention is more complex than the abstinence, faithfulness, and condom debate, and there are certain cases where solely promoting abstinence or faithfulness may not work, such as with discordant

couples. In order to reduce these tensions and their negative effect on intended HIV/AIDS prevention efforts the Catholic Church would need to relax its restrictions on the promotion of condom use, particularly as condoms have proven to be an effective HIV/AIDS prevention strategy. The Catholic Church in Tanzania has already shown its willingness to relax its position on controversial issues, such as by allowing the organization to target and work with men who have sex with men, and the current Pope, Pope Benedict XVI, has recently ended the Catholic Church's absolute ban on condoms by permitting them within certain instances, such as with male commercial sex workers (BBC News, 2010). It is therefore not infeasible for the Church to further relax its position on condoms. By basing policy on belief as opposed to evidence, and advocating for strategies that go against national HIV/AIDS response efforts, the Catholic Church is contributing to the unbalanced messages and confusion about the effectiveness of condoms in HIV/AIDS prevention discussed within the NMSF. Further research is needed in order to understand the effects of these unbalanced messages on overall response efforts.

Unlike the Catholic organization, the Anglican organization was part of a faith structure that chose to remain silent on issues of sexuality and HIV prevention. As stated above, the organization itself had a degree of separation from the Anglican Church and no faith directives concerning how it should respond to HIV prevention were given. At the same time, the organization did not have a clear organizational policy concerning HIV/AIDS. Actors therefore retained a degree of discretion in their relations with clients, basing their decisions on their own individual professional or religious understanding of HIV/AIDS, which resulted in diverse HIV/AIDS prevention practices. Similar to the Catholic organization, these conflicting HIV/AIDS prevention messages have the potential to impact negatively on HIV/AIDS prevention efforts. While the Anglican Church's silence regarding HIV/AIDS prevention reduces the tensions that were found within the Catholic organization, the organization's lack of HIV/AIDS policy contributes to the implementation of these competing messages. While I recognize that the lack of policy may be a pragmatic approach, in order to reduce the potential negative impact of the organization's current conflicting HIV prevention messages, an appropriate organizational policy and uniform organizational response would need to be created. As the effects of these conflicting messages on the health of the community and overall HIV prevention efforts are unknown, this is also an avenue for future research.

As discussed above, compared to the Catholic and Anglican organizations, the Muslim organization is not accountable to a larger religious body; as an organization it therefore

retains a large degree of discretion regarding its HIV prevention response. At the same time, however, it is part of what has been described as a permeating faith structure which, compared to other religions, is more regulating with regards to everyday life. This, in addition to the organization's identity as a non-professional volunteer faith-based organization, led to a shared religious understanding of HIV/AIDS and therefore lack of conflicting bio-medical and religious discourses within the organization. As a result, the organization had a uniform and consistent approach to HIV/AIDS. At the same time, however, the organization's explicit association of HIV infection to sin, or *zinaa* (adultery and fornication), likely perpetuates HIV-related stigma, particularly gender-related stigma where women are regarded as the bearers of morality, evidenced by the organization's gender specific messages about how women should dress. The association of HIV/AIDS to sex, sin, immorality, and religious beliefs, and its relationship to HIV-related stigma was discussed in Chapter 2. HIV-related stigma has been proven to affect HIV/AIDS prevention efforts negatively. It is important, therefore, for the organization to recognize how religiously influenced HIV prevention messages and strategies can perpetuate HIV-related stigma and negatively influence overall prevention efforts. In addition, the organization's HIV/AIDS prevention response was found to conflict with national response efforts, particularly in relation to the promotion of condoms to the unmarried population. Similar to the Catholic and Anglican organizations, more exploration is therefore needed into the impact of the organizations' messages on national HIV/AIDS response efforts. In particular, religious and organizational leaders need to be made aware through education and training about how their prevention response can affect national prevention efforts, such as what is advocated for within the National Multi-Sectoral Framework.

8.4.3 Strengthening FBOs' Role in Wider HIV/AIDS Prevention Response Efforts

Chapter 4 discussed how the Tanzanian government needs to work with FBOs if they are to effectively respond to the HIV/AIDS epidemic. In order to do so, however, it is important for there to be a better understanding of FBOs' HIV/AIDS prevention response. This study therefore sought to explore the factors influencing the HIV/AIDS prevention policy process, and how faith is reflected in and interacts with these factors, in order to understand better the processes that influence FBOs' HIV/AIDS prevention response. By understanding these processes, and how they conflict with the national HIV/AIDS response, I hope that the government will be able to identify how best to intervene or work with FBOs in order to meet their HIV/AIDS prevention targets.

As discussed above, the NMSF states that all CSOs, including FBOs, have to operate within the framework of the NMSF. However, by allowing FBOs to respond to HIV/AIDS according to their beliefs, as opposed to evidence, the government is undermining national HIV/AIDS prevention response efforts. By increasing their capacity to enforce the NMSF and ensure organizations are implementing evidence-based prevention interventions, a more balanced and uniform approach to HIV/AIDS prevention can be achieved within the country. In order to do so, however, the government needs to first ensure that national policy documents are clear and specific and are effectively disseminated to all FBOs working in the area of HIV/AIDS, particularly as only one of the three organizations within this study possessed national policy documents. This would require the distribution of policy documents and instruction of FBOs' management of their effective use. In addition, increased advocacy and regulation of FBOs is needed if FBOs are going to accept and/or promote condoms, particularly in relation to discordant couples. At the same time, the government must recognize that if organizations are to work within the national response, they must be given adequate support and resources to do so.

Further research could therefore explore how FBOs' HIV/AIDS prevention response corresponds to the NMSF, in terms of how FBOs are using the NMSF, how FBOs understand the NMSF, and ways in which the FBO response specifically contradicts the NMSF. To support this, further research could also explore what kind of support is needed for FBOs to work within the NMSF, what is needed to ensure FBOs do not contradict national response efforts, and ways in which the NMSF could be better enforced when FBOs' HIV/AIDS prevention response is found to contradict with the NMSF. This research could also be supported by the inclusion of government perspectives about the role of FBOs in national HIV/AIDS response efforts. Such research would complement this study by providing a better picture of the overall faith-based response to HIV/AIDS prevention in addition to providing specific examples of how FBOs' response corresponds to or contradicts with national response efforts and what is needed to ensure FBOs work according to the NMSF. As this research also has implications beyond Tanzania and the findings may be useful for governments within other countries, particularly those which have a large faith-based HIV response, future research could also explore the factors influencing the faith-based response to HIV/AIDS prevention within other contexts.

The donor context also plays a role in shaping national and organizational HIV/AIDS prevention response efforts. The ability of organizations to access funding affects their HIV/AIDS-related activities and their overall involvement in HIV/AIDS response efforts. Although the size of each organization differed, there was a stark difference in the organizations' ability to access funding and funding sources. The Catholic organization had the largest funding base, most of which came from non faith-based sources and, despite the short-term nature of funding grants, the organization was able to continually access funding to ensure the longevity of most programmes. The Anglican organization, on the other hand, sourced funding from predominately Anglican donors whose funding went to short-term projects that completed within 1-3 years. In comparison, the Muslim organization was unable to access funding from external donors, leaving them reliant on member contributions to implement their services. The Muslim organization's lack of capacity to obtain resources affected its ability to respond to the HIV/AIDS epidemic. If it is to access funding it needs to develop the capacity, in the form of skills and knowledge, to work within donors' boundaries. At the same time, it is important for donors to recognize the potential of non-professional organizations, like the Muslim organization, to respond to the epidemic. Exploring the effect of donor boundaries on the role of non-professional organizations within overall response efforts is therefore an important area for future research, especially if such organizations are being systematically excluded due to their inability to access funding. In particular, this research could explore the effect of basket funding on the role of non-professional organizations, which appeared to be related to the Muslim organization's inability to obtain funding.

8.5 Conclusion

FBOs are important actors within overall HIV/AIDS prevention response efforts; however, currently understanding of FBOs' HIV/AIDS prevention responses is lacking. In order to adequately engage with such organizations and effectively include them in HIV/AIDS response efforts, there needs to be an understanding of the factors that shape organizations' HIV/AIDS prevention policy processes and response. This chapter analysed the study's main findings by comparing the factors influencing the HIV/AIDS prevention policy process within the three case study organizations, in order to better understand the processes that influence FBOs' HIV/AIDS prevention content, or response. This study found that FBOs' HIV/AIDS prevention response varies between organizations depending on the faith structure of which they are a part, the presence or absence of organizational policy, and the professional nature of the organizations and their actors. It also found that it is the interaction between these factors that influences

organizations' HIV/AIDS prevention response, and the extent to which this response corresponds with or contradicts national response efforts. The chapter concluded with a discussion of the implications of the findings for research, policy, and practice.

It is clear that faith-based organizations play an important role in the overall HIV/AIDS response. Their influence and moral authority over issues closely connected to HIV, and their ability to reach large groups of people through existing networks, for example, have placed them in a unique position to contribute to HIV/AIDS prevention and mitigation. At the same time, the faith-based response to HIV/AIDS is often seen as incompatible with more secular and evidence-based approaches to HIV/AIDS. The faith-based response to HIV/AIDS, however, is not uniform; it differs across different types of FBOs, and across FBOs of different faiths. It is therefore important to try to understand better the different faith-based responses to HIV/AIDS and how they are translated into practices which affect national response efforts. As organizations' programmes and activities are highly influenced by their policy processes, the study sought to understand the organizations' overall HIV/AIDS prevention response through the factors that influence their HIV/AIDS prevention policy process, and how faith is reflected in and interacts with the factors within this process. The research therefore applied the role of faith to Walt and Gilson's health policy framework in an attempt to gather new evidence and gain further theoretical understanding of organizational HIV/AIDS prevention policy processes of faith-based NGOs of different faiths.

As evidenced by the above case studies, there are multiple inter-relating and sometimes conflicting factors that influence faith-based NGOs' HIV/AIDS prevention response efforts. It is the interaction between these factors, and how actors negotiate between them, that shape how an organization responds to the epidemic. By exploring the factors and processes that influence the HIV/AIDS prevention policy process of faith-based NGOs, this research has contributed to a greater understanding of the faith-based response to HIV/AIDS. By understanding these factors and processes, and how they conflict with the national HIV/AIDS response, I hope that not only more appropriate policies can be developed and implemented within FBOs, but the government can identify how best to intervene or work with FBOs in order to meet their HIV/AIDS prevention targets. I hope that by doing so a more uniform and evidence-based approach to HIV/AIDS prevention can be achieved, improving the overall role of FBOs in the fight against HIV/AIDS. In addition, as FBOs provide up to 70% of health provision, much of which includes HIV/AIDS prevention and mitigation, this research has

important implications outside the Tanzanian context. By framing a research agenda for faith-based NGOs' HIV/AIDS prevention policy processes, and filling a gap within the literature on the understanding of the faith-based response to HIV/AIDS prevention, I hope that this research will be used for further explorations into, and understanding of, the overall faith-based response to HIV/AIDS. It is only after the faith-based response to HIV/AIDS is better understood that they can be effectively included within overall HIV/AIDS response efforts.

References

- Abbott, S., Shaw, S., & Elston, J. (2004). Comparative Analysis of Health Policy Implementation. *Policy Studies*, 25(4), 259-266.
- ActionAid (2006). Stepping Stones. Retrieved 08 April 2011, from <http://www.actionaid.org/main.aspx?PageID=137>
- AKDN (2007). Aga Khan Development Network Retrieved 25 March 2010, from <http://www.akdn.org/default.asp>
- Anglican organization (2006). *Constitution*. Dar es Salaam, Tanzania: Anglican organization.
- Anglican organization (2010-2011). Anglican organization. Retrieved 29 June 2011
- Anglican organization (undated-a). *Je nipime virusi vya ukimwi (VVU)?* Dar es Salaam, Tanzania.
- Anglican organization (undated-b). *UKIMWI* Dar es Salaam, Tanzania.
- ARHAP (2006). *Appreciating Assets: The Contribution of Religion to Universal Access in Africa*. Cape Town: Report for the World Health Organization.
- ARHAP (2011). African Religious Health Assets Programme. Retrieved 1/11/11, from <http://www.arhap.uct.ac.za/index.php>
- ASAP (2008). *The HIV epidemic in Tanzania Mainland: Where have we come from, where is it going, and how are we responding?* Dar es Salaam, Tanzania: AIDS Strategy & Action Plan (ASAP), UNAIDS, and Tanzania Commission for AIDS (TACAIDS).
- Baggott, R. (2007). *Understanding Health Policy*. Bristol: The Policy Press.
- BAKWATA (2007). *Islam and AIDS: AIDS Policy Guide*. Dar es Salaam, Tanzania: Baraza Kuu La Waislamu Tanzania (BAKWATA).
- Balogun, A. S. (2011). Islamic perspectives on HIV/AIDS and antiretroviral treatment: the case of Nigeria. *African Journal of AIDS Research*, 9(4), 459-466.
- Bano, M. & Nair, P. (2007). *Faith-based Organizations in South Asia: Historical Evolution, Current Status and Nature of Interaction with the State*. Birmingham: Religion and Development Research Programme, University of Birmingham.
- Barker, C. (1996). *The Health Care Policy Process*. London: SAGE Publications.
- Barnett, T. & Whiteside, A. (2006). *AIDS in the Twenty-First Century: Disease and Globalization*. New York: Palgrave Macmillan.
- Baum, F. (2008). *The New Public Health*. Victoria: Oxford University Press.
- Baylies, C. (2000). Perspectives on gender and AIDS in Africa. In C. Baylies & J. Bujra (Eds.), *AIDS, Sexuality and Gender in Africa: Collective Strategies and Struggles in Tanzania and Zambia*. Oxen: Routledge.
- BBC News (2009). Pope's condom stance sparks row Retrieved 11 October 2011, from <http://news.bbc.co.uk/1/hi/7950671.stm>
- BBC News (2010). Pope condones condom use in exceptional cases - book. Retrieved 16 May 2011, from <http://www.bbc.co.uk/news/world-europe-11804398>
- Benedetti, C. (2006). Islamic and Christian Inspired Relief NGOs: Between Tactical Collaboration and Strategic Diffidence? *Journal of International Development*, 18, 849-859.
- Benotsch, E. G., Stevenson, L. Y., Sitzler, C. A., Kelly, J. A., Makhaye, G., Mathey, E. D., et al. (2004). HIV Prevention In Africa: Programs And Populations Served By Non-Governmental Organizations. *Journal of Community Health*, 29(4), 319-336.
- Berger, J. (2003). Religious Nongovernmental Organizations: An Exploratory Analysis. *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, 14(1), 15-39.
- Boesten, J. (2011). Navigating the AIDS Industry: Being Positive and Poor in Tanzania. *Development and Change*, 42(3), 781-803.

- Boesten, J. & Poku, N. K. (Eds.). (2009). *Gender and HIV/AIDS: Critical Perspectives from the Developing World*. Farnham: Ashgate.
- Britten, N. (2006). Qualitative Interviews. In C. Pope & N. Mays (Eds.), *Qualitative Research in Health Care*. Malden, Oxford & Carlton: Blackwell Publishing.
- Browning, M. D. (2009). HIV/AIDS Prevention and Sexed Bodies: Rethinking Abstinence in Light of the African AIDS Pandemic. *Theology & Sexuality*, 15(1), 29-47.
- Bureau of African Affairs (2009). Background Note: Tanzania. Retrieved 23 February 2010, from <http://www.state.gov/r/pa/ei/bgn/2843.htm>
- Bureau of Democracy, Human Rights, and Labour (2007). International Religious Freedom Report 2007. Retrieved 24 February, 2010, from <http://www.state.gov/g/drl/rls/irf/2007/90124.htm>
- Bureau of Democracy, Human Rights, and Labour (2008). International Religious Freedom Report 2008. Retrieved 14 May, 2010, from <http://www.state.gov/g/drl/rls/irf/2008/108395.htm>
- Bureau of Democracy, Human Rights, and Labour (2009). International Religious Freedom Report 2009. Retrieved 14 May, 2010, from <http://www.state.gov/g/drl/rls/irf/2009/127259.htm>
- Buse, K., Jones, N., & Hawkes, S. (2008). *How to analyse policy to effect change: practical guidelines*: ODI.
- Buse, K., Mays, N., & Walt, G. (2005). *Making Health Policy*. Maidenhead: Open University PRESS.
- Campbell, C., Foulis, C. A., Maimame, S., & Sibiya, Z. (2005). "I Have an Evil Child at My House": Stigma and HIV/AIDS Management in a South African Community. *American Journal of Public Health*, 95(5), 808-815.
- Campbell, C., Nair, Y., & Maimane, S. (2006). AIDS, Stigma, Sexual Moralities and the Policing of Women and Youth in South Africa. *Sexual Moralities* 83, 132-138.
- Campbell, C., Nair, Y., Maimane, S., & Nicholson, J. (2007). 'Dying Twice': A Multi-level Model of the Roots of AIDS Stigma in Two South African Communities. *Journal of Health Psychology*, 12(3), 403-416.
- Casale, M., Nixon, S., Flicker, S., Rubincam, C., & Jenney, A. (2010). Dilemmas and tensions facing a faith-based organization promoting HIV prevention among young people in South Africa. *African Journal of AIDS Research*, 9(2), 135-145.
- CCT (2007-2009). Christian Council of Tanzania. Retrieved 18 March 2010, from <http://cct-tz.org/index.php>
- Clarke, G. (2006). Faith Matters: Faith-Based Organizations, Civil Society and International Development. *Journal of International Development*, 18, 835-848.
- Clarke, G. (2008). Faith-Based Organizations and International Development: An Overview. In G. Clarke & M. Jennings (Eds.), *Development, Civil Society, and Faith-Based Organizations: Bridging the Sacred and the Secular*. New York: Palgrave Macmillan.
- Coates, T. J., Richter, L., & Caceros, C. (2008). Behavioural strategies to reduce HIV transmission: how to make them work better. *Lancet*, 372(669-684).
- Collins, C., Green, A., & Hunter, D. (1999). Health sector reform and the interpretation of policy context. *Health Policy and Planning*, 47, 69-83.
- Conger, G. (2010, January 1). Row over condoms is settled. *The Church of England Newspaper*, p. 7.
- Conger, G. (2011, June 24). Church politics behind archbishop's arrest warrant. *The Church of England Newspaper*, p. 9.
- Creswell, J. W. & Miller, D. L. (2000). Determining Validity in Qualitative Inquiry. *Theory into Practice*, 39(3), 124-130.
- CSSC (2004-2009). Christian Social Services Commission. Retrieved 18 March 2010, from <http://www.cssc.or.tz/index.php>

- Denis, P. (2009). The Church's Impact on HIV Prevention and Mitigation in South Africa. Reflections of a Historian. *Journal of Theology for Southern Africa*, 134, 6681.
- Denny, F. M. (1994). *An Introduction to Islam*. New York: Macmillan Publishing Company.
- Denscombe, M. (2007). *The Good Research Guide: for small-scale social research projects*. New York Open University Press.
- Dickinson, C. & Buse, K. (2008). *Understanding the politics of national HIV policies: the roles of institutions, interests and ideas*: HLSP Institute.
- Dilger, H. (2009). Doing Better? Religion, the Virtue-Ethics of Development, and the Fragmentation of Health Politics in Tanzania. *Africa Today*, 56(1), 89-110.
- Dilger, H., Burchardt, M., & Dijk, R. v. (2010). Introduction - The redemptive movement: HIV treatments and the production of new religious spaces. *African Journal of AIDS Research*, 9(4), 373-383.
- DPP (2008). *Annual Health Statistical Abstract Tanzania Mainland 2008*. Dar es Salaam, Tanzania: Health Information and Research Section, Department of Policy and Planning (DPP).
- Ellis, S. & ter Haar, G. (2004a). *Religion and Development in Africa*: Commission for Africa.
- Ellis, S. & ter Haar, G. (2004b). *Worlds of Power: Religious Thought and Political Practice in Africa*. London: Hurst & Company.
- Ezzy, D. (2002). *Qualitative Analysis: Practice and Innovation*. London: Routledge.
- Ferrari, L. L. (2011). Catholic and Non-Catholic NGOs Fighting HIV/AIDS in Sub-Saharan Africa: Issue Framing and Collaboration. *International Relations*, 25(85), 85-107.
- Gausset, Q. (2001). AIDS and cultural practices in Africa: the case of the Tonga (Zambia). *Social Science & Medicine*, 51, 509-518.
- Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report*, 8(4), 597-607.
- Goldstein, J. & Keohane, R. O. (1993). Ideas and Foreign Policy: An Analytical Framework. In J. Goldstein & R. O. Keohane (Eds.), *Ideas and Foreign Policy: Beliefs, Institutions, and Political Change*. Ithaca and London: Cornell University Press.
- Gray, P. B. (2004). HIV and Islam: is HIV prevalence lower among Muslims? *Social Science & Medicine*, 58, 1751-1756.
- Green, A. & Matthias, A. (1997). *Non-Governmental Organizations and Health in Developing Countries*. London: Macmillan Press Ltd.
- Green, A., Shaw, J., Dimmock, F., & Conn, C. (2002). A Shared Mission? Changing Relationships between government and church health services in Africa. *International Journal of Health Planning and Management*, 17, 333-353.
- Green, E. C. (2001). *The Impact of Religious Organizations in Promoting HIV/AIDS prevention*. Paper presented at the Challenges for the Church: AIDS, Malaria & TB, Christian Connections for International Health.
- Gupta, G. G., Parkhurst, J. O., Ogden, J. O., Aggleton, P., & Mahal, A. (2008). Structural approaches to HIV prevention. *Lancet*, 372, 764-775.
- Hamblin, J. & Reid, E. (1991). *Women, the HIV Epidemic and Human Rights: A Tragic Imperative*: United Nations Development Program. Issue Paper 8.
- Hancock, B., Ockleford, E., & Windridge, K. (2007). *Trent Focus for Research and Development in Primary Health Care: An Introduction to Qualitative Research*: Trent Focus.
- Hansen, E. C. (2006). *Successful Qualitative Health Research: A Practical Introduction*. Maidenhead: Open University Press.
- Harman, S. (2009). Fighting HIV and AIDS: Reconfiguring the State? *Review of African Political Economy*, 36(121), 353-367.
- Hartwig, K. A. (2001). *Tanzania's Organizational Response to the AIDS Pandemic: An Embedded Case Study of Arusha Region, 1989-1999*. University of North Carolina, Chapel Hill.

- Hasnain, M. (2005). Cultural Approach to HIV/AIDS Harm Reduction in Muslim Countries. *Harm Reduction Journal*, 2(23), 8 pages.
- Hill, M. (1997). *The Policy Process: A Reader*. Essex: Pearson Education Limited.
- Hill, M. (2005). *The Public Policy Process*. Essex: Pearson Education Limited.
- James, R. (2009). *Praxis Paper 22: What is distinctive about FBOs?: How European FBOs define and operationalise their faith: INTRAC*.
- Jayasinghe, S. (2007). Faith-based NGOs and healthcare in poor countries: a preliminary exploration of ethical issues. *Journal of Medical Ethics*, 33, 623-626.
- Jenkins-Smith, H. C. & Sabatier, P. A. (1993). The Study of Public Policy Processes. In P. A. Sabatier & H. C. Jenkins-Smith (Eds.), *Policy Change and Learning: An Advocacy Coalition Approach* (pp. 1-9). Boulder: Westview Press.
- Jenkins, B. (1997). Policy Analysis: Models and Approaches. In M. Hill (Ed.), *The Policy Process: A Reader* (pp. 30-38). Essex: Pearson Education Limited.
- Jones, G. R. (2001). *Organizational Theory: Text and Cases*. Upper Saddle River, New Jersey: Prentice Hall.
- Jones, P. (2004). When 'development' devastates: donor discourses, access to HIV/AIDS treatment in Africa and rethinking the landscape of development. *Third World Quarterly*, 25(2), 385-404.
- Joshua, S. M. (2011). A critical historical analysis of the South African Catholic Church's HIV/AIDS response between 2000 and 2005. *African Journal of AIDS Research*, 9(4), 437-447.
- Kelly, J. A., Somlai, A. M., Benotsch, E. G., Amirkhanian, Y. A., Fernandez, M. I., Stevenson, L. Y., et al. (2006). Programmes, Resources, And Needs of HIV-Prevention Nongovernmental Organizations (NGOs) In Africa, Central/Eastern Europe And Central Asia, Latin America And The Caribbean. *AIDS Care*, 18(1), 12-21.
- Kelly, K. J. & Birdsall, K. (2010). The effects of national and international HIV/ AIDS funding and governance mechanisms on the development of civil-society responses to HIV/AIDS in East and Southern Africa. *AIDS Care*, 22(S2), 1580-1587.
- Lacey, A. & Luff, D. (2007). *Trent Focus for Research and Development in Primary Health Care: Qualitative Data Analysis: Trent Focus*.
- Leurs, R., Tumaini-Mungu, P., & Mvungi, A. (2011). *Mapping the Development Activities of Faith-Based Organizations in Tanzania: Religions and Development*, Working Paper 58.
- Levy, N. C., Miksad, R. A., & Fein, O. T. (2005). From Treatment to Prevention: The Interplay Between HIV/AIDS Treatment Availability and HIV/AIDS Prevention Programming in Khayelitsha, South Africa. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 82(3), 498-509.
- Lewis, J. M. (2005). *Health Policy and Politics: networks, ideas and power*. Melbourne: IP Communications.
- Liebowitz, J. (2002). *The impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa: Health Economics and HIV/AIDS Research Division (HEARD)*, University of Natal.
- Lipsky, M. (1980). *Street Level Bureaucracy: Dilemmas of the Individual in the Public Services*. New York: Russell Sage Foundation.
- Lipson, J. G. (1994). Ethical Issues in Ethnography. In J. M. Morse (Ed.), *Critical Issues in Qualitative Research Methods* (pp. 333-355). London: Sage Publications.
- Long, T. & Johnson, M. (2000). Rigour, reliability and validity in qualitative research. *Clinical Effectiveness in Nursing*, 4, 30-37.
- Lux, S. & Greenaway, K. (2006). *Scaling up Effective Partnerships: A guide to working with faith-based organizations in the response to HIV and AIDS: Ecumenical Advocacy Alliance*.
- Maulana, A. O., Krumeich, A., & Borne, B. V. D. (2009). Emerging discourse: Islamic teaching in HIV prevention in Kenya. *Culture, Health & Sexuality*, 11(5), 559-569.

- Maxwell, J. A. (1992). Understanding and Validity in Qualitative Research. *Harvard Educational Review*, 62(3), 279-300.
- Mayer, K. H., Skeer, M., & Mimiaga, M. J. (2010). Biomedical Approaches to HIV Prevention. *Alcohol Research & Health*, 33(3), 195-202.
- Mbogoni, L. E. Y. (2005). *The Cross versus The Crescent: Religion and Politics in Tanzania from the 1880s to the 1990s*. Dar es Salaam: Mkuki na Nyota Publishers.
- Mbonu, N. C., Borne, B. v. d., & Vries, N. K. D. (2009). Stigma of People with HIV/AIDS in Sub-Saharan Africa: A Literature Review. *Journal of Tropical Medicine*, 2009, 14 pages.
- Mercer, C. (1998). Reconceptualizing state-society relations in Tanzania: are NGOs 'making a difference'? *Area*, 31(3), 247-258.
- Merson, M. H., O'Malley, J., Serwadda, D., & Apisuk, C. (2008). The history and challenge of HIV prevention. *Lancet*, 372, 475-488.
- Miller, F. A. & Alvarado, K. (2005). Incorporating Documents into Qualitative Nursing Research. *Journal of Nursing Scholarship*, 37(4), 348-353.
- Mmanda, E. (2008). *NGO Work in Tanzania: Highlights of relevant facts, policies and laws* Helsinki, Finland: KEPA.
- MoFA & GoT (2009). *United Republic of Tanzania Health Sector Programme of Support HSPS IV (2009-2014): Overall Programme Document*: Ministry of Foreign Affairs Denmark and Government of Tanzania.
- MOHSW (2007). *Health Sector HIV and AIDS Strategic Plan*. Dar es Salaam, Tanzania: Ministry of Health and Social Welfare - Tanzania Mainland.
- MOHSW (2009). *Health Sector Strategic Plan III July 2009-2015*. Dar es Salaam, Tanzania: Ministry of Health and Social Welfare.
- MOHSW & WHO (2007). *Tanzania Service Availability Mapping 2005-2006*. Geneva: Ministry of Health and Social Welfare and World Health Organization.
- Moszynski, P. (2008). Kenyan Muslim clerics decide to campaign against use of condoms. *British Medical Journal*, 336, 1154.
- NACP (2008). HIV/AIDS in Tanzania. Retrieved 02 March 2010, from http://www.nacp.go.tz/about_us/HIV_AIDS_in_Tanzania.php
- NBS (2005). *Tanzania Demographic and Health Survey 2004-2005*. Dar es Salaam, Tanzania: National Bureau of Statistics and ORC Macro.
- NBS & Macro International Inc (2009). *Tanzania HIV/AIDS and Malaria Indicator Survey: Key Findings*. Calverton, Maryland, USA: National Bureau of Statistics (NBS) and Macro International Inc.
- Noar, S. M. (2008). Behavioral Interventions to Reduce HIV-related Sexual Risk Behavior: Review and Synthesis of Meta-Analytic Evidence. *AIDS Behaviour*, 12, 335-353.
- Ogden, J. & Nyblade, L. (2005). *Common at its Core: HIV-related Sigma Across Contexts*: International Centre for Research on Women (ICRW).
- Olivier, J., Cochrane, J. R., Schmid, B., & Graham, L. (2006). *ARHAP Literature Review: Working in a bounded field of unknowing*. Cape Town: African Religious Health Assets Programme.
- Padian, N. S., Buve, A., Balkus, J., Serwadda, D., & Jr., W. C. (2008). Biomedical interventions to prevent HIV infection: evidence, challenges, and way forward. *The Lancet*, 372, 585-599.
- Parker, R. G., Easton, D., & Klein, C. H. (2000). Structural barriers and facilitators in HIV prevention: a review of international research. *AIDS*, 14(suppl 1), S22-S32.
- Parker, W. & Birdsall, K. (2005). *HIV/AIDS, Stigma and Faith-based Organizations: A review*: Developed by Centre for AIDS Development, Research and Evaluation (CADRE) on behalf of Futures Group.
- PASADA (2006). *Building on Hope: PASADA Best Practices*. Dar es Salaam, Tanzania: PASADA.

- PASADA (2007a). *Let's Talk About HIV/AIDS: A Tool for Community Educators*. Dar es Salaam, Tanzania: PASADA.
- PASADA (2007b). *PASADA Annual Report 2007*. Dar es Salaam, Tanzania: PASADA.
- PASADA (2009). *Employment Contract*. Dar es Salaam, Tanzania: PASADA.
- PASADA (Undated). *Guidelines for presenters of "now that you know" or now you know that you can live with HIV*. Dar es Salaam, Tanzania: PASADA.
- Patterson, A. S. (2005). Introduction: The African State and the AIDS Crisis. In A. S. Patterson (Ed.), *The African State and the AIDS Crisis*. Aldershot: Ashgate.
- Poku, N. K. & Whiteside, A. (2004). Introduction: Africa's HIV/AIDS Crisis. In N. K. Poku & A. Whiteside (Eds.). Aldershot: Ashgate.
- Pope, C., Ziebland, S., & Mays, N. (2006). Analysing Qualitative Data. In C. Pope & N. Mays (Eds.), *Qualitative Research in Health Care*. Malden, Oxford & Carlton: Blackwell Publishing.
- Porter, R. W. & Hicks, I. (1998). *Knowledge Utilization and the Process of Policy Formation: Towards a Framework for Africa: Health and Human Resources Analysis for Africa (HHRAA)*, USAID.
- Pressman, J. L. & Wildavsky, A. (1984). *Implementation*. Berkeley, CA: University of California Press.
- Rankin, S. H., Lindgren, T., Kools, S. M., & Schell, E. (2008). The Condom Divide: Disenfranchisement of Malawi Women by Church and State. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 37, 596-606.
- Rasmussen, L. (1993). *Christian-Muslim Relations in Africa: The Cases of Northern Nigeria and Tanzania Compared*. London & New York: British Academic Press.
- RFE (2006). Rapid Funding Envelope for HIV/AIDS: Tanzania. Retrieved 09/08/11, from <http://www.rapidfundingenvelope.org/>
- Ritchie, J. & Spencer, L. (1993). Qualitative data analysis for applied policy research. In A. Bryman & R. Burgess (Eds.), *Analysing Qualitative Data* (pp. 173-193). London: Routledge.
- Ritichie, J., Spencer, L., & O'Connor, W. (2003). Carrying out Qualitative Analysis. In J. Ritichie & J. Lewis (Eds.), *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage Publications.
- Sabatier, P. & Mazmanian, D. A. (1979). The conditions of effective implementations: a guide to accomplishing policy objectives. *Policy Analysis*, 5, 481-504.
- Setel, R. W. (1999). Local Histories of Sexually Transmitted Diseases and AIDS in Western and Northern Tanzania. In P. W. Setel, M. Lewis, & M. Lyons (Eds.), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa*. Westport, Connecticut & London: Greenwood Press.
- Sider, R. J. & Unruh, H. R. (2004). Typology of Religious Characteristics of Social Service and Educational Organizations and Programs. *Nonprofit and Voluntary Sector Quarterly*, 33(1), 109-134.
- Siplon, P. (2005). AIDS and Patriarchy: Ideological Obstacles to Effective Policy Making. In A. S. Patterson (Ed.), *The African State and the AIDS Crisis*. Aldershot: Ashgate.
- Spencer, L., Ritchie, J., & O'Connor, W. (2003). Analysis: Practices, Principles and Processes. In J. Ritichie & J. Lewis (Eds.), *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage Publications.
- Stein, J., Lewin, S., & Fairall, L. (2007). Hope is the pillar of the universe: Health-care providers' experiences of delivering anti-retroviral therapy in primary health-care clinics in the Free State province of South Africa. *Social Science & Medicine*, 64, 954-964.
- Stillwaggon, E. (2000). HIV Transmission in Latin America: Comparison with Africa and Policy Implications. *South African Journal of Economics*, 68(5), 985-1011.
- Stillwaggon, E. (2005). *AIDS and the Ecology of Poverty*. Oxford: Oxford University Press.

- Sumartojo, E. (2000). Structural factors in HIV prevention: concepts, examples, and implications for research. *AIDS*, 14(suppl 1), S3-S10.
- TACAIDS, NBS, & ORC Macro (2005). *Tanzania HIV/AIDS Indicator Survey*. Calverton, Maryland, USA: Tanzania Commission for AIDS (TACAIDS), National Bureau of Statistics (NBS), and ORC Macro.
- TACAIDS, ZAC, NBS, OCGS, & Macro International Inc (2008). *Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)*. Dar es Salaam, Tanzania: Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and Macro International Inc.
- TEC (2002). Tanzania Episcopal Conference. Retrieved 18 March 2010, from <http://tecdirectory.tripod.com/TECBook.htm>
- TEC (2004). *HIV/AIDS Policy*. Dar es Salaam, Tanzania: Tanzania Episcopal Conference (TEC).
- Thomas, L., Schmid, B., Gwele, M., Ngubo, R., & Cochrane, J. R. (2006). "Let us Embrace": *The Role and Significance of an Integrated Faith-Based Initiative for HIV and AIDS*. Eastern Cape, South Africa: ARHAP.
- Tiendrebeogo, G. & Buyckx, M. (2004a). *Bulletin 361: Faith-Based Organizations and HIV/AIDS Prevention and Impact Mitigation in Africa*. Amsterdam: Royal Tropical Institute, KIT Development, Policy and Practice.
- Tiendrebeogo, G., Buyckx, M., & Beelen, N. V. (2004b). Faith-based responses and opportunities for a multisectoral approach. *Sexual Health Exchange*, 2004/1, 1-3.
- Trinitapoli, J. (2009). Religious teachings and influences on the ABCs of HIV prevention in Malawi. *Social Science & Medicine*, 69, 199-209.
- Turmen, T. (2003). Gender and HIV/AIDS. *International Journal of Gynecology and Obstetrics*, 82, 411-418.
- UMFAA (2001). *Constitution of United Muslim Fighters Against AIDS (UMFAA)*. Dar es Salaam, Tanzania: United Muslim Fighters Against AIDS (UMFAA).
- UMFAA. (undated). UKIMWI NA UISLAMU. Dar es Salaam, Tanzania: United Muslim Fighters against AIDS (UMFAA).
- UNAIDS (2010). *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010: Joint United Nations Programme on HIV/AIDS (UNAIDS)*.
- UNAIDS & WHO (2008). *Epidemiological Fact Sheet on HIV and AIDS: United Republic of Tanzania*. Geneva: Joint United Nations Programme on HIV/AIDS and World Health Organization
- URT-PMO (2001). *National Policy on HIV/AIDS*. Dar es Salaam: United Republic of Tanzania Prime Minister's Office.
- URT-PMO (2007). *National Multi-Sectoral Strategic Framework on HIV and AIDS (2008-2012)*. Dar es Salaam, Tanzania: United Republic of Tanzania Prime Minister's Office.
- URT (2002). *The Non-Governmental Organizations Act, 2002*.
- URT (2007). *The HIV and AIDS (Prevention and Control) Act*. Dar es Salaam, Tanzania: United Republic of Tanzania.
- URT (2009). *Poverty and Human Development Report*. Dar es Salaam, Tanzania: Research & Analysis Working Group, United Republic of Tanzania (URT).
- VPO (2001). *The National Policy on Non-Governmental Organizations (NGOs)*.
- Walt, G. (1994). *Health Policy: An Introduction to Process and Power*. London & New Jersey: Zed Books.
- Walt, G. & Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning*, 9(4), 353-370.
- Web, D. (2004). Legitimate Actors? The Future Roles for NGOs Against HIV/AIDS in Sub-Saharan Africa. In N. K. Poku & A. Whiteside (Eds.), *The Political Economy of AIDS in Africa* (pp. 19-32). Aldershot: Ashgate.

- Weller, S. & Davis-Beaty, K. (2002). The effectiveness of male condoms in prevention of sexually transmitted diseases. (Protocol). *Cochrane Database of Systematic Reviews*(4).
- Weller S.C. & Davis-Beaty K. (2002). Condom effectiveness in reducing heterosexual HIV transmission. *Cochrane Database of Systematic Reviews*(1).
- Whiteside, A. (2002). Poverty and HIV/AIDS in Africa. *Third World Quarterly*, 23(2), 313-332.
- Whiteside, A. (2005). The Economic, Social, and Political Drivers of the AIDS Epidemic in Swaziland: A Case Study. In A. S. Patterson (Ed.), *The African State and the AIDS Crisis*. Aldershot: Ashgate.
- WHO (2006). *Country Health System Fact Sheet 2006: United Republic of Tanzania*: World Health Organization.
- WHO (2007). *Sound Choices: Enhancing Capacity for Evidence-Informed Health Policy*. Geneva: World Health Organization.
- WHO (2009). *World Health Statistics 2009*. Geneva: World Health Organization.
- World Factbook, C. (2011). The World Factbook: Tanzania. Retrieved 18 November 2011, from <https://www.cia.gov/library/publications/the-world-factbook/geos/tz.html>
- Zou, J., Yamanaka, Y., John, M., Watt, M., Ostermann, J., & Thielman, N. (2009). Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes. *BMC Public Health*, 9(75).

Appendix A – Literature Search Strategy

Databases used:

Web of knowledge
 Science Direct
 Embase
 Google Scholar
 OVID Medline

Search Terms:

Policy processes

Religion and HIV/AIDS
 Religion and HIV/AIDS Prevention

Religion in Africa
 Religion and Development

Faith-based organizations/ Religious organizations
 Faith-based organizations and policy

Faith-based organizations and HIV/AIDS
 Faith-based organizations and HIV/AIDS and Africa
 Faith-based organizations and HIV/AIDS and Tanzania

Faith-based organizations and HIV/AIDS prevention
 Faith-based organizations and HIV/AIDS prevention and Africa
 Faith-based organizations and HIV/AIDS prevention and Tanzania

Faith-based organizations and HIV/AIDS policy
 Faith-based organizations and HIV/AIDS policy and African
 Faith-based organizations and HIV/AIDS policy and Tanzania

Non-governmental organizations (NGO)
 Non-governmental organizations and HIV/AIDS
 Non-governmental organizations and HIV/AIDS and Africa
 Non-government organizations and HIV/AIDS prevention
 Non-government organizations and HIV/AIDS prevention and Africa

HIV/AIDS in Africa
 HIV/AIDS in Tanzania
 HIV/AIDS prevention
 HIV/AIDS prevention in Africa
 HIV/AIDS prevention in Tanzania

Appendix B – Research Process and Activities

Table 8 – Research Process and Activities

Stage/ Activity	2007	2008				2009				2010				2011			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Literature review																	
Defining research project																	
Preparation of transfer report																	
Ethical approval and research clearance																	
Preparation of data collection tools																	
Data collection																	
Preliminary Analysis during Data collection																	
Transcription																	
Data management - Coding																	
Data management - Charting																	
Data analysis																	
Writing up of thesis																	

Appendix C – Fieldwork Timetable

Table 9 – Fieldwork Timetable June 2009 – November 2009

Task	June	July	August	September	October	November
Country familiarization						
Contextual data collection						
Selection of case studies						
Catholic Org. data collection						
Anglican Org. data collection						
Muslim Org. data collection						

Appendix D – Interview Topic Guides

Interview Topic Guide – Contextual Interviews

- 1. Role of organization in HIV/AIDS prevention**
- 2. Role within organization**
- 3. HIV/AIDS prevention policy in the Tanzania**
 - what is it?
 - role of FBOs within policy? Does it say it?
- 4. National policy towards FBOs in health sector**
 - clear role for FBOs
 - tensions
 - how tied in are FBOs to government?
- 5. Challenges facing health system/ policy in Tanzania**
 - resources, donor constraints, structural
 - relationship of HIV/AIDS to other health issues (malaria, TB, etc.), in terms of priority, funding, etc.
 - any particular tensions within HIV/AIDS policy/ planning?
 - things that people don't agree on, have caused conflict
 - anything in particular with regards to FBOs?
- 6. How organization is involved with FBOs**
 - relationship with FBOs
 - support member FBOs – how?
 - policy formation?
 - if yes, what influences policy formation (evidence, religion, external pressure, etc.)
 - types of support given
- 7. FBOs working in HIV/AIDS prevention**
 - number of FBOs in country
 - services provided
 - anything that makes a FBO distinct (from an NGO)
 - Examples of FBOs programmes/ interventions that are influenced by their faith
- 8. Impact of FBOs in HIV/AIDS prevention**
- 9. Decision-making processes within FBOs**
 - how autonomous are FBOs?
 - pressures on FBOs in the decision-making process
 - what FBOs have to consider that other organizations do not
- 10. Authority of religion in country/ organization**
 - in decision-making processes
 - influence of African traditional religions

11. Examples of FBOs in the country, Dar es Salaam

- are some FBOs considered better than others, why?
- are any distinct? Why/ why not?
- any particular FBOs that I should include in study? Why?

12. Anything else would like to add?

13. Anyone else within or outside organization useful to interview

14. Useful reports or documents for research (ex. policies, annual reports)

- general documents about health system in Tanzania
- HIV/AIDS policy documents
- documents regarding FBOs

15. General documents about health system in Tanzania that I have to read

16. Newspaper articles, interesting coverage of HIV/AIDS or faith in media

Interview Topic Guide – Catholic Organization

- 1. Role within organization**
 - contribution to HIV/AIDS prevention decision-making
- 2. Organization a FBO – why?**
 - an NGO?
 - differences between faith-based and secular organizations
 - comparative advantage, disadvantages
- 3. Chose to work for organization – why?**
 - 3.1 Share religion with organization**
 - same denomination
 - religion associated with
 - African traditional religion
- 4. How is department involved in prevention?**
 - works with community education department?
 - how?
 - messages
- 5. Decision-making processes**
 - steps taken
 - who was involved
 - was individual involved?
 - factors considered when making decision?
 - What affected how the decision was made?
- 6. Policy-making processes**
 - specific policies that department uses?
- 7. How are policies/ decisions communicated to you?**
- 8. Stakeholders involved in decision-making processes**
 - influence of each, which has most influence
 - donor
 - Catholic Church
 - government
 - clients
 - staff
 - what does the influence of each look like?
- 9. How are government policies modified to fit the values/ stance of the Catholic Church?**
- 10. How are Catholic values communicated to members in organization?**

11. How does your own faith influence the work that you do?

- influence decisions made?
- difficulty of not sharing religion or denomination of organization
- own beliefs contradict organizations?
- having same religion facilitates decision-making process?

12. External pressures or influences affecting decision/ how it was made

- Donors
- Culture – gender issues
 - Resources (human and financial)
 - Community Needs
 - research/ evidence
- where they came from (particular organization?)
- how they influence
- affect on role in decision-making process

13. Relationship with government

- relationship with NACP, TACAIDS

14. Anything else to add

- how policies are made
- role within organization

15. Examples of FBOs I should visit in addition to PASADA**16. Anyone else within or outside organization useful to interview****17. Useful reports or documents for research (ex. policies, annual reports)****18. Newspaper articles, interesting coverage of HIV/AIDS or faith in media****19. Useful meetings or other events to attend**

Interview Topic Guide – Anglican Organization

1. Role within organization

-specific programs involved in

2. Organization a FBO – why?

-differences between faith-based and secular organizations
-comparative advantage, disadvantages

3. Chose to work for organization – why?

3.1 Share religion with organization

-same denomination
-religion associated with
-African traditional religion

4. Structure of organization/ history

5. How is organization involved in prevention?

-how?
-messages

6. Decision-making processes

-steps taken
-who was involved
-was individual involved?
-factors considered when making decision?
-What affected how the decision was made?

7. Policy-making processes

-specific policies used? (government, Anglican, own?)
-why?

8. How are policies/ decisions communicated to you?

9. Stakeholders involved in decision-making processes

-influence of each, which has most influence
-donors
-Anglican Church
-government
-clients
-staff
-community
-what does the influence of each look like?

10. How are government policies modified to fit the values/ stance of the Anglican Church?

11. How are Anglican values communicated to members in organization?

12. How does your own faith influence the work that you do?

- influence decisions made?
- difficulty of not sharing religion or denomination of organization
- own beliefs contradict organizations?
- having same religion facilitates decision-making process?

13. External pressures or influences affecting decision/ how it was made

- Donors
- Culture – gender issues
- Resources (human and financial)
- Community Needs
- research/ evidence
- where they came from (particular organization?)
- how they influence
- affect on role in decision-making process

14. Relationship with government

- relationship with NACP, TACAIDS

15. Anything else to add

- how policies are made
- role within organization

16. Anyone else within or outside organization useful to interview**17. Useful reports or documents for research (ex. policies, annual reports)****18. Useful meetings or other events to attend**

Interview Topic Guide – Muslim Organization

- 1. Role within organization**
- 2. Organization a FBO – why?**
 - differences between faith-based and secular organizations
 - comparative advantage, disadvantages
- 3. Chose to work for organization – why?**
 - 3.1 Share religion with organization (Shiites, Sunnis, Sufis)**
 - prominence of each sub-group in Tanzania
- 4. Structure of organization**
 - higher body that organization has to report to?
 - regional branches have to report to main branch?
- 5. Relationship with BAKWATA, other Muslim organizations?**
 - structure of Muslim community within Tanzania
- 6. Interpretation of/ approach to HIV/AIDS – in relation to Quran?**
 - how contracted
 - interpretation of suffering in relation to Quran
 - different among Islamic sub-groups?
- 7. How is organization involved in HIV prevention?**
 - programs
 - messages
- 8. Islamic principles used in HIV prevention – in relation to Quran**
 - what principles?
 - how are they used?
 - repercussions for not following Quran?
- 9. How are Islamic values communicated to members in organization?**
- 10. Policies used within organization – with regards to HIV prevention**
 - National policy, NMSF
 - BAKWATA policy
 - why/ why not use?
 - have you read policies?
 - how are they interpreted?

11. Approach to promoting condoms – different from government, how was decision made

- how is it different/ modified?
- how is it passed down to volunteers?

- steps taken
- who was involved
- was individual involved?
- factors considered when making decision?
- What affected how the decision was made?

12. What do you do when the issue of condoms comes up?**13. Programs for commercial sex workers**

- include MSM?
- differs from government approach?
- how was decision made?

14. Stakeholders involved in decision-making processes

- influence of each, which has most influence
 - donor
 - higher body
 - government
 - clients/ community
 - staff/ volunteers
- what does the influence of each look like?

15. How does your own faith influence the work that you do?

- influence decisions made?

16. External pressures or influences affecting decision/ how it was made

- Donors
- Culture – gender issues
 - Resources (human and financial)
 - Community Needs
 - research/ evidence
- how they influence
- affect on role in decision-making process

17. Organization's relationship with government

- relationship with NACP, TACAIDS

18. Anything else to add

19. Anyone else within or outside organization useful to interview**20. Useful reports or documents for research (ex. policies, annual reports)****21. Useful meetings or other events to attend**

Appendix E – Documents Reviewed

List of Documents Reviewed in each Organization

Catholic Organization

1. PASADA Volunteer Agreement and Code of Conduct
2. Let's talk about HIV/AIDS: A Tool for Community Educators
3. PASADA Recruitment and Selection Policy
4. Building on Hope: PASADA Best Practices
5. Now that you know or now that you know you can live with HIV (Guidelines for "Now that you know" session)
6. PASADA Employment Contract 2009
7. PASADA Annual Report 2007
8. Tanzania Episcopal Conference (TEC) HIV/AIDS Policy
9. Tanzania Catholic Church Health Policy

Anglican Organization

1. Organization's Constitution
2. Brochure – AIDS: Can you recognize an HIV positive person by looking? No you can't.
3. Brochure – Should I test for HIV/AIDS? Know the importance of it.
4. Organization's website
5. Organization's newsletters x3

Muslim Organization

1. UMFAA Constitution
2. Brochure – AIDS and Islam
3. Program report 2009
4. Funding proposals x2

Appendix F – Document Per-forma

Category	Information
1. Basic information	
Document name	
Date Per-forma completed	
Full reference of document	Complete citation of document (Author, date title, series title, publisher etc)
Document obtained from: (link to interview, if relevant)	How did you obtain the document? Did an interview respondent give you the document?
Any problems in obtaining the document?	
2. Content	
Brief summary of relevant information on:	The following sections should only be brief summaries of any content of the document. This helps researcher familiarize themselves with the document, without having to go back to the full text of the document.
Content	
Context	
Actors	
Religion	
Use of evidence?	
Are there any obvious gaps in content you would expect to be present?	Reading the document, did you suddenly think “The authors have missed out some important content. I wonder why?” If so, note the missing content here.
3. Context	
Audience for document	Who is the document aimed at? The general public? Academics? Is it an internal document, only indeed for one organization?
Do the characteristics of the audience affect the	Based upon the answer above, do you think the content has been tailored (customised) to meet the audience’s needs? For

content of the document?	example, a newspaper article on a private sector abortion clinic may be written in easy to read language, and focus on more lurid or shocking details.
Circulation of the document (scale, channel):	If known, approximately how many copies of the document were produced and distributed? How was the document distributed? (bookshops, libraries, PDF on website etc)
What is the political or ideological purpose underpinning the document?	Think about the political or ideological values of the publishing organization, or the authors, and whether these values would affect the content of the document. For example, a summary report from the World Bank on the role of the private sector in maternal health might reflect the underlying ideology of this organization.
Do you detect any obvious bias in the document? If so, what kind?	Similar to the above question, do you think the content is being presented in a biased way, so the reader is not getting the full range of evidence, or the interpretation in the document is not supported by the evidence? For example, if an NGO writes an evaluation report of their work, aimed at the audience of potential donors, would the NGO be more likely to focus on positive aspects of their work?
Is the document related to any other documents analysed? If so, which documents, and how?	Links between documents. For example, are standards based upon a previously published policy document?
6. Any other comments	
	Anything else about the document you think is of relevance to research objectives.

Appendix G – Observation Schedule

Research Objective	Research Questions	Data Needed On	From Where?	Questions to Consider
<p>1. Identify and assess what factors influence the HIV/AIDS prevention policy process of faith-based NGOs, in relation to process, context, actors, and content.</p>	<p>1.1 What key contextual factors influence the HIV/AIDS policy process of each faith-based NGO?</p>	<p>Organizational HIV/AIDS activities</p> <p>Country context</p> <p>Contextual issues (ex. resource constraints, donor ideology, etc.)</p> <p>Resource constraints</p>	<p>Activities</p> <p>Events</p> <p>Conversation</p> <p>Meetings</p> <p>Community observation</p>	<p>What issues do individuals consider when formulating policies?</p> <p>-What do they talk about?</p> <p>Are there any constraints to policy formation?</p> <p>Are there any constraints to policy formation?</p> <p>What is the community setting and does it have an effect on policy formation (urban vs. rural)?</p> <p>-What do people say about the area in which they live in regards to HIV/AIDS and policy?</p> <p>How are women treated?</p> <p>-What do people say about women?</p> <p>-How do they act towards women?</p> <p>What are the perceptions prevalent within the organization about HIV/AIDS?</p> <p>-What do people say about it?</p> <p>-Are they evident within the community?</p> <p>What is the leadership within the organization like? Does it create cooperation or conflict?</p> <p>-How do people react to people with greater authority? What do people say about them?</p>

				<p>Is the organization part of a wider network? Do they answer to the network? -What do people say about the network?</p> <p>Does the organization rely on donor support? If so, how much? -Do people talk about their donor(s)? -How do people talk about their donor(s)? -What do they say?</p> <p>Are there other health concerns that dominate policy formation? If so, what? -Do people talk about other health concerns?</p> <p>Does the organization have legitimacy within the community? -How do people respond to the organization? -What do people say about the organization?</p> <p>Is the organization able to mobilize resources? -Do people talk about needing more resources?</p> <p>Do people talk about what they have/ what they need?</p>
	1.2 What key process factors influence the HIV/AIDS policy process of each faith-based NGO?	Policy/ decision-making processes	Conversation Meetings Actions	<p>Where do FBOs formulate policies? -Through meetings, informal discussion, via the Internet?</p> <p>What kinds of meetings are used within the</p>

				policy process?
	1.3 What actors and actor-related factors influence the HIV/AIDS policy process of each faith-based NGO?	Actors	Conversation Actions Events Activities Meetings	Who is involved in the policy process?
	1.4 What is the HIV/AIDS prevention policy content, in terms of policy and practice, in each faith-based NGO?	HIV/AIDS prevention policies	Conversation Events Activities Meetings	What HIV/AIDS policies are used? Where are HIV/AIDS policies found? Are there any policies mentioned during activities, events, or meetings? -What is said about them?
2. Identify and assess the role of faith within the HIV/AIDS prevention policy process of faith-based NGOs.	2.1 Where in the HIV/AIDS prevention policy process does faith have a role (i.e. process, context, actors, content)?	Organizational activities HIV/AIDS prevention policies Decision-making processes Religious ideologies	Meetings Conversation Prayer	Is there any prayer? Does the organization talk about religious morals with service users? Are there any reoccurring religious ideologies (ex. scripture) coming through what people say or do? Do people discuss/ talk about religious principles/ scripture? Are religious principles/ scripture discussed in meetings, and informal gatherings?

				<p>Is religious scripture/ prayer used to justify any HIV/AIDS policies?</p> <p>Are religious principles discussed on a regular basis? -What religious principles?</p> <p>What other factors, if any, are considered alongside religion/ faith?</p>
	2.2 What role does faith play within the HIV/AIDS prevention policy process of faith-based NGOs?	See above	See above	See above
	2.3 What factors influence the role of faith with the HIV/AIDS prevention policy process?	See above	See above	See above
3. Identify how the key process, context, actor, and faith factors inter-relate to form the HIV/AIDS prevention policy content, in terms of policy and practice, within each faith-based NGO.	3.1 What is the inter-relationship between key process, context, actor, and faith factors in relation to faith-based NGOs' HIV/AIDS prevention policy content in terms of policy and practice?	See above	See above	See above

Appendix H – Observation Notes

PASADA
September 3 2009
Clients Meeting

Meeting held in church hall on the Catholic Church compound on the first Thursday of every one. Meeting was to be from 9-11am, however, due to problems with registration it didn't start until about 9:30 and lasted until about 11:30. There were about 120 people in attendance. Upon registration each client is given a packet of milk.

Meeting started with a religious song and then a prayer in which all the clients took part in.

Meeting conducted entirely in Swahili which made it difficult to follow. First part of interview was spent giving information about HIV/AIDS to the clients. For example, the employees were dispelling the misconception that aloe vera lowers CD4 count, which a client had brought up previously.

During the meeting the clients were given the opportunity to speak. I am told it is here that they are able to voice their concerns, and talk about HIV/AIDS.

Who is attending?

- clients
- staff – VCT, PMTCT
- other staff came in at end
- saved milk for staff
- big rush at end for extra milk
- clients register as they enter, didn't have enough paper, caused delay in registration when went to get more paper

What is their role?

Clients

- listeners
- participants
- leaders of song, prayer
- receivers of charity
- HIV positive
- register on entering with card
- received milk upon registering
- membership based on status

Staff

- VCT
- PMTCT
- facilitators
- organizations
- leaders
- public speakers
- teachers

- administration
- sense of authority – people doing registration stringent on who got milk, made sure no one took two, save some for themselves
- membership based on role within PASADA

What is happening?

- song
- prayer
- discussion on HIV/AIDS issues
- ex. Aloe vera used as way to raise CD4 count (dispelled myth)
- clients given time to speak near end
- laughing
- group needed to be brought to order multiple times
 - use a sound technique where facilitator says a work and then group responds

- began with song and prayer
- then VCT took over
- VCT and PMTCT spook, other PASADA staff members at back appear to not have a role
- come near end when clients given time to speak – there to listen
- come to get milk
- staff doing admin

- tone – light – laughing
- not serious feeling
- spend a long time on one issue

- facilitators stand when speaking, walk around room
- clients stand when speaking

When is this event occurring?

- 1st Thursday of the month, once a month
- now that you know meetings
- this is for any people who are HIV positive that found out that month
- about 2 hours
- reoccurring, all clients know about it, given opportunity to join

Where is this event occurring?

- church hall with cross on wall on Catholic Church compound where PASADA building is
- birds living in walls
- on church grounds, space used for meeting place
- same place each time
- everyone gets a seat
- staff stay in back
- clients face centre for room

Why is this event occurring?

- to give messages to clients
- to get feedback from clients

How is this event organized?

-beginning unorganized, long queue, ran out of paper, little control over people taking a second milk, aggressive to those who tried

-rush to get extra milk at end – due to poverty?

-starts with registration, song, prayer, VCT talking, PMTCT talking, clients talking

-rules and norms → mechanism to keep order, ensure people are listening

-sequence of events appears to be routine

-church grounds, head office

Appendix I – Coding Framework

Catholic Organization

1. Condoms
 - 1.1 Organizational Practice/
Condom messages
 - 1.2 Actor condom beliefs
 - 1.3 Catholic Church condom
policy/ approach
 - 1.4 Organizational condom policy
 - 1.5 Government condom policy
 - 1.6 Context – External (culture,
socio-economic, religious,
donors, resources, etc.)
 - 1.7 Actors (beliefs, interests,
experience)
 - 1.8 Other
2. Discordant Couples
 - 2.1 Condoms
 - 2.2 Organizational policy
 - 2.3 Organizational practice
 - 2.4 Church Policy/ Approach
 - 2.5 Context – External (culture,
socio-economic, religious,
donors, resources, etc.)
 - 2.6 Actors (beliefs, experiences,
interests)
 - 2.7 Other
3. MSM
 - 3.1 Organizational policy
 - 3.2 Organizational practice
 - 3.3 Catholic Church
policy/approach
 - 3.4 Program Development
(process
 - 3.5 Context – External (culture,
socio-economic, religious,
donors, resources, etc.)
 - 3.6 Actor (beliefs, experiences,
interests)
 - 3.7 Context – Internal

3.8 Other

4. Other Prevention Topics
 - 4.1 Abstinence
 - 4.2 Faithfulness
 - 4.3 Behaviour Change
 - 4.4 Transmission
 - 4.5 Testing
 - 4.6 Context – External (culture,
socio-economic, religious,
donors, resources, etc.)
 - 4.7 Other
5. Catholic Church
 - 5.1 Ethics/ Values
 - 5.2 Policy/ Regulations/ Approach
 - 5.3 Teachings
 - 5.4 Relationship with FBO/
Influence
 - 5.5 Context – External (culture,
socio-economic, religious,
donors, resources, etc.)
 - 5.6 Context – Internal
 - 5.7 Other
6. Religious Factors
 - 6.1 Faith Influence
 - 6.2 Prayer
 - 6.3 Religious Text
 - 6.4 Religious Figures
 - 6.5 Religious Leaders
 - 6.6 Religious Plurality
 - 6.7 Spiritual Counselling
 - 6.8 Other
7. Other Factors
 - 7.1 Holistic Care
 - 7.2 Hope
 - 7.3 Operate without discrimination
 - 7.4 Stigma
 - 7.5 Resources
 - 7.6 Other

- 8. Bio-Medical
 - 8.1 Ethical Considerations
 - 8.2 Medicine/ Science
 - 8.3 Provision of Facts
 - 8.4 Use of research/ evidence
 - 8.5 Professionalism
 - 8.6 Other
- 9. Country Context
 - 9.1 Economic Context
 - 9.2 Health Context
 - 9.3 Legal Context
 - 9.4 NGO Context
 - 9.5 Political Context
 - 9.6 Religious Context
 - 9.7 Social Context
 - 9.8 Other
- 10. Culture
 - 10.1 Cultural Beliefs
 - 10.2 Cultural context
 - 10.3 Gender
 - 10.4 Cultural practices
 - 10.5 Traditional Healers
 - 10.6 Widow inheritance
 - 10.7 Polygamy
 - 10.8 Other
- 11. Actors
 - 11.1 Advisory Board
 - 11.2 Bishop
 - 11.3 Donors
 - 11.4 Government
 - 11.5 Community/ Environment
 - 11.6 Beneficiaries
 - 11.7 Other
- 12. Organizational Actors
 - 12.1 Actor Motivation
 - 12.2 Actor Faith
 - 12.3 Actor Experience
 - 12.4 Volunteers
 - 12.5 Staff
 - 12.6 Expertise/ profession/ Education
 - 12.7 Professionalism
 - 12.8 Other
- 13. Decision-Making
 - 13.1 Decision-making
 - 13.2 Decentralized decision-making
 - 13.3 Centralized decision-making
 - 13.4 Organizational policy
 - 13.5 Departmental policy
 - 13.6 Organizational practice
 - 13.7 Other
- 14. Organizational Characteristics
 - 14.1 Autonomy
 - 14.2 Leadership
 - 14.3 Organizational environment
 - 14.4 Organizational identity
 - 14.5 Organizational origins
 - 14.6 Vision/ mission
 - 14.7 Other

Anglican Organization

1. Condoms and Discordant Couples
 - 1.1 Organizational Practice/
Condom messages
 - 1.2 Actor condom beliefs
 - 1.3 Anglican Church condom
policy/ approach
 - 1.4 Organizational condom policy
 - 1.5 Government condom policy
 - 1.6 Context – External (culture,
socio-economic, religious,
donors, resources, etc.)
 - 1.7 Other
2. Anglican Church
 - 2.1 Ethics/ Values
 - 2.2 Policy/ Regulations/ Approach
 - 2.3 Teachings
 - 2.4 Relationship with FBO/
Influence
 - 2.5 Context – External (culture,
socio-economic, religious,
donors, resources, etc.)
 - 2.6 Other
3. Religious Factors
 - 3.1 Faith Influence
 - 3.2 Prayer
 - 3.3 Religious Text
 - 3.4 Religious Figures
 - 3.5 Religious Plurality
 - 3.6 Spiritual Counselling
 - 3.7 Other
4. Other Factors
 - 4.1 Ethical Considerations
 - 4.2 Medicine/ science
 - 4.3 Provision of facts
 - 4.4 Use of research/ evidence
 - 4.5 Resources
 - 4.6 Stigma
 - 4.7 Other
5. Actors
 - 5.1 Advisory Board
 - 5.2 Bishop
 - 5.3 Donors
 - 5.4 Government
 - 5.5 Community/ Environment
 - 5.6 Beneficiaries
 - 5.7 Other
6. Context
 - 6.1 Cultural context
 - 6.2 Social context
 - 6.3 Health context
 - 6.4 Religious context
 - 6.5 Other
7. Organizational Actors
 - 7.1 Actor Motivation
 - 7.2 Actor Faith
 - 7.3 Staff
 - 7.4 Expertise/ profession/
Education
 - 7.5 Other
8. Organizational Characteristics
 - 8.1 Autonomy
 - 8.2 Organizational identity
 - 8.3 Organizational origins
 - 8.4 Vision/ mission
 - 8.5 Structure
 - 8.6 Other
9. Decision-Making
 - 9.1 Decision-making
 - 9.2 Organizational policy
 - 9.3 Organizational practice
 - 9.4 Other

Muslim Organization

1. Muslim
 - 1.1 Head-office branch relationship
 - 1.2 Mosque
 - 1.3 Muslim Ethics, Values
 - 1.4 Muslim HIV Approach/ Regulations
 - 1.5 Umbrella FBO-FBO relationship
 - 1.6 Umbrella FBO HIV policy
 - 1.7 Other
2. Condoms and Discordant Couples
 - 2.1 Organizational Practice/ Condom messages
 - 2.2 Discordant couples
 - 2.3 Actor condom beliefs
 - 2.4 Organizational condom policy
 - 2.5 Government policy
 - 2.6 Other
3. Religious Factors
 - 3.1 Faith Influence
 - 3.2 Prayer
 - 3.3 Religious Text
 - 3.4 Religious Figures
 - 3.5 Religious Plurality
 - 3.6 Religious Teaching
 - 3.7 Other
4. Other Factors
 - 4.1 Resources
 - 4.2 Stigma
 - 4.3 Education
 - 4.4 Other prevention topics
 - 4.5 Science/ Use of Research and Evidence
 - 4.6 Seminars & Training
 - 4.7 Other
5. Context
 - 5.1 Cultural context
 - 5.2 Other context
 - 5.3 Donor context
 - 5.4 Government context
 - 5.5 Community context
 - 5.6 Other
6. Organizational Actors
 - 6.1 Actor Motivation
 - 6.2 Actor Faith
 - 6.3 Members
 - 6.4 Expertise/ profession/ Education
 - 6.5 Other
7. Decision-Making
 - 7.1 Decision-making
 - 7.2 Organizational policy
 - 7.3 Leadership
 - 7.4 Activities
 - 7.5 Other
8. Organizational Characteristics
 - 8.1 Organizational identity
 - 8.2 Organizational origins
 - 8.3 Vision/ mission
 - 8.4 Structure
 - 8.5 Other

Appendix J – Section of Chart used for Analysis

<p>5.0 Catholic Church - 4c pages</p> <p>Participant #.</p>	<p>5.1 Ethics, values - 24 pages</p>	<p>5.2 Policy/ Regulations/ Approach - 2 pages (health policy) - 7 pages (HIV policy) - 4 pages (approach) - 3 pages (CC policy) - 10 pages (regulations)</p>	<p>5.3 Teachings</p>	<p>5.4 Relationship with FBO/ Influence - 13 pages (influence) - 9 pages (umbrella) -22 pages (relationship)</p>
<p>No. 1</p>	<p>Within the Catholic Church have values, as a board wouldn't monitor to see if org is complying with values – if clients complain than would address (1/24).</p> <p>Values exemplified in the general feel and atmosphere of org, the handling of patients people don't shout – see there is a human level, services provided (1/24).</p> <p>A Catholic institution should be exemplified through its action (not anti-church actions), its org structure, leadership – not so much</p>	<p>Within policy say that people should be able to look at characteristics of an institution and know that it is Catholic – by the way they were taken care of (1/24).</p> <p>Issue of HIV positive people wanting to get married or have abortions is a technical policy issue (3/24).</p> <p>TEC policy – supersedes all other policies on all things moral and ethical – includes issue of abortion, relationship between spouses, assisted death. Statement might be</p>		

	<p>about specific values, but what is expected from a Catholic institution (2/24).</p> <p>As an advisory board have not had an issue that dealt with values –like HIV positive people wanting children or abortion for HIV positive women – might be being handled at the individual level (2/24).</p> <p>Some things that might be considered anti-Catholic: to be on the pill, teaching on family planning (not permitted by the Catholic Church) (3/24).</p> <p>People need to be able to make an informed decision – CC will teach on why other methods not acceptable – human value is at stake, church is at stake (3/24).</p> <p>Church will explain human value in relation to God and Christ, at the same time being informed about other</p>	<p>superfluous as no Catholic institution would be doing such things (3/24).</p> <p>Individuals w/in the Catholic church might be doing immoral things, but not as an institution – can't say won't abide by TEC policy as an institution (3/34).</p> <p>People need to be able to make an informed decision – CC will teach on why other methods not acceptable – human value is at stake (3/24).</p> <p>Is the stand of the Catholic Church that it will do all possible as long as doesn't go against the law, the government or other partners, as long as there is respect for the moral and ethical conduct of the CC (4/24).</p> <p>Some things that might be considered anti-Catholic: to be on the pill, teaching on</p>		
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	<p>methods – with information doesn't mean people will be saints, is individual choice (3/24).</p> <p>If told by outside to do something against moral and spiritual stance would refuse (4/24).</p> <p>Is the stand of the Catholic Church that it will do all possible as long as doesn't go against the law, the government or other partners, as long as there is respect for the moral and ethical conduct of the CC (4/24).</p>	<p>family planning (not permitted by the Catholic Church) (3/24).</p> <p>The HIV/AIDS TEC policy is in the context of the TEC health policy (1/2).</p> <p>Have not come out in the open by writing it in policy, but there is room for discussion at the individual level with DC, and then making use of a specific prescription based on medical and religious experts – unfortunate that this information hasn't been given out (1/7).</p> <p>Hasn't been put out in open that there is possibility of individual decision, but if ask church leaders thinks will say the same – safely say it is an unwritten policy (2/7).</p> <p>PASADA is not autonomous when it comes to policy areas, are bound by the diocesan policy and the TEC</p>		
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		<p>policy – if they were not to follow there would be questions. In terms of management and daily activities are autonomous (2/7).</p> <p>If PASADA was found not to be in line with TEC policies would be advised, the ED would be advised, the bishop and cardinal would be advised. If ED doesn't follow than higher leaders are advised – will have to comply or will be fired (1/3).</p>		
No. 46	<p>In principle some practices might be wrong, but dealing with human beings, problem is to help individual. Do not have right to throw anyone away, everyone is a child of God and has right to services (5/24).</p> <p>Some values are taken for granted as part of being Christian, like compassion, and are not contested, don't need policy regarding (like condoms) (5/24).</p>	<p>Pastoral approach – do something in a loving, brotherly way rather than dogmatic, ethical, or moral way (4/24).</p> <p>Catholic Church morals and ethics are pillars of the pastoral health care. Morals – must teach people to change behaviour, attitude change. Only way to be morally right (5/24).</p> <p>CC does not believe in</p>		

	<p>Issue of condoms is a touchy one – most other religious organizations don't agree on it, why is contested area (6/24).</p> <p>If PASADA does not follow principles of CC church will be brought back in line – not about winning the battles but about winning the war – if divert from the war have no reason to have PASADA, better to leave it to others to do their job (6/24).</p> <p>Mainly around issue of condoms – fight against promiscuity, cant' fight against HIV if not fighting against promiscuity and behaviour – condom can't protect you 100% (6/24).</p>	<p>condoms, insist on abstinence, faithfulness (5/24).</p> <p>CC policy superseding all others in ethics and morality – go with condoms mostly – no institution can decide to make program (5/24).</p> <p>There is the metaphor about the three boats, CC has two boats, the third is sinking (5/24).</p> <p>Some values are taken for granted as part of being Christian, like compassion, and are not contested, don't need policy regarding (like condoms) (5/24).</p> <p>Slogans used are different, instead of be faithful to your partner, be faithful to your wife (6/24).</p> <p>There is a draft Archdiocese policy, but came to take up and use the national policy more – when there is a</p>		
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		<p>national policy no reason to do much with a diocesan policy – doing the same thing no need to reinvent wheel. Using it as a draft, didn't go for a definite diocesan one (2/7).</p> <p>Diocesan policy used as a consultation document, trying to bring in and work with parishes (3/7).</p> <p>PASADA is expected to follow the Archdiocese HIV/AIDS policy (3/7).</p> <p>Pastoral approach – should not condemn, should educate, get people not to be seen as sinners, to care of the sick, encourage testing – to approach HIV in a loving and brotherly way, rather than a dogmatic, ethical, moral way (2/4).</p> <p>Feel that should learn from practice rather than make theories which won't go to practice, might not be</p>		
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		<p>practical (3/4).</p> <p>If PASADA doesn't follow the principles of the CC will be repercussions, will have to be brought back into line at any cost (4/4).</p>		
No. 21	<p>CC a strong organ, have own ethics on issues in relation to HIV, have guidelines and policies – have a lot of influence (7/24).</p> <p>Believes that have to live with principles, CC has principles of living, ones that favour health – have to be a good believer, follow what the church says (faithfulness – if faithful won't get HIV, love your neighbours) (8/24).</p> <p>Cultural practices not only lead to unhealthy behaviour but are against religious principles – don't promote activities b/c against church principles and do not promote health (9/24).</p>	<p>CC a strong organ, have own ethics on issues in relation to HIV, have guidelines and policies – have a lot of influence (7/24).</p> <p>MSM is a sin – totally unacceptable in the church – need to be careful when dealing with issue (9/24).</p> <p>Has read the Archdiocese health policy, does not have in department (1/2).</p> <p>Head of the depts. should share diocese policy with colleagues in departments, not sure every dept has a copy. Head of depts. know the policies (1/2).</p> <p>Three years in PASADA and</p>	<p>Church encourages people not to have sex before marriage b/c will be breaking the 6th commandment of the 10 commandments – is in the Bible (8/24).</p> <p>CC messages: abstinence until marriage, undergo VCT b/f marriage, faithful to partner (4/7).</p>	<p>CC a strong organ, have own ethics on issues in relation to HIV, have guidelines and policies – have a lot of influence (7/24).</p> <p>B/c under the Roman Catholics have to follow ethics, do this w/o discriminating – don't promote condoms or other family planning methods, promote faithfulness (9/24).</p> <p>Although operating under the RC Church, do not discriminate in their service provision (3/22).</p>

	<p>In order to be in accordance with CC values have own HIV training guide – to include relevant information – guides complement one another (9/24).</p> <p>Have started a program to meet with MSM – taking care of the dignity and ethics of the RC church (9/24).</p>	<p>health policy of archdiocese has not been discussed (2/2).</p> <p>CC guidelines and policies guides in developing messages to targeted audience, have to go within the policy guideline, otherwise would be a problem (3/7).</p> <p>Have to follow the policy on sensitizing people about condoms – have to be careful b/c church doesn't sensitize people on condoms (3/7).</p> <p>CC messages: abstinence until marriage, undergo VCT b/f marriage, faithful to partner (4/7).</p>		
No. 35	<p>One of CC ethics is condoms – have to obey even if don't want to; contraceptives, don't advertise (11/24).</p> <p>If working with CC have to obey the rules, even if not RC – have to obey their rules (11/24).</p>	<p>PASADA under the umbrella of the RC church – operating under the regulations and ethics of the CC – don't promote condoms, operate w/o discrimination (10/24).</p> <p>If working with CC have to obey the rules, even if not</p>		<p>PASADA under the umbrella of the RC church – operating under the regulations and ethics of the CC – don't promote condoms, operate w/o discrimination (10/24).</p> <p>If working with CC have to obey the rules, even if not</p>

	<p>Own Christian policies match PASADA's – there to help the poor, sick, needy (5/7).</p>	<p>RC – have to obey their rules (11/24).</p> <p>Become aware of ethics, rules of CC in contract, when sign is among the instructions (11/24).</p> <p>There is a Roman Catholic health policy – for people who are giving health services (2/2).</p> <p>PASADA expected to follow RC health policy as giving health services. PASADA has own policies according to services providing, according to donors, environment, patients, MOH policies, but some will follow RC (2/2).</p> <p>Is freedom, but have to follow CC regulations (4/7).</p> <p>Operating under RC policy – if donor wants something that RC doesn't accept, won't accept donor (4/7).</p> <p>Have to follow government</p>		<p>RC – have to obey their rules (11/24).</p> <p>Staff is under the RC, would not exist w/o RC church – thought it was important to have PASADA. RC is supporting the government – depend on each other (2/13).</p> <p>If donor wants something that RC doesn't accept, won't accept donor, b/c operating under RC policy (2/13).</p> <p>Influence of the CC is to make sure PASADA exists and follows the RC regulations and gov't regulations – even gov't knows RC don't advertise condoms (3/13).</p> <p>CC church approach to condom promotion – those are the regulations, have to follow (2/10).</p> <p>Church doesn't have money</p>
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		<p>policy but also have to follow RC polices, also have to obey donor regulations and policies – patient at the centre of it all (4/7).</p> <p>Own Christian policies match PASADA’s – there to help the poor, sick, needy (5/7).</p> <p>CC church approach to condom promotion – those are the regulations, have to follow (2/10).</p> <p>Organizational policy made according to donor needs, CC regulations – management works with these (3/10).</p>		<p>to give to PASADA (6/22).</p> <p>In outreach clinics use buildings that belong to other congregations under CC – need to ask for space sometimes to work, operate less days (6/22).</p> <p>Need to consult bishop, church priest if want to expand the building, because operating near the church, PASADA is in the church of RC (6/22).</p>
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Appendix K – Participant Information Sheet

HIV/AIDS DECISION-MAKING IN FAITH-BASED ORGANISATIONS: A RESEARCH STUDY

What is this study about?

This research is being conducted as part of my PhD in international health with the Nuffield Centre for International Health and Development at the University of Leeds, in the United Kingdom.

The aim of this study is to better understand how faith-based organisations (FBOs) use religion, for example, religious principles and doctrine, when making decisions relating to their HIV/AIDS services.

What are the benefits?

I am hoping that this research will help FBOs, their partners, and their networks to gain an increased understanding about FBOs, which could enhance partnership formation and benefit overall HIV/AIDS work.

In addition, information learned from this study may help to further understand FBOs, as well as help to develop further research and policy development for HIV/AIDS.

Why FBOs & HIV/AIDS?

FBOs make an important contribution to the prevention and mitigation of HIV/AIDS.

The magnitude of HIV/AIDS in sub-Saharan Africa has meant that decision-makers need to engage with all types of health and development organisations, such as FBOs, in order to ensure that effective programmes and interventions are put in place.

The factors that influence how and why organisations respond to the AIDS crisis is not well understood, yet, for other actors to adequately engage with FBOs in the fight against HIV/AIDS, it is important to understand the beliefs, ideas, and motivations that drive their work.

How will the research be done?

The research will take place in a small number of FBOs in Dar es Salaam, Tanzania, from June 2009 to November 2009.

I will be spending time getting to know the organisations taking part in this study – speaking to key members of the organisation, their partners, and the people that use their services. The research will be conducted using a combination of interviews, document review, and observation.

Taking part in the study

There will be absolutely no financial cost to participants for taking part in this study. Participation is completely voluntary. The names of all participants will be kept completely confidential throughout the study.

Contact:

Principal Researcher

Rosemary Morgan

Tanzania contact information (June to November 2009):

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MAAAMUZI YAFANYWAYO NA MASHIRIKA YA DINI KUHUSU VIRUSI VYA UKIMWI / UKIMWI

Utafiti unahusu nini?

Utafiti huu ni sehemu ya mafunzo yangu ya shahada ya uzamili (PhD) afya ya kimataifa ninayofanya Nuffield kituo cha afya na maendeleo ya kimataifa chuo kikuu Leeds Uingereza.

Lengo la utafiti huu ni kufahamu vizuri zaidi namna mashirika ya dini yanavyotumia dini, yaani, taratibu na miongozo iliyo katika dini zao wanapofanya maamuzi yanayohusiana na huduma kuhusu virusi vya UKIMWI/UKIMWI.

Kuna faida gani?

Ninategemea kuwa utafiti huu utasaidia mashirika ya dini, pamoja na washirika wao, na mtandao mzima waweze kuyaelewa mashirika ya dini ili kuongeza ushirikiano katika shughuli za UKIMWI.

Zaidi ya hayo, taarifa itakayotokana na utafiti huu itasaidia kuyaelewa zaidi mashirika ya dini, pia kubuni tafiti nyingine na kutengeneza sera kuhusu virusi vya UKIMWI/UKIMWI.

Kwa nini mashirika ya dini na virusi vya UKIMWI/UKIMWI?

Mashirika ya dini yanachangia kwa kiasi kikubwa mapambano ya kuzuia kuenea kwa virusi vya UKIMWI/UKIMWI.

Kiwango cha kuenea kwa virusi vya UKIMWI/UKIMWI kusini mwa jangwa la Sahara kinataka kwamba wanaofanya maamuzi washirikiane na wengine wanaotoa huduma za afya na maendeleo ikiwa ni pamoja na mashirika ya dini, ili kuhakikisha kuwa mipango na mikakati inayotekelezeka imewekwa.

Vitu vinavyochangia namna na kwa nini mashirika yanajitokeza kupambana na janga la UKIMWI havieleweki. Hivyo ili wadau wengine waweze kushirikiana na mashirika ya dini kupambana na virusi vya UKIMWI/UKIMWI, ni muhimu kuelewa imani, mawazo na msukumo wa kazi yao.

Utafiti utafanyika namna gani?

Utafiti utafanyika katika mashirika machache ya dini yaliyoko Dar-es Salaam, Tanzania, kuanzia Juni mpaka Novemba 2009.

Nitatumia muda kuyafahamu mashirika ya dini yatakayohusika katika utafiti huu. Kwa mfano, kuongea na watu muhimu kwenye mashirika hayo, washirika wao, pamoja na watu wanaotumia huduma zao. Utafiti utatumia mbinu mbalimbali kama vile: usaili (mahojiano); kupitia nyaraka mbalimbali; na, kutazama kwa makini yanayotendeka.

Kushiriki katika utafiti

Hakutakuwa na gharama yoyote kushiriki katika utafiti. Kushiriki kwako ni kwa hiari yako mwenyewe. Jina lako litatunzwa kwa siri kubwa wakati wote wa utafiti.

Mawasiliano

Mtafiti mkuu

Rosemary Morgan

Juni 2009 mpaka Novemba 2009

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UNIVERSITY OF LEEDS

Appendix L – Participant Consent Form

PARTICIPANT INFORMATION SHEET & CONSENT FORM*

*To be read by or explained to participant prior to interview

Study Title: HIV/AIDS Decision-Making in Faith-Based Organisations

Introduction

I would like to invite you to take part in a research project. Before you decide if you want to be a part of this project, it is important that you are aware of why the study is being done and what your participation involves. Please ask me if you have any questions, would like any further information, or anything is unclear. If you agree to take part, you will be asked to sign this consent form. You will get a copy of this form to keep.

Confidentiality

The answers that you provide will be kept completely confidential. Your name and contact details will only be known to the principal researcher and will always be kept in a secure location. Your name will never be used in connection with any of the information you tell me.

Any publication of this study will not use your name or identify you personally. The information that you provide may be reviewed by the Ethics Committee of the National Institute for Medical Research in Tanzania, the Ethics Committee at the University of Leeds, as well as study consultants. However, your name will not be attached to any information you provide, and any person reviewing the information will not be able to identify you personally.

Rights as a research subject

Your involvement in this study is completely voluntary. You may choose not to take part in this study. You do not have to answer any questions that you do not want to answer. However, your honest answer will be of great benefit to this study. You may also end the interview at any time without giving a reason, in which case, if you wish, the information you previously provided will be destroyed. Your choice not to participate will not affect how you will be treated today or in the future.

Length of interview

The interview will last no more than 90 minutes. If you need to end the interview earlier please inform the researcher.

Questions?

If you have any questions about this study or a research-related issue, please contact:

June 2009 to November 2009:
Tanzania contact information:

Rosemary Morgan

December 2009 onwards:

Rosemary Morgan
Nuffield Centre for International Health and Development
Room G.02 Leeds Institute of Health Sciences
University of Leeds
Charles Thackrah Building
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Thank-you for taking the time to read this information sheet.

Please keep this sheet in a safe place. You may need to contact me.

Signature

If you have read the information sheet, or had it explained to you, have had all your questions answered satisfactory, and agree to take part in the study, please sign your name below.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Participant identification number: _____

Taarifa kwa Mshiriki pamoja na Fomu ya Kukubali Kushiriki katika Utafiti*

*Isomwe au maelezo yatolewe kwa mshiriki kabla ya usaili.

Jina la utafiti: Maaamuzi yafanywayo na Mashirika ya Dini Kuhusu Virusi vya UKIMWI na UKIMWI.

Utangulizi

Napenda kukukaribisha ushiriki katika utafiti huu. Kabla hujaamua kushiriki, ni vema ukaelewa kwa nini utafiti unafanyika na wewe utashiriki vipi. Tafadhali niulize kama una swali lolote, kama unahitaji maelezo zaidi au kama kuna jambo halijawa wazi. Kama umekubali kushiriki utatakiwa kuweka saina yako katika fomu hii. Utapewa fomu hii uweke kwa kumbukumbu zako.

Siri

Taarifa utakazotoa zitatumizwa kwa siri kubwa. Jina lako pamoja na taarifa nyingine utakazotoa atajua mtafiti peke yake na ataziweka mahali pa usalama ambapo mtu mwingine hawezi kuzipata. Jina lako halitahusishwa kabisa na taarifa utakazonipa mimi.

Taarifa zitakazoandikwa au kuchapishwa kutokana na utafiti huu hazitahusishwa na jina lako au viashiria vingine vitakavyofanya wewe binafsi ujulikane. Taarifa utakazotoa zinaweza pia kupitiwa na kamati ya taifa inayoangalia utafiti wa afya Tanzania, kamati ya nidhamu ya utafiti chuo kikuu Leeds Uingereza pamoja na wataalamu wa tafiti. Hata hivyo, jina lako halitahusishwa na habari utakazotoa, na mtu yeyote atakayepitia taarifa hizo hataweza kuzihusisha na wewe binafsi.

Haki zako kama mshiriki

Kuhusika kwako na utafiti huu ni kwa hiari yako mwenyewe. Unaweza kuacha kutoshiriki. Siyo lazima kujibu swali ambalo usingependa kujibu. Hata hivyo, usahihi na uwazi wa majibu yako utakuwa na manufaa makubwa kwa utafiti huu. Pia una uhuru wa kuacha kuendelea na usaili huu wakati wowote ukijisikia kufanya hivho bila kutakiwa kutoa sababu. Kwa maana hivo, kama ukipenda kufanya hivyo, taarifa ulizotoa awali hazitatumika na zitaharibiwa. Uamuzi wako kutoshiriki hautahusishwa na utakavyohudumiwa leo au siku zijazo.

Muda wa usaili

Usaili hautachukua zaidi ya dakika 90 (saa moja na nusu). Kama utapenda kumaliza mapema mjulishe mtafiti.

Maswali

Kama una maswali yoyote kuhusu utafiti au jambo linalohusiana na utafiti huu, tafadhali wasiliana na: Rosemary Morgan

Atakuwa Tanzania kuanzia Juni 2009 mpaka Novemba 2009.
Simu ya mkonono:

Baada ya Desemba wasiliana naye kwa anwani ifuatayo:

Rosemary Morgan
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Ahsante kwa muda wako uliotumia kusoma habari zilizo katika fomu hii.

Tafadhali weka fomu hii mahali pa usalama. Utahitaji kuwasiliana na mimi.

Saini

Kama umesoma fomu hii, au kama umepewa maelezo na ukaridhishwa na majibu ya maswali yako, na umekubali kushiriki katika utafiti, tafadhali andika jina lako na weka saini kama ilivyoonyeshwa hapa chini.

Namba ya utambulisho ya mshiriki _____

Fomu hii ikishajzwa: nakala moja apewe mshiriki na nakala moja iwekwe kwenye faili la mtafiti.

When completed: 1 for participant, 1 for researcher site file