Responses to the global HIV and AIDS pandemic: a study of the role of faith-based organisations in Lesotho

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Abstract

This article attempts to establish the key contribution by people of faith to the global HIV pandemic response, using Lesotho as a case study. Particular focus is paid to the work of selected religious organisations in Lesotho in this context, assessing their capacities to coordinate an effective HIV and AIDS action at the grassroots levels through education, health care, development, and social service activities. Empirical evaluations and findings regarding the level and quality of faith-based engagement in this field establish the basic premise of this article, namely, that faith-based organisations are contributing energy, expertise, and experience in order to achieve the commitment of the global commitment to advance universal access to HIV prevention, treatment, and support. Although the article is particularly focused on the Lesotho context, its tremendous implications for simulated studies and approaches across Sub-Saharan Africa are accentuated.

Keywords: HIV and AIDS, Sub-Saharan Africa, Lesotho, faith-based organisations, rights-based approaches

Resume

Cet article tente d’établir la contribution clé par les gens de foi, sur la réponse de pandémie mondiale du VIH, en utilisant le Lesotho comme l’étude de cas. Une attention particulière est accordée aux travaux des organisations religieuses sélectionnés au Lesotho, dans ce contexte, l’évaluation de leurs capacités à coordonner une action efficace contre le VIH et le sida au niveau de la base, par l’éducation, les soins de santé, le développement et les activités de services sociaux. Les évaluations empiriques et conclusions concernant le niveau et la qualité de l’engagement des organisations confessionnelles dans ce domaine établissent le principe de base de cet article, à savoir que les organisations confessionnelles contribuent de l’énergie, de l’expertise et de l’expérience afin d’atteindre l’engagement mondial pour faire avancer l’accès universel à la prévention de VIH, son traitement et le soutien. Bien que l’article soit particulièrement axé sur le contexte de Lesotho, ses énormes implications pour les études en simulation et des approches à travers l’Afrique sub-saharienne sont accentuées.

Mots-clés: VIH, l’Afrique sub-saharienne, Lesotho, organisations confessionnelles, droits de l’homme

1. Introduction/Background

Globally, faith-based organisations (FBOs) are an integral part of life and society, found within every community. They have much credibility because of their involvement at the grassroots level, their involvement with the people in every aspect of their lives, and for the many services they offer (Morgan, Green & Boesten 2013). As social and cultural institutions, FBOs shape social norms, beliefs, attitudes, and people’s realities with regard to sexual self-understanding, which makes them a crucial partner in HIV and AIDS prevention. Worldwide, many FBOs have contributed or are still searching for an effective approach to responding to the HIV and AIDS pandemic. There is indeed evidence of FBOs’ contributions in the health sector, providing care and support, building infrastructure, capacity building through training programs, and mobilising large numbers of volunteers to contribute to causes they consider worthy (Vitillo 2009). In Barbados, for example, the major religious organisations (Catholic, Protestant, Pentecostal, and Muslim) collaborated with the government in prevention through promotion of the ABC approach (Abstinence, Being faithful, and Condom use), which is believed to have contributed to the decline of HIV prevalence among pregnant women from 10% to 1.2% between 2002 and 2008 (Caribbean HIV & AIDS Alliance 2012).

Similarly, collaborative efforts between the government and religious organisations of all faiths contributed to reduction in sexual partners and the rise of age of sexual engagement as well as the reduced rate of HIV infection, making Senegal one of the African success stories concerning the HIV and AIDS epidemic (Lom 2001; Joint United Nations Programme on HIV and AIDS 2012).
AIDS [UNAIDS] 2012). Across the world, education on HIV and AIDS and capacity building among church ministers has benefitted from their contributions in prevention interventions (Vitillo 2009). At the same time, many FBOs have been associated with obstacles in HIV and AIDS prevention, opposing use of prevention measures such as condoms and sexuality education, instead advocating abstinence and mutual monogamy strategies, which have been proven ineffective (Piot, Bartos, Ghys, Walker & Schwartländer 2001; Piot, Kazatchkine, Dybul & Lob-Leyt 2009). Yet, in several African countries, the contributions of FBOs are neither well-researched nor well-documented. Instead, their positive efforts are overlooked, and some even criticised for being anti-condom, for fuelling AIDS-related stigma and discrimination, and for forbidding Christian burial of those suspected of having died of AIDS (Mathai 2005; Maundeni, Dinama & Boikhurst 2012). While acknowledging such accusations, this study examines their contributions through care and support for those affected by the disease as well as initiatives for preventing further spread of the epidemic. The study also examines the challenges that hamper their communication and prevention efforts.

In reaction to the HIV and AIDS epidemic, several organisations in Lesotho, like in most developing countries, have invested millions of dollars over the past two decades in programmes that focus on prevention through behavioural change, many of which focus on sexual practices and intravenous drug use (Anozie 2011). Vital areas of investment have been allocated towards increasing awareness and knowledge, reinforcing attitudes and maintaining interests, motivating cues to action and demonstrating simple skills, increasing demand for health services and reinforcing behaviours, as well as building social norms (James & Katundu 2006). However, not all of these programmes are successful, and sometimes they fail to bring about appropriate behavioural change. Some researchers suggest changing the communication approaches to incorporate other strategies that seek to increase understanding and therefore motivate compliance (e.g. Rodriguez-Garcia, Bonnel, Wilson & N’Jie 2013). Others recommend communicating within social, political, and cultural contexts for behavioural change to occur (Ferreira 2004).

Among others, this study examines faith-based efforts in Lesotho with special attention to their strategies and challenges in HIV and AIDS prevention and management.

## 2. Theoretical framework

Contemporary health communication intermediations are based on solid theoretical frameworks that address behavioural change, including the social cognitive theory (Arihinenbuwa & Obregon 2000), theory of reasoned action (Fishbein & Middletadt 1989), and social influence theory (Fishbein et al. 2001). Common health communication paradigms like the AIDS risk reduction model, the health belief model, and the extended parallel process model of fear appeal have also informed health communication interventions (Fishbein, Middletadt & Hitchcock 1991). In reviewing the HIV and AIDS communication interventions across diverse developing countries, Bertrand, O’Reilly, Denison, Anhang and Sweat (2006) observed that contemporary models view behavioural change as a linear relationship between individual knowledge and action with the assumption that individuals can or will exercise total control over their sexual behaviour. These models are criticised for disregarding the influence of contextual variables – social-political and economic contexts within which the individual functions – as well as other related differentials of self-efficacy and power in sexual interactions.

The role of mass media and other communication strategies in behavioural formation and change is thus clearly documented. Studies on some African countries also emphasise the critical role of relational communication and of opinion officials to influence behavioural change at an individual level (Parker, Rau & Peppa 2007). Aggleton (1997), for instance, notes the importance of personal influencers in changing the beliefs, attitudes, behaviours, and practices of those who trust and follow them or through social interactions. Religious and other community officials fall in this category of change agents at an individual, societal, and policy level, and are therefore appropriate in addressing HIV- and AIDS-related issues at these levels.

### 2.1 The social influence theory

Social influence theory explains why some people listen to others and how one person persuades others to change their beliefs, opinions, and attitudes (Friedkin 1998; Tufte 2002). Research has found that people are willing to go against their own beliefs to harm another when instructed to do so by an authority, while some use opinions of others as a guide to reality in situations that are ambiguous and uncertain (Möllenhberger 1997). The theory focuses on the social realities of participants with implications for understanding social influence, messages, and meanings from their viewpoint. From this perception, social influence consists of the processes whereby people aggregate appropriate behaviour and form, maintain, or change social norms and the effects thereof, as well as the social conditions that give rise to such norms. The particular tool of social influence includes social norms, network membership, conformity pressures, media influences, social comparison, and modelling (Anderson & Rodriguez 2003). There is validation that people form and conform to social norms, and that there are influences intrinsic in social relationships and inherent pressures for agreement, even without instructions to agree or explicit group memberships (Frank et al. 2012).

In HIV and AIDS prevention, social influence and social norms directly impact high-risk sexual behaviours. For example, in their study among adolescents’ perceptions on condom use, Kerrigan, Witt, Glass, Chung and Ellen (2006) found that those who perceive that their peers support condom use are more likely to use them. Social influence approaches emphasise behavioural expectations and standards (social norms) present in the environment and prepare the learner to resist pressure to engage in risk-taking behaviours (Brown et al. 2008). Exploring smoking attitude, Tesoriero, Gieryc, Carrascal and Lavigne (2010) also note that social influence through everyday interpersonal interactions in social networks may serve to spread health information or, conversely, to reinforce risk-taking behaviour as a social norm as in the cases of smoking and other peer-influenced behaviours such as sexual practices or drug use. In the case of HIV and AIDS, they observe that normal relations is noteworthy in
creating a common representativeness of diseases which they argue is a generally fabricated outcome and practice of routine conversation (p. 829). Such structure sometimes determines how the disease is addressed based on how social networks view it and its impact within their environment or network. The theory thus explains the potential of religious officials as social influencers and the impact FBOs might have in addressing HIV- and AIDS-related issues such as stigma and discrimination based on their socially constructed norms and their role in society.

It is important to note that Lesotho has established a national-level policy on HIV and AIDS, including national strategic plans and other legislation. At the same time, the Government of Lesotho has recognised the need for a multisectoral plan to address HIV and AIDS, and this is most often where the role of FBOs has been included. In the context of Lesotho, therefore, the social influence theory, more than any other theoretical postulations, serves as the premise for this study. Its validation and appropriateness are evinced by the findings made as well as the conclusions drawn.

3. FBOs: definitional quandary and contextual issues

As with many terminologies within the broader development sphere, a fixed definition of ‘faith-based organisations’ (FBOs) does not exist (Massey 2010). There is indeed no universal definition of an FBO. Invariably, any entity that declares itself to be ‘faith-based’ is, de facto, faith-based. The intent is to encourage any organisation that has a faith-inspired interest in providing services to apply for government or donor funds and that faith-based charities should be able to compete on equal footing for public funds to provide public services. It is therefore not uncommon for a church to establish separate community-based organisations – often they are community development corporations established to develop economic programmes and provide financial support for a community. The context in which the terminology of ‘faith-based’ is used here is limited to church organisations because these are the only organised and prominent social agents responding to the HIV and AIDS problem in Lesotho in a tangibly structured manner.

Clarke (2006) identified three typologies of FBOs: (a) congregations built around a corporeal structure of worship or geographical grouping of worshippers; (b) national networks of congregations, including national denominations and their social services affiliates as well as other networks of related organisations; and (c) self-supporting religious organisations that are incorporated separately from congregations and national networks. Quite often in developing countries, these FBOs have missionary work as their origins. Overall, FBOs are organisations affiliated with a religious structure, doctrine, or congregation. However, FBOs are not simply those agencies that have vaguely stated religious motivation (such as World Vision) or origins (such as Oxfam). Rather, they must have an active relationship with a religious institution (such as Lutheran World Service or Caritas).

Seemingly, the invisibility of FBOs in community development work is now diminishing. There has been recognition more recently both within the development sector and by FBOs themselves that there is synergy to be gained by secular and sectarian agencies engaging with one another in a more purposeful manner. As participatory community-focused patterns of development have become increasing dominant in recent years, FBOs have become increasingly ‘attractive’ as agents or key stakeholders in the development process due to their strong links to local communities (Marshall 2010). Furthermore, FBOs themselves have also begun to spearhead interaction with aid donors to seek increased association (and finance) in community development interventions. Over the past decade, a number of international platforms have been developed that have brought together FBOs and international donors to explore how to leverage the experience and expertise that both groups can bring to improving the lives of the poor. FBOs are now increasingly partnering development institutions in advancing their community and social justice initiatives (Swart 2010).

A distinctive abolition of the introverted nature of FBOs is the realisation that FBOs are also legitimate part of the civil society that offer gateway into local communities, networks across countries and regions, and, more often than not, expertise in community development processes and interventions. This recent ‘acceptance’ of FBOs mirrors the ‘acceptance’ of secular NGOs during the 1990s by the same donors (Olarinmoye 2012). After all, enhancing aid effectiveness requires accessing and engaging with local communities and there is now the recognition that FBOs (like NGOs) can facilitate this access and engagement for donors.

While FBOs have historically played an important role in delivering health and social services in developing countries, little research has been done on their role in HIV prevention and care, particularly in Africa. The present study therefore aimed to address this gap by conducting an exploratory, qualitative study of FBO involvement in HIV and AIDS in a country hard hit by the HIV and AIDS epidemic (Olowu 2012). The study involved key informant and stakeholder interviews with health and FBO officials and site visits to FBO-sponsored HIV and AIDS clinics, hospices, programmes, and other activities. This paper summarises the findings of this exploratory study. It provides an overview of the epidemic in Lesotho and the range of HIV prevention and care activities conducted by FBOs. Further, it discusses the challenges to FBO involvement in HIV prevention and care. Finally, it provides recommendations for promising ways that FBOs can address the HIV epidemic, both independently and in collaboration with other entities, such as ministries of health. The findings should be of interest to funders, policymakers, and health and FBO officials who want to understand the role that FBOs can play in the fight against HIV and AIDS.

In the context of this study, I consider the strategies adopted by FBOs in Lesotho. The ability of FBOs to successfully engage with the Basotho community around issues of sexuality and sexual practice portend lessons for other FBOs elsewhere seeking to reduce HIV transmission through sustained behaviour change. Whilst a single model or approach for HIV and AIDS...
interventions by FBOs does not exist, this paper does conceptualise a 'wheel' of successful characteristics based upon the experience of this organisation. For the avoidance of doubt, this paper recognises that FBOs are distinct from traditional NGOs, such as those working on democratic struggles and the like, and require an FBO model of HIV and AIDS engagement. Therefore, the characteristics discussed should be considered by other FBOs operating within the HIV and AIDS sector in Africa.

4. Procedures and methods

4.1 Choice of Lesotho

This report presents analysis and findings from a sustained study carried out on the Kingdom of Lesotho as part of the NRF-funded 'Mapping a Rights-Based Approach to HIV and AIDS Pandemic in Lesotho: Implications for State-Civil Society Initiatives in the Southern African Region' project. This present study is the sixth in a series of case studies undertaken by the author since 2010.

Together, the Lesotho case studies are designed to contribute to the understanding of the role of non-state actors in stemming the tide of the HIV and AIDS problem in Africa. The totality of the project aims to provide evidence on the socio-economic and political impacts of bottom-up strategies and initiatives. In addition, it aims to strengthen data collection processes and build capacity around ongoing evaluations. The project promotes a mixed method approach to researching its sub-themes and their implications for the broader African region. The proximity of Lesotho to the author's institutional base as well as the availability of local assistants and Sesotho translators strengthened the author's choice of the Lesotho case study.

4.2 Data collection

The data collection occurred principally between May and October 2013 and consisted of three primary data collection activities: (a) searches of published literature, grey literature (i.e. materials not easily found through conventional channels, such as publishers, and includes organisational reports, technical reports from government agencies or scientific research groups, working papers, white papers, etc.), and organisational websites for information about HIV and AIDS in Lesotho and/or FBO involvement; (b) telephonic interviews with key informants or community experts familiar with the region to collect initial information about their HIV activities and/or identify key stakeholders and FBO projects/activities that should be visited and/or interviewed during site visits; and (c) two-day visits to each district of Lesotho to interview stakeholders and conduct site visits to FBO-sponsored HIV and AIDS projects and activities.

Each interview lasted a minimum of two hours. Although the English language, which is widely spoken across Lesotho, was used in information-gathering, a native Sesotho speaker who served as a research assistant elaborated in Sesotho any questions used in information-gathering, a native Sesotho speaker who served as a research assistant elaborated in Sesotho any questions used in information-gathering. The main reason for non-participation was unavailability of a representative of the FBO to participate in a survey during the period allowed for data collection. Attempts to replace some of these potential respondents with others from the same denomination were unsuccessful.

The gender representation in the oral interviews was overwhelmingly masculine (80% male; 20% female). The ages of respondents ranged between 30 and 72 years with a median of 46 years. All interviewees stated that female members outnumbered male members in the FBOs of which they were members. More than half of respondents said their weekly services were attended by up to 100 people, while 5% said they were attended by more than 500 people.

4.3. Participants

Through the published literature, organisational websites, and key informants, principal stakeholders involved in HIV and AIDS in Lesotho were identified. These stakeholders included persons affiliated with government agencies, bilateral assistance agencies, FBOs, other NGOs (international and local), and organisations representing people living with HIV and AIDS (PLWH). During site visits, a purposive sample of members of organisations that represented the range of organisations involved in HIV was interviewed. Further, within the FBO group, individuals representing a range of denominational groups (Catholic, Evangelical, and Protestant) were sought for inclusion.

In addition to purposive sampling, the snowball sampling method was used, where individuals interviewed were asked to identify other individuals or organisations in any of the above stakeholder categories. Because the purpose was to understand how FBOs had been involved in HIV and AIDS and what were some of the successes and challenges of that involvement, focus was on FBOs that in fact had been involved in some way in HIV and AIDS in Lesotho. It could have been informative to interview FBOs that had not been involved to understand some of the challenges, but because of limited resources, this group was not included in the study. On the other hand, although attempt was made to include representatives of other stakeholder groups (e.g. government, bilateral assistance, NGOs) that also had some experience with or knowledge of FBOs involved in HIV and AIDS, this experience or knowledge was not necessarily critical because their perspectives of FBO involvement (awareness of activities, challenges to involvement, etc.) were equally as informative.

4.4. Site visits

In addition to the interviews, first-hand information about in-country HIV and AIDS activities by visiting local clinics, hospitals, hospices, orphanages, HIV support groups, an HIV and AIDS awareness day parade, and a prison was obtained. Since note-taking was not appropriate during these visits, team discussions were audio-recorded, involving those who had participated in the site visit, immediately afterward (usually driving to our next site visit or interview) to document conversations and
observations made during the visit, as well as any insights gained. Notes were then constructed from the audio-recordings.

4.5. Analysis
A qualitative analysis using descriptive and interpretative techniques followed the transcription of information. Once transcribed, an additional research assistant was contracted to assist in organisation and analysis of participant responses, which was done by themes rather than by simply aggregating numbers, since the latter approach is not appropriate for focus group research (Kitzinger 1995). Themes that emerged from the responses were identified, creating a running list of metaphors and phrases that were repeated across the texts while keeping in mind the original research questions. This type of analysis involves focusing on the general agreement among participants in each group (e.g. was this attitude or belief held by other members in the same focus group?) (Lopez & Willis 2004).

For credibility and validity of study findings, a member-checking method was used. Harper and Cole (2012) note that member-checking, which consists of the researcher restating, summarising, or paraphrasing the information received from a respondent, ensures that what was heard or written down is, in fact, correct. Member-checking was done continuously during and after each focus group, through repeating respondents’ statements and prompting for clarification where necessary. Following the completion of the study, findings from the study were presented at a capacity-building HIV and AIDS workshop for FBO officials in Lesotho. Workshop participants, the majority of whom had participated in the study, discussed the findings in detail, providing feedback and critical commentary to ensure accuracy of interpretations. Member-checking adds credibility, accuracy, and richness to a final report (Harper & Cole 2012).

Our interviews with managers of FBOs, public health officials, and NGO bosses in all the 10 districts of Lesotho revealed striking differences in perspectives on the HIV epidemic and the challenges it poses for their respective missions and mandates. Given these differences in mission, underlying values, and positions on specific issues, such as homosexuality and the ethics of condom use, it would be easy to draw a rather guarded conclusion about the potential role that FBOs can play in addressing the challenges posed by the HIV epidemic viewed from a public health perspective.

4.6. Ethical considerations
This study was based on the North-West University research ethical rules as enunciated in the Human Research Ethics Committee Clearance of 14 March 2013. In pursuance of the terms of this clearance, the free, prior consent of the respondents was expressly sought for and their privacy rights were not infringed upon as their views were kept confidential and rightly preserved.

5. Research questions
The starting point in analysing the roles that FBOs can play in addressing the epidemic is the range of activities that they have already undertaken. These are roles that FBOs have willingly assumed, regard as consistent with their mission, and have the capacity to undertake. However, the analysis must not stop there, unless we are willing to conclude at the outset that FBOs’ capacity and willingness have been stretched to their limits. To understand the current and potential roles of FBOs in HIV prevention and care in Lesotho, and to develop a realistic assessment of what FBOs can do beyond what they are already doing, as well whether it is feasible to get more FBOs engaged in the fight against HIV and AIDS, we must grapple with a series of questions, namely:

1. What is the need for HIV and AIDS services in Lesotho? Who is most affected by the HIV and AIDS epidemic and what services are currently available, either from public or private sources?
2. How have FBOs been involved in HIV and AIDS – for example, what is the range of activities in which they have engaged and how has this varied over time and/or across different countries and types of FBOs?
3. What are the facilitators and barriers to FBO involvement in HIV and AIDS?
4. Given what is known about the epidemic and past FBO involvement, what are the most important roles for FBOs? What can make FBOs more effective in the fight against HIV and AIDS in Lesotho?

6. HIV and AIDS activities of FBOs in Lesotho
To understand how FBOs might best be engaged in addressing HIV and AIDS in Lesotho, what HIV- and AIDS-related activities they are currently involved in were first examined, since that provides an initial indication of what they are able and willing to do. Those activities, reporting results from our fieldwork in four districts of Lesotho – Maseru, Mokhotlong, Quthing, and Butha-Buthe – were examined. This fieldwork included qualitative interviews of a range of stakeholders, including FBO officials, government officials, health care providers, PLWH, representatives of bilateral assistance agencies, and officials from other NGOs, as well as site visits to FBO HIV-related programmes. The range of activities that FBOs are engaged in around HIV and AIDS in the four districts utilising the framework noted earlier, Prevention, Testing, Care and Support Services (which is divided into pastoral care and social support, hospice care, and medical care and mental health treatment), and Stigma Reduction and Advocacy, were examined. FBOs involved across all these categories of activities were found, with the majority related to providing care and support for PLWH.

6.1. Education
A majority of prevention activities focus on education. Children and youth are the primary targets of education efforts, but PLWH and their families also receive some attention. Some use formal curricula implemented through schools (e.g. Anglican Church of Lesotho) or community-based organisations (e.g. Norwegian Church Aid working with local congregations and other organisations), and some are less formal and take a broader community approach (e.g. the African Palliative Care Association approach used by several FBOs in Lesotho in which street theatre, games, and other interactive methods are used to teach
community youth about HIV). Still others provide prevention education to youth who attend other FBO activities (e.g. a church camp). FBOs that provide prevention education for PLWH and their families tend to connect with these groups through their clinical care or community-based support groups.

6.2. Excluded and stigmatised groups

Very few FBOs directly prevent education efforts toward high-risk, highly stigmatised populations, such as MSM or commercial sex workers. FBOs that do work with MSM and sex workers tend to be those that provide clinical services to PLWH, perhaps sensitising them to the needs of stigmatised groups. Nevertheless, the decision to serve highly stigmatised groups can create difficulties for FBOs. One FBO official explained that his organisation had to move its clinic location several times because of violent opposition from people in the neighbourhood. In fact, one time, the neighbours organised and broke into the clinic, took out all the furniture and put it under a tree, and used a new lock to lock clinic staff out. For nine days, they held clinic under that tree (P. M., personal communication, 14 June 2013).

6.3. Influence of theology

FBOs' prevention messages are strongly influenced by theology. A Protestant minister in Quthing stated that his church teaches that prevention, that is, taking care of oneself, comes out of a belief that all people are made in the image of God and that prevention is necessary for church members to serve as witnesses of the Christian faith to others (M. R., personal communication, 4 July 2013).

An evangelical FBO official in Butha-Buthe also stressed the importance of providing information about HIV to help people make informed decisions. However, the message of this organisation focuses on the negative consequences of having premarital sex, similar to the Old Testament prophets declaring that 'bad things are coming'. According to him, 'What happens a lot is what the prophet [Hosea] said, 'My people perish for lack of knowledge’. We believe that giving knowledge is our work: announcing that bad things are coming, and [people] are responsible for the decisions they make' (D. M., personal communication, 10 August 2013).

6.4. Varying attitudes to condom use

Lesotho’s FBOs have widely varying attitudes on condom use. FBO attitudes towards condoms fell along a continuum from (a) anti-condom (condoms are a bad thing); (b) silence on condoms (don’t ask/don’t tell); (c) promote/mention condoms under limited circumstances and for limited purposes (e.g. for sero-discordant couples); (d) promote condoms in general but as the least important mechanisms of ABC (abstain, be faithful, and condomise); (e) promote condoms as equally or most important mechanisms in general prevention. Examples of FBOs across this continuum were found, although most tended to cluster under (a)’ (anti-condom) or ‘(c)’ (promote for sero-discordant couples). For example, at the time of this study, Catholic Relief Services (CRSs) personnel could discuss condoms with PLWH, but not with the general population (AVERT 2013). Further, there was a general perception across the country that the Pope had approved the use of condoms among sero-discordant couples, although there has been no such papal statement issued. In our study, one manager of a Catholic FBO explained that, by appealing to the value of ‘protecting life’, they can provide information about condoms, and, although Catholics are not allowed to distribute condoms, they can direct people to the Ministry of Health and Social Welfare (MOHSW) and other sources that can provide them. Only a small number of FBOs were willing to teach about condoms to the general population, and an even smaller number were willing to distribute condoms.

Even when they make specific exceptions, FBO officials are reluctant to be seen as promoting the use of condoms in general. For example, a Protestant religious minister in Maseru explained that sometimes the context requires that condoms be taught, even though FBO policy is not to ‘promote’ condoms (A. L., personal communication, 6 July 2013). Promotion of condoms among the more general population seems to have a negative connotation among a wide range of religious ministers – with the concern that this gives the message that it is acceptable to be promiscuous. Others, while acknowledging the effectiveness and importance of condoms in HIV prevention, expressed frustration at always being asked about their position on condom use, as if this were the only important issue regarding their involvement in HIV.

6.5. Voluntary counselling and testing

Some FBOs have started to offer rapid HIV testing (saliva and blood), both to the general population and to high-risk groups. FBOs in Lesotho have been particularly active in trying to extend rapid testing into outlying areas of the country (e.g. Caritas International and in collaboration with the MOHSW, Christian Health Association of Lesotho (CHAL). At the time of this study, only one FBO official in Qacha’s Nek (a Catholic priest) who was doing HIV testing and counselling was identified.

6.6. Medical care and mental treatment

Less frequent activities involving medical care and mental health treatment in Lesotho were heard of, although a study included examples of such care (Mahlalele & Osiki 2009). However, this type of activity was relatively infrequent compared with, for example, provision of hospice care (discussed next). Caritas International, an FBO associated with the Vatican, has played a key role in collaboration with the AIDS Healthcare Foundation and the Lesotho’s MOHSW to scale up ART. Another faith-based clinic run by Christian Aid (UK) provides medical management of a small number of HIV-positive patients, and the Victory Church provides medical care, though not ART, to AIDS patients.

In Qacha’s Nek, the Salvation Army provides care to PLWH in that part of the country and is one of the few providers of such care outside of the capital.

6.7. Hospice care and home-based care

A relatively large number of FBOs in the four study districts have been involved in providing hospice or shelters for PLWH and home-based care.
Few FBO-sponsored hospices or shelters in Lesotho were visited. These hospices ranged from small, informal, and resource-poor outposts (e.g. a two-room rented apartment with no running water that houses 20 HIV-positive persons in a clean and well-organised manner) to medium-sized, well-funded, and self-contained hostels containing few buildings to provide sleeping quarters, dining facilities, schools, and clinics, with on-site, trained health care personnel. Generally, hospices are few and far between in Lesotho. One church minister at the Lesedi Hospice, run by the Catholic Diocese of Aliwal, explained that FBOs in Lesotho have purposely not developed hospices because they fear it will contribute to stigma and will diminish family support (P. M., personal communication, 5 August 2013).

6.8. Care and community support of PLWH and their families

Some FBOs are also involved in providing care and social support for PLWH and their families. These activities include (i) pastoral care, including counselling, prayer, and care of the dying, (ii) support groups, and (iii) targeted assistance (food, income generating, and housing).

Concerted efforts have been made in each of the 10 districts of Lesotho to engage more congregations in providing pastoral care to persons infected and affected by HIV. For example, a collaborative effort has been established between the United Nations Children’s Fund (UNICEF) and the Lesotho Council of Churches (the local affiliate to the World Council of Churches) to develop a theological framework and plan of action for faith-based involvement in HIV and AIDS care and support.

6.9. Advocacy and stigma reduction

Health and FBO officials both described extensive HIV stigma and discrimination across the country, which affect those already identified as positive, as well as those at risk or not yet identified. They reported that this stigma is often prevalent even in the most intimate relationships, especially the family. For example, a majority of the members of an HIV-positive support group Maseru told us that they had not disclosed their positive status to their family members. Narratives were heard of family members who disclosed being HIV-positive and were rejected by their families (thrown out of the house) or kept ‘hidden’ so that others in the community do not know because families fear negative repercussions. For example, a health worker who provides care to PLWH expressed the perception that many PLWH become isolated out of shame and fear and are abandoned and die alone (A. L., personal communication, 6 August 2013).

Although this case seems rather extreme, interviewees narrated stories of similar cases from FBO workers who described difficulties working with PLWH in their congregations. They described cases where families kept AIDS patients hidden from the community, even from the pastors of their churches. There were reports that this acute stigma was a reason why it is hard to get a handle on HIV epidemiology, since some die never having been registered by the health care system as an HIV and AIDS case. There were also reports that even when cases have been identified as HIV-positive, sometimes their deaths are not registered as HIV and AIDS related. A regional health official explained how stigma can cause family members to hide the fact that the cause of death was AIDS. (C. R., personal communication, 7 August 2013).

A few organisations appear to be focusing specifically on reducing stigma and discrimination more generally in the population.

7. Attitudes and beliefs among FBOs

Some Lesotho FBOs see HIV as a divine punishment. Both FBO and health officials mentioned this barrier. This view increases the stigma against PLWH and also discourages people from getting tested and/or revealing their HIV-positive status to their congregations. For example, one health official from a bilateral assistance agency observed that mixing health-related issues with religion (i.e. moral judgements regarding behaviour) actually impedes prevention (M. M., personal communication, 9 August 2013).

A Lutheran pastor also indicated that the majority of churches in Lesotho are evangelical and have a condemnatory attitude towards those who are HIV-positive:

Here in Lesotho, the majority of churches are conservative, almost fundamentalist. So these topics of HIV/AIDS are associated with sin. You should not touch them, and he who is HIV-positive is that way because she/he has sinned, and they must be condemned. (I. R., personal communication, 11 August 2013)

FBO attitudes towards HIV and AIDS are also related to attitudes about homosexuality. Some FBO officials expressed a variety of attitudes towards gay individuals, although they tended to concur that homosexuality was ‘abnormal’ and inconsistent with biblical teachings. Some groups (particularly the more conservative ones) said they would not accept gays at all in their churches or seminaries, and some use counselling to ‘treat’ homosexuals (i.e. to change them to heterosexuals). An evangelical FBO official explained that his church sees homosexuality as a sin that needs to be changed once someone wants to live within the church:

I believe that homosexuals and people with these tendencies are people that have deviated from their development. Just as they fell into this problem, they can come out of it. So what we need to do is return them to their correct [sexual] identity, not so much in helping them or preparing the community to live with people like that. It’s the same thing as sin. (S. S., personal communication, 11 August 2013)

There was general consensus among health officials who worked with MSM across the country that gays feel shamed and guilt-ridden by FBOs because of FBO teachings that homosexuality is a sin, that homosexuals are not children of God, and that homosexuals are rapists. Sometimes these teachings can lead to increased risk of HIV for gays, particularly if they become homeless (due to rejection by their families) and have to resort to sex work or other high-risk behaviours, as noted by a health official in Maseru:
There have been cases with youth who have come to discover their homosexuality and their families reject them because they belong to a religious group that is telling them, ‘Kick him out of your house’. Because once someone is homosexual, [these churches teach that] he is no longer ‘a son of God’. The church sometimes plays an important role in manipulating families. We come in to help people when they have been kicked out and realise they have to go to the streets or resort to [commercial] sex work to survive, to have a roof over their heads. (T. T., personal communication, 11 August 2013)

Some health officials felt that religious groups help fuel anti-gay sentiment and in extreme cases might even promote some of the violence being committed against gays in the region. A health official in Qacha’s Nek shared:

Churches are the ones that promote hate crime assassinations against sexual identity in Lesotho. I hope they don’t want to kill us, but they do promote it. In 2004, three police officers reportedly killed a sex worker. We don’t know why they killed her but I suspect it was because of religious prejudice. (M. N., personal communication, 3 September 2013)

Several officials of Lesotho’s FBOs argued that HIV stigma is largely due to its association with promiscuity and male–male sexual contact. They told us that, because of chauvinism, women are generally scorned more than men are for promiscuity, that is, it is somewhat expected of men to have lots of sexual experience and multiple sexual partners, but women are expected to be virgins before marriage and to remain faithful to their husbands. On the other hand, an FBO official indicated that women are probably less scorned than men for being HIV-positive, because of the association in people’s minds of HIV with male–male sex:

In terms of promiscuity, male promiscuity seems to get a little more social acceptance, but every now and again you will hear people say ‘men are dogs’. But somehow it is not really scorned upon, if I may use that term. Whereby a promiscuous woman is likely to be dealt with more harshly in terms of public opinion, and they would find rather derogatory words to describe her. (M. M., personal communication, 5 September 2013)

Many respondents pointed to gay male populations as the earliest communities affected by HIV and the most affected communities. Respondents indicated that, in addition to being rejected by their families and churches, HIV-positive gay men were also reportedly marginalised by government hospitals that sometimes refused to give medicine and care. For example, one NGO official said: ‘They denied integrated care to us gays, perhaps because we belong to a different community. They treated gays or the commercial sex workers as if we didn’t have any right to life’ (L.M.M., personal communication, 5 September 2013).

Some FBO officials said they try to refrain from ‘judging’ and discriminating against gays, while still maintaining that they are not in agreement with their ‘lifestyle’, that is, ‘loving the sinner not the sin’. Further, a Protestant minister stressed that HIV should be seen just like any other disease:

The danger I have discovered is with a judgmental attitude [toward the person with HIV] . . . but HIV is simply another disease, just like cancer, leukaemia, whatever. And until we get to that stage around the world, not only here at home, we will not overcome the barrier of discrimination. It is simply another illness, end of story. Until we treat it in that way, we will not overcome it. (L. L., personal communication, 5 September 2013)

Nonetheless, very few of the FBO officials interviewed expressed complete acceptance of gays and same-sex relations. Attitudes towards HIV appeared to be changing in some churches, particularly as epidemics become more generalised. An NGO official in Maseru felt that most churches have moved from a judgemental attitude to one of compassion, at least for women and children, but still lack information that would help them relate more closely to the epidemic (O. L., personal communication, 18 September 2013).

There are anecdotal reports of some pastors and other religious ministers encouraging PLWH to stop their medications and rely instead on prayer. For example, a health official from an NGO that provides care to PLWH confirmed that there are stories of some religious congregations encouraging PLWH to rely on prayer instead of ART, but this health official’s organisation required all volunteers to go through a rigorous training on HIV and limited the type of involvement that congregations can have in their facility. Congregations/volunteers can provide pastoral care and religious services, but cannot come in only to perform religious ‘healings’. This NGO official acknowledged that occasionally religious groups have interfered with ART in public hospitals, possibly leading some patients to refuse drugs (M. N., personal communication, 18 September 2013).

Judgemental attitudes on the part of FBOs towards gays, MSM, and commercial sex workers and FBOs’ limited reach into these groups were seen by health officials as additional challenges to FBO involvement in prevention and supporting PLWH. For example, it was noted that, in Lesotho, the epidemic is more concentrated in groups (MSM, sex workers) that the church does not generally reach.

Some FBO prohibitions against condom use and/or reluctance to promote condoms are also seen as important barriers by health officials. One health official in Mafeteng stated that this prohibition or reluctance is the biggest obstacle to allowing FBOs to take a positive role in the fight against HIV.

8. Organisational barriers to FBO efforts on HIV and AIDS in Lesotho

FBO and health officials both acknowledged a number of organisational barriers to FBO involvement in HIV and AIDS efforts. Such barriers are especially prevalent given the proliferation of different types of denominations and non-denominational
churches across Southern Africa. The Catholic Church remains the largest denomination in Lesotho but without the hegemony of the past, with more than 50% of Basotho people identifying themselves as Catholics. However, other Christian groups, especially evangelical, Pentecostal, and/or nondenominational groups, have grown to the point that they now collectively represent 30% of the population, but no one non-Catholic denomination represents over 10% (CIA 2013).

Some health officials have found it challenging to work with the faith community because of its diversity. For example, a number of health officials noted that there is no one structure that brings together all faith groups, and this makes it hard to coordinate more broadly with this sector. Further, a health official saw challenges in working with churches not only because of diversity among denominations and religions but also multiculturalism of the country’s population. Inter-denominational associations of like-minded churches do exist as well as some more ecumenical coalitions that bring together Catholics and Protestants, such as the Lesotho Council of Churches and the Ecumenical Christian Council of Lesotho. Interestingly, these associations have been behind some of the more visible efforts around HIV and AIDS in these countries, along with denomination-specific efforts such as the Episcopal Church’s work in HIV prevention and treatment.

8.1. Resource barriers
FBO officials were quick to note the lack of resources for FBO HIV activities. First, they emphasised that many churches are small and do not have resources, while the larger, more wealthy churches tend to have little interest in matters related to social justice. For example, a regional official of an international FBO that works with evangelical churches in Lesotho observed:

Many of the churches have modest resources; and thinking of the largest ones, they tend to concentrate on preaching a ‘theology of prosperity’, right? So there is very little interest in any other issues of the economy, justice, or health. There is very little interest. The emphasis is on other things. (P. T., personal communication, 20 September 2013)

However, beyond the congregational level, it is also important to consider resources at the denominational, inter-denominational, and international levels. Much of the HIV and AIDS activity at these higher levels seemed to be related to opportunities to obtain external funding (e.g. through the Global Fund, or from private donors that supported an FBO mission). Some FBO officials lamented that international funding has focused mostly on condom-based HIV prevention strategies. This made it difficult for FBOs to secure funding for their abstinence and ‘be faithful’ strategies.

FBO officials also found it challenging to coordinate with health care providers, given their uneven distribution particularly in rural areas. For example, an FBO official in Quthing whose organisation does HIV testing explained that doing testing in more remote areas of the country that do not have facilities that provide HIV care or strong referral networks creates a real dilemma for them (L. K., personal communication, 19 September 2013).

8.2. Conflict between FBOs and secular health organisations
Quite apart from the barriers to FBO involvement in HIV and AIDS described above, the interviews revealed fundamental differences in values between religious and health officials that lead them in different directions on HIV prevention and also limit their ability to work collaboratively in relationships. Most importantly, many religious officials favour some prevention methods (such as abstinence or ‘being faithful’) and oppose others (such as condoms) mostly on religious beliefs, with less emphasis on evidence of effectiveness. In contrast, health officials favour prevention methods that have been proven effective in preventing HIV transmission. The difference in preferred methods is probably less divisive than the difference in fundamental values that underlie these preferences, which serve as barriers to trust.

While some FBO officials lamented the lack of funding for ‘abstinence’ and ‘be faithful’ prevention strategies, health officials were concerned that these strategies have not been proven effective. Many health officials noted that although FBOs were engaged in many activities, there has been little assessment of their impact. For example, a health official of a bilateral assistance agency in Maseru attributed the lack of evaluation to the fact that there is often little to no financial accountability for the monies and donations that churches receive (FBOs rely heavily on donations), and that there is no sound evidence that the programmes administered by faith-based communities are effective. Some studies have been done but are flawed by methodological problems.

9. Lessons learned
Based on the findings from our interviews, several potential roles for FBOs were identified in addressing HIV and AIDS in Lesotho. FBOs might take a larger role in prevention and testing, in partnership with public health providers. It is unrealistic to expect many FBOs to shift their focus towards high-risk populations and promotion of condom use. It is more constructive to accept that different organisations, whether FBO or non-FBO, have entirely different comfort levels with regard to specific approaches to behavioural risk reduction, and to find ways for organisations to work together while respecting those differences. Nonetheless, there is still a lot that FBOs could do in the fight against AIDS, for example, by encouraging people to get tested and get information about HIV, particularly because churches exist in all communities. FBOs that provide testing in partnership with public health providers can send a constructive message that HIV is a disease for which treatment is available and that people should know their status.

FBOs might become more involved in providing care and support services (especially some services that are rarely addressed). FBOs already provide many services of this sort. These activities might be expanded to include other needed services, such as transportation, food, housing, and income-generating activities. One
other important role that certain FBOs seem uniquely qualified to undertake is that of reducing the stigma associated with HIV in the faith community and the broader population. In view of FBOs’ moral authority, broad reach, and ability to influence attitudes, stigma reduction is an area in which FBOs could have an especially strong impact. Indeed, stigma reduction seems critical to realise the full capacity of congregations to address the needs of PLWH.

Advocacy is another area in which the role of FBOs might be expanded. Some FBOs have assumed an advocacy role for PLWH, advocating for greater access to health care, antiretrovirals (ARV), or workplace rights. These advocacy efforts can be quite important in countering the effects of discrimination or simple lack of attention.

Collaboration with other organisations is needed. If FBOs are to play a constructive role in addressing HIV in collaboration with the health care system, they must also recognise the unique and complementary strengths that each sector can bring to addressing it. There are also a series of activities that they can assume in collaboration with the health care system:

- **Complement** the activities of others by addressing gaps outside the scope of others’ missions or that others are unable to complete, for example, by establishing housing projects for PLWH and hospices and facilitating income-generating activities in which PLWH could engage once their health has been stabilised by ARV.
- **Reinforce** the activities undertaken by others, for example, by reinforcing prevention messages, counselling congregations on safe sex practices, and encouraging people to get tested.
- **Facilitate** the activities of other organisations, for example, by offering opportunities for health officials to promote the use of condoms in conjunction with other activities that FBOs are directly responsible for organising.
- **Support** the activities undertaken by others, for example, by recognising the efforts of others and encouraging people to support other organisations’ programmes.

Like elsewhere around the world, FBOs have engaged in a wide range of HIV and AIDS prevention activities in Lesotho, but have tended to focus on certain ones. There was evidence of some FBO activity in HIV prevention with high-risk groups (sex workers, MSM) and broader involvement in ‘abstinence-only’ strategies targeted at youth. Less frequently conducted prevention activities included HIV testing, and condom education and distribution. There were also FBOs involved in a wide range of care and support activities, most frequently medical care and pastoral care and social support of PLWH and families. Less frequent social support activities include those related to nutrition, income generation, and housing. Finally, participants revealed FBO involvement in a variety of stigma-reduction and advocacy-related activities, including raising general community awareness about HIV as well as targeted efforts to build networks of PLWH and ensure treatment access.

FBOs can also allow others, such as the MOHSW or similar agency, to observe, monitor, and evaluate FBO programmes using objective criteria and rigorous analysis. There is also need to build FBO capacity to evaluate own programmes.

The findings of this study suggest that officials in the public health sector might find it worthwhile to think creatively about ways to make effective use of the strengths and capabilities of FBOs in addressing some of the critical needs posed by the HIV epidemic. Donor organisations can also play a critical role in fostering collaboration between FBOs and public agencies by providing the funds to evaluate and sustain such partnerships.

**10. Concluding remarks**

This study describes the potential role of religious organisations in the battle against HIV and AIDS generally: that faith-based initiatives are pivotal to the success of prevention and care efforts in Lesotho as well as worldwide. Churches are found in nearly all communities in the country and wield a significant level of cultural, political, social, educational, and economic influence. The Church can be viewed as the largest, most stable and most extensively dispersed NGO in most Southern African Development Community (SADC) countries. Churches are respected within communities and most have existing resources, structures, and systems upon which to build. They possess the human, physical, and financial resources needed to support and implement small- and large-scale initiatives. They can undertake these actions in a very cost-effective manner, due to their ability to leverage volunteer and other resources with minimal effort. Unfortunately, the resources, capabilities, and potential of the Church are considerably neglected or untapped, and it has not been considered part of the solution and/or a driving force in the fight against HIV and AIDS.

Health and FBO officials recognised many of the same challenges to FBO involvement in HIV and AIDS: FBOs’ tendency to interpret HIV in religious terms and thus to advocate a purely spiritual, rather than medical, response to the disease; and FBOs’ general inability to discuss sexuality. Health officials also emphasised other issues, including uncertainty over the impact of FBO efforts and FBOs’ stigmatising attitudes towards MSM. FBO officials tended to emphasise organisational and resource barriers. Nevertheless, there was an overall sense that FBOs could make important contributions by leveraging their broad reach and influence to raise awareness and decrease stigma towards PLWH and provide support and care to PLWH, particularly where gaps exist, such as in nutrition and income-generating activities. FBO involvement in prevention was perceived as more problematic than care and support services by many of the health officials.

All in all, there are critical roles for FBOs that contribute substantially to the well-being of communities, families, and individuals with HIV. Some FBOs have used their influence to advocate for needed policies, including debt cancellation and universal access to treatment. Religious groups have also used their reach in communities to ensure that there is a comprehensive web of support for people with HIV. We must applaud these efforts and hope that
these initiatives persist and multiply along the revelations of this modest study.

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