
Taking it to the Pulpit: Repositioning FBOs as Critical Agencies in the HIV/AIDS Response in South Africa

Edlyne Eze Anugwom

Additional information is available at the end of the chapter

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Abstract

In spite of significant gains achieved in the fight against HIV/AIDS, it remains a huge public health challenge in South Africa. Therefore, there is a need for continuous concerted efforts involving critical agencies like faith-based organizations (FBOs) that are already prominent in health care. The chapter examines how FBOs involved in HIV/AIDS response can be repositioned and further empowered. Though FBOs remain very critical and relevant to the national response in the country given their grassroots reach and influence; there is ambivalence on the value of such roles and how they relate to the national response. The main findings include: FBOs are not fully integrated into the national response framework; in spite of laudable strides, FBOs still embody a negative influence on the response especially in terms of the use of condoms; FBOs lack capacity in such crucial areas as networking and partnership; however, they are active in rural enclaves and in the prevention and care aspects of the response. There is a need to strengthen these FBOs, align their initiatives to both the national framework and orthodox knowledge regarding the pandemic. This chapter recommends programs to build the managerial and technical capacities of these FBOs

Keywords: : HIV/AIDS, faith-based organizations, response framework, capacity, South Africa

1. Introduction

Despite considerable strides made in the fight against HIV/AIDS in Africa, it still remains a formidable challenge in the areas of public health and general development in the continent. This entails that there is no gainsaying the need for continued concerted efforts at addressing the menace of the pandemic. Without doubt, Faith-Based Organizations (FBOs)

have emerged as critical agencies of health provisioning in Africa especially with reference to HIV/AIDS. Thus, these FBOs appear as imperative avenues for fighting the pandemic in Africa. In view of the foregoing, the aim of this chapter is to assess the role of FBOs in South Africa in the response and more critically how such roles can be repositioned and enhanced to contribute more meaningfully to the overall national response. Thus, this chapter argues that while significant progress has been made in the fight against HIV/AIDS in South Africa,^{1,2} there is still a need for a much more concerted approach which should reposition and harness the value of Faith-Based Organizations (FBOs) as mediators in social life of citizens. In other words, its aims include to examine the roles of FBOs in the HIV/AIDS response, how such roles are integrated within the larger national response framework, the opportunities/niches which these FBOs embody, as well as the constraints or limitations suffered by these FBOs and how their undoubted visibility can be enhanced in improving the response.

There is no gainsaying the fact that FBOs play critical roles in the health behaviour and health choices that people make in South Africa and the whole of the continent. This stems both from the remarkable level of religiosity among South Africans especially those who are largely marginal to the socioeconomic spheres of the society and the widespread prominence of these FBOs. As social indicators and even cursory observation would reveal, those who are most vulnerable to HIV/AIDS and also bear a high burden of the pandemic are people from the above category who are mainly poor, uneducated and more often than not excluded [3–5].

While South Africa has obviously weathered the storm of AIDS mainly through the global emphasis on ARVs and a much improved prevention program emphasizing safe sex, condom use, marital fidelity, knowledge of HIV/AIDS status, and reframing of AIDS as not a death penalty, there is still much work to be done not only to sustain the progress made but to ensure that the optimism expressed about overcoming the pandemic in the last few years is met. There is no doubt, as anyone familiar with the checkered history of South Africa with the AIDS pandemic would concede that FBOs were critical in the efforts of people to deal with the pandemic especially in terms of caregiving and provision of psychological and physical support to those afflicted and affected by AIDS; the role of FBOs in this regard seems both expected and in line with a consistent mediation in the health decisions of people in Africa [3, 6, 7].

Interestingly, while FBOs in Africa as a whole have responded to the pandemic, much of the response has been largely moralistic and often showing rejection of the core foundations of the campaign especially with regard to condom use and the issue of premarital sex [7]. The above calls attention to the need for AIDS policy planners and intervention agencies in South Africa to reflect on ways through which the FBOs can significantly benchmark their AIDS services and stance on the orthodoxy regarding the pandemic.

¹ Almost 20% of all HIV-positive people in the whole world live within South Africa's borders [1].

² While HIV prevalence among young South Africans is regarded as one of the highest in the world, there has been a significant decline from 10.3% in 2005 to 5.6% in 2016 (see, [2]). However, there is still a long way to go before Eureka.

In spite of the implicit recognition of the value of FBOs in the national response especially through the existence of faith-based sector in the South African National AIDS Council (SANAC), there remains to emerge a sustained and systematic thorough-going effort to fully integrate, deepen, and recalibrate the actions of the FBOs in the response. In other words, there is yet to really emerge a broad-based national and committed effort to locate these FBOs and their diverse actions squarely within the broad response framework as well as the obvious paucity in efforts to empower, strengthen, and effectively streamline the FBO contribution to the response.

The Christian AIDS Bureau for Southern Africa (CABSA) has arisen to inject the needed impetus and collaborative energy into the FBOs role in the HIV/AIDS response [8]. However, while re-emphasizing the important role of FBOs in the response, the CABSA's Executive Director, Lyn van Rooyen, argued that there is a need for FBOs to rethink their role in relation to the HIV/AIDS response [9]. But while the role of the FBOs in the response remains largely undoubted, what has remained mainly unknown is the connection between these roles and the largely national or state level response. In other words, how does the role played by these FBOs intertwine, feed in and integrate with the comprehensive response framework and whether such roles are defined and structured by the guiding rubrics of the national strategy especially in the rudiments of prevention usually captured in the ABC acronym (abstinence, be faithful, and condoms).³

Even though a good number of studies [10–12] have been carried out on the health roles of FBOs in Africa, there is no doubt that there is still the need for more information and knowledge about the range of HIV/AIDS services provided by these organizations and more critically how and at what juncture these services interface with those from formal agencies. But even beyond the above is the need to understand the trajectories of the FBOs driven response and how these have been consistent or otherwise with the perceived dynamism of the general state-driven response.

Therefore, as has been argued, “generalizations about FBOs’ HIV/AIDS prevention responses are unhelpful as they create an inaccurate picture of FBOs’ HIV/AIDS response efforts” ([13], p. 314). In other words, there is a need for nuanced knowledge about the FBOs contribution which takes cognition of peculiarities, alignment and consistency with the broad national response framework and integration within such a broad framework. But in order to achieve the needed integration and consistency with the broader national response, there is a need for a better understanding of the peculiar predicaments these FBOs face and how these FBOs and their efforts can be better repositioned to squarely connect with the national response framework.

2. Profile of the FBOs engaged in the response

According to the Pew Research Center [14], the religious affiliations of South Africans range from preponderance of Protestantism to a significant (rapidly increasing) presence of Islam.

³ At a recent fora with FBOs, SANAC expressed concern that there is the substitution of ARV treatment with holy water and other faith-based commodities which are not scientifically proven to be effective against the pandemic [8].

In its estimation, the religious affiliations or spread of South African population (i.e., those who profess any form of religion) are protestant (41%), African Independent Churches (AICs) (27%), Catholics (11%), and Islam somewhere between 1.6 and 3% [14]. Be that as it may, Faith-Based Organizations in reality in South Africa represent a plethora of entities ranging from places of worship to even quasi-development or social organization with a mission of faith. These entail that FBOs are of various types and share a broad commonality in the faith nature or centeredness of the organization concerned or its parent body.

However, this chapter adopts a very generous definition of FBOs involved in the HIV/AIDS response. This definition is robust and involves different sizes and types of FBOs operating at local, provincial, and national levels. Therefore, FBOs in this case refer to a broad set of faith-based organizations or institutions including national religious structures like the South African Bishops Conference, faith-based non-governmental organizations like Youth for Christ, community-based or local parishes and congregations, church-based or aligned social service agencies, and other social service agencies and projects tied to faith-based organizations or churches (see also [5]). In spite of the above general conceptualization, it is necessary to mention that the real work of intervention whether in terms of care or prevention or even access to treatment is more readily crystallized at the community or local level. For instance, while the national FBO body or coalition like the Bishops Conference may issue proclamations and provide general guidelines, the nitty-gritty of dealing with those affected and infected usually lies with the different parishes, congregations, and similar spatially delimited church groups or organizations. While both levels of efforts are complementary and important, the response patterns and interactions play out mostly at the local and community levels.

As cursory observation would reveal, there is a preponderance of these FBOs in the urban areas of the country. This entails that accessing of HIV/AIDS services would be particularly challenging for rural dwellers especially when one takes cognizance of the fact that the formal response structures are equally not well entrenched in the rural enclaves. Further characterization of FBOs here depends essentially on the material available in the South African National AIDS Database [3]. The database shows 162 FBOs involved in the response of which 96% are Christian and 40% are Muslim. Among the Christian FBOs, the distribution was Catholic 14%, Dutch Reformed Churches 11%, Pentecostal/Charismatic 11%, Anglican 7%, Methodist 6%, and others 8%. Apart from the above denominational and demographic characteristics, these FBOs can equally be characterized as networks and coalitions (4%), faith-based NGOs (16%), and projects/special initiatives (47%). Incidentally, these categories are hardly mutually exclusive and overlaps occur. In spite of these, the highest number of FBOs engaged in the response is in the project-oriented categories (47%), followed by faith-based NGOs (16%) and social service outlets (13%), while the lowest of less than 5% is found among networks and coalitions which suggest glaring capacity and integration challenges generally.

In spite of the above, the FBOs are usually concentrated in the area of prevention rather than treatment and management. In other words, the bulk of the activities of the FBOs are awareness, counseling, and to an extent testing. But they usually shun from the provision of core medical care and hardly focus on condom seen largely as inconsistent with the scripture and liturgy of these organizations. In a curious sense, the FBOs seem to have replaced condom promotion with abstinence. Hence, they are much more comfortable with preaching and privileging abstinence rather than focusing on condoms.

3. Overview of the history and roles of the FBOs in the general response

The role of FBOs in Southern Africa in providing care and support to those infected and affected by HIV/AIDS has been globally acknowledged [15–17]. In other words, there is a recognition, even where self-referent, that African FBOs are critical or important role players in the HIV/AIDS response especially in care giving (see, [18–21]) and also in the areas of prevention and awareness creation. At the same time, even while recognizing the roles of these FBOs, some authors have equally indicated these organizations as acting in ways that often undermine the overall response [21–23]. In other words, while there is no doubt that these FBOs do certain things in terms of the pandemic, there is ambivalence in terms of the net effect of such contributions and how the various roles of the different FBOs conflate with the overall national strategy and broad efforts.

The role of the FBOs in the response in South Africa is equally underpinned by the realization that the real push for a systematic and state-wide recognition of the pandemic and needed response came from civil society groups and leaders who had to confront the unyielding denialism of the government regarding the pandemic between 1998 and 2008. In fact, this denialism under the then government of Thabo Mbeki gave rise to the non-acceptance and disavowal of the link between HIV and AIDS. A good survey of the history and politics of AIDS in South Africa between 1994 when democratic governance commenced and 2008 would certainly highlight the undaunted fight of civil society groups including FBOs for the mainstreaming of HIV/AIDS in national health framework and provisioning [1, 18, 24].

Apart from using the media and strategic awareness creation and coalitions, there was even utilization of legal means including the popular court case on the need of the state to provide nevirapine for PMTCT, the abdication of which these groups argued was really unconstitutional [1, 25]. In that historic case, the High Court in Pretoria found in favor of civil society arguing that a countrywide PMTCT program is in reality an ineluctable obligation of the South African State [24]. Incidentally, the then Health Minister, Tshabalala-Msimang appealed the court decision but lost in a historic case that generated great criticism and public opprobrium for the state. Going forward from the change in 2002, the government eventually signed off on a new National Strategic Plan (NSP) on HIV and AIDS and STIs (2007–2011) produced by SANAC. Given an onslaught of internal dissension, international condemnation, and even ridiculing of the government, it was a matter of time before the state made a volte-face. The change came in 2002 when a cabinet statement offered acceptance of the link between HIV and AIDS, the rolling out of PMTCT in the nine regions of the country, and the launching of the Strategic STI (including AIDS) Plan (2002–2005) among other measures [1, 24]. Following that was the approval eventually by the cabinet in November 2003 of an Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa as a whole [1, 24]. However, the first broad-based National Strategic Plan (2007–2011) that was led by SANAC but which involved dialog and consultation with stakeholders and the political class finally emerged in 2006 [1, 24].

Currently, there is a new National Strategic Plan for HIV, TB, and STIs (2017–2022) which is the fourth plan in this regard and embodies the aspiration to build on the progress that has been achieved in the national response so far [26]. The fact that the present plan aims

at “saturation of high-impact prevention and treatment services and strengthened efforts to address the social and structural factors that increase vulnerability to infection” ([20], p. xiii) means an increased opportunity for non-governmental groups including FBOs to find credible niche and relevance in the response. Interestingly, goal 6 of the Plan which is, “promote leadership and shared accountability for a sustainable response to HIV, TB and STIs” embody the desire to capture, strengthen, and create spaces for role performance by the private sector, labor and civil society organizations in the national response.

4. Methodology

This chapter derived its information from documentary sources of data and the extant literature. The review of literature for this chapter was based on the following general criteria:

Database: The literature search focused essentially on databases known for housing information and journals on social sciences and health, public health, HIV/AIDS, and religion and health in Africa. Thus, the following databases were utilized: South Africa Database on HIV/AIDS, Google Scholar, ProQuest, Medline Plus, UWC Online Library, and Cochrane Library.

Data type: Primary and secondary data, that is, papers that were derived through field work studies or surveys and those that were generated through documentary data or literature review.

Terms/concepts used: Terms and concepts use for the literature search included HIV/AIDS, Africa, South Africa, religion, Health; Faith-Based Organizations in Africa response to HIV/AIDS in Africa, and UNAIDS.

Geographical focus: Africa, Southern Africa, and South Africa.

Inclusion criteria: Papers and articles utilized for the review were selected on the basis of the following criteria: focus on HIV/AIDS and religion; HIV/AIDS and FBOs in Africa; published between 2000 and 2017; social science articles on FBOs and health-seeking behaviour in Africa; role of FBOs in HIV/AIDS and health provision in Africa.

Exclusion criteria: The following criteria were used in excluding material in the review process: papers dealing with HIV/AIDS in other regions of the world; extreme-dated papers, that is, papers published before 2000; gray literature and opinion articles; papers focusing only on biomedical aspects of HIV/AIDS in Africa.

The above guided the literature review for this chapter and provided information and insight for a thorough-going overview of the FBOs response to the HIV/AIDS pandemic and the teasing out of both the structural impediments to the optimal utilization of these FBOs and the unique opportunities they still portend, especially in reaching the teeming number of those either vulnerable or marginal to the socio-economic spheres of the society. Therefore, while there is undoubtedly a good volume of published materials in the above regard, this chapter prioritized those focusing on the role and involvement of FBOs in the response to HIV/AIDS, the state of the response in South Africa, as well as the nature of FBOs involved in the response.

5. Results and discussion

The results and discussion in this chapter would be organized under two main headings, namely opportunities and niches of FBOs in the HIV/AIDS response and the constraints/impediments to the FBOs response.

5.1. Opportunities and niches of FBOs in the HIV/AIDS response

As obvious from the foregoing discussions, FBOs in South Africa and even the continent at large play critical roles in the health-seeking behaviour of people including HIV/AIDS. However, the role of the church in the above capacity often raises concerns regarding the nature of such involvement and its consistency with biomedical standards and procedures. In spite of this, the FBOs in South Africa offer opportunities and/or possess niches relevant to the response. Some of these are examined subsequently.

5.1.1. *Grassroots/community reach*

Perhaps, the greatest niche of the FBOs is captured in their grassroots or community reach and engagement capacity. In this case, the FBOs usually mobilize and engage with people and communities at the grassroots and have utilized this capacity to render services and support to those affected by the pandemic [7, 13, 15]. Specifically, the FBOs have been largely prominent at this level in the areas of care and support, counseling, and providing psycho-moral support of various types. The believability of the FBOs from the point of view of the people and the high faith imbued in these organizations give them the ability not only to intercede but mediate the response in ways that can be really effective if properly managed and channeled along the broader state level response framework.

As has been argued, “FBOs are at the centre of community life in much of South Africa and have extensive reach into the most remote and isolated parts of the country. These organizations hold positions of trust, which give their actions and words considerable potency. They have frequent opportunities to interact with their congregations and communities and have the ability to influence social norms and behaviours through moral teachings” [27]. Therefore, the relevance and value of the FBOs are further enhanced by the realization that these organizations have very robust community level roots and presence. These position them as critical agencies at the community level in addressing and mediating health challenges of members and others at that level. In other words, both their visibility and acceptance at the community level far outweigh those of the formal health system or state-driven HIV/AIDS agencies. Hence, they remain important agencies for influencing and impacting both health-seeking decisions and access to health care of people especially at community and rural enclaves.

5.1.2. *FBOs and understanding of sexuality and sexual behaviour*

There is without doubt a need to seriously nuance our understanding of the role of FBOs and religiosity as a whole on sexuality and sexual behaviour in African societies. This is especially the case in view of the fact that evidence from studies in developing countries of the world

places religiosity and religious organizations in an ambivalent position in relation to sexuality and sexual behaviour [28–32]. Therefore, these studies reveal that while people especially youth who profess religion or are religious are less likely to have sexual partners and be initiated into sexual activities, they are also prone to be less sensitive to the need for protection when they become sexually active. However, studies from Africa would tend to neutralize the influence of religion on sexual activity by young people who are religious in relation to the other members of the society [6, 33–35]. But these studies did not dispute the undoubted influence of the church in personal life and social behaviour of Africans.

5.1.3. Protection from early sexual activity and promiscuity

Also, religious organizations and churches spend energy on moral principles and the denouncement of promiscuity. The undeniable fact is that religion plays a role in protecting young people from early sexual activity, sex adventurism, and general promiscuity, all of which may be positive to the HIV/AIDS elimination drive. But the way and manner the church goes about performing the above roles with specific reference to HIV/AIDS would seem really important. In other words, the church can function as both the linchpin of the response in communities and at the same time ironically perpetrate practices and values that ultimately seem antithetical to the response especially in terms of dealing with those who are affected and infected and also in decreasing vulnerability and eliminating risky behaviour by young people [6, 7, 27].

Even though efforts have been made starting from 2003 to understand and document the activities of these FBOs in the response as part of a general view of community level activities around the pandemic, it is ambivalent whether the outcomes of such evaluations and assessments have become effectively utilized in strengthening the national response to HIV/AIDS. Perhaps, concrete attempts at doing the above would have entailed the enhancement of the capacity of the FBOs.

5.2. Constraints/impediments to the FBOs response

Definitely, the concern in this chapter apart from the main focus of proffering measures for strengthening the FBOs contribution to the response is also the need to overcome some of the inadequacies and actions or mis-actions of these organizations which ultimately portend negative consequences for the response. These may include subjecting the HIV/AIDS core messages to wrongful and slanted biblical interpretations, over-utilization of religious doctrines in evaluating HIV/AIDS prevention messages and overtly moralizing tendencies which interfere with what the church can and cannot do within the response. Some of these issues are addressed subsequently.

5.2.1. Funding limitations and technical incapacity

While the South African government and its agencies often fund FBOs run or owned social service agencies and projects involved in the response, they hardly commit to the churches or congregations or response initiatives embedded in them. The end product is that while the former do not have adequate funding in spite of what comes from statutory agencies,

the latter are usually dependent on donations and goodwill from church members and thus always in acute need of funding in order to function effectively [7].

Even where funding exists especially in terms of programs of international multi-lateral development agencies, FBOs have not been very successful in accessing these funds. In other words, while some of the FBOs have accessed such funds, many have been unable due to capacity challenges to make optimum use of this channel of funding. The FBOs often lack the technical capacity to develop project proposals and even position papers often necessary to attract or compete for such funding. Poor networking and partnership also hinder these groups. Incidentally, fundamentalist and isolationist (seen here as resistance to external influence and values) leanings of FBOs also come in the way of their ability to reach out.

Therefore, scarcity of fund is generally seen as militating against the effectiveness of the FBOs. Many of the FBOs involved in different aspects of the response experience funding challenges followed by lack of equipment or infrastructure [5]. The above challenges can be easily appreciated against the background of the nature and primary goals of FBOs which cast them as non-profit and not engaged in business or economic ventures for making money. FBOs largely depend on free-will donations and offertory of church members. In many cases, even the specialized or dedicated HIV/AIDS units of churches or denominations are equally dependent on the goodwill donations of members and whatever money allocated from the general church pool. In spite of the assistance of government and international agencies, HIV/AIDS response in light of the heavy burden from it remains more or less resource guzzling. Therefore, the extent and depth of coverage or response effectiveness depends on the availability of funding and the necessary equipment and infrastructure without which actions toward addressing the pandemic are severely encumbered.

5.2.2. Conflation and sin-oriented approach

There is also the nagging issue of conflation and sin-oriented definition of the pandemic by a good number of the FBOs. This orientation hinders the effectiveness of FBOs in the response. In such a situation, there arises conflation of sexuality and morality and the treatment or perception of AIDS as the fruit of sin [27]. In other words, there is often the tendency among the FBOs to indirectly and in some few cases directly blame the victims. AIDS is thus seen as an issue which underlines both immorality and sinful predilection of those affected [4, 21].

A crucial bulwark in the FBO response to the pandemic lies especially in the adoption of a moral kaleidoscope in the perception of the pandemic. In almost all instances, the church sees HIV/AIDS as more a reflection of individual moral laxity and irresponsibility than just the occurrence of disease. Often times, the emphasis is placed on ascertaining how the individual became infected rather than on prioritizing service. Therefore, even though the Catholic church or most of the Pentecostal churches are berated for unshifting and loud stance on condoms, the FBOs generally suffer from the above moralization of the pandemic and are also encumbered by patriarchal and hierarchical structures that while preserving the church as a consistent and fixed embodiment of spirituality reproduces gender inequality that enhances vulnerability and the inability of women to access HIV/AIDS services [7].

5.2.3. *Traditional conservatism*

Perhaps, equally constraining, the role of the FBOs in the challenge of the pandemic is the nature of the church as a largely conservative and very slow-changing entity. There is no doubt that the response in South Africa like in so many other countries in the continent calls for dynamism and working in concert and collaboration with other stakeholders. The noted conservatism of the church and the abhorrence of “outside” interference may actually make it difficult to integrate FBO response activities into a broad systematic response framework [13, 15, 36].

5.2.4. *Non-integration into larger service delivery networks*

An important evaluation of the roles and activities of FBOs in the HIV/AIDS response in South Africa has been carried out by CADRE [31]. The evaluation profiled these FBOs and outlined such technical issues as funding, capacity, and networking in the FBOs and underlined the significant roles of these FBOs especially in the areas of care and prevention. However, the report located a couple of challenges confronting these organizations, ranging from the scope or extent of reach and funding but more critical is the finding of the evaluation that the activities of these FBOs do not appear to be integrated into the larger service delivery networks [5]. In other words, these FBOs while performing critical functions are not systematically connected to the larger response framework and are dogged by funding and technical challenges. Thus, while these FBOs remain undoubtedly imperative to the response, their effectiveness has not been maximized or systematically harnessed. Therefore, the picture of the mid-2000s painted in the evaluation remains largely the same till now. In fact, there is the feeling that these FBOs in the euphoria of the remarkable strides achieved in the response in the country have become almost lethargic and have not advanced much in terms of improved capacity.

5.2.5. *Other constraints*

The capacity of FBOs to perform in the response is also limited by the fact that what apparently appears like FBO agencies involved in the response are in reality a case of these agencies taking on the added responsibility of dealing with HIV/AIDS. In other words, HIV/AIDS responses are often embedded in organizations that predated the pandemic with clear mandates beyond HIV/AIDS. These militate against the development of a clear-cut HIV/AIDS-focused capacity even in the long run in these FBOs [5, 7]. Even more perturbing is that often times, one perceives the FBOs in the response in the form of tiny islands cut off from each other and from the big sea. In this sense, there is a dearth of effective networking and coalition across FBOs in the response. This really militates against capacity development as each FBO's effort becomes disparate from the others, and there is hardly meaningful integration, sharing of resources, sharing of lessons learnt, and interdependence even on delimited scope.

6. Conclusion: Strengthening and mainstreaming FBOs response to HIV/AIDS in South Africa

The FBOs are usually very important components of the social life of a large number of South African citizens who are really marginal to the socio-economic spheres of the society. These

citizens see the church as more or less the mainstay of their existence. Thus, FBOs are fulcrums of their economic, political, and health decisions and crucially condition their beliefs about diseases including HIV/AIDS and the desired (scripturally or denominationally) response. Incidentally, the citizens who belong to this category are also those mainly at risk and highly vulnerable to HIV/AIDS. It stands to reason therefore that re-aligning these FBOs to the orthodox response framework and improving their capacities as health mediators would in the medium run greatly improve the HIV/AIDS response in the country as a whole.

It was in recognition of the role of the FBOs that the SANAC encourages regular dialog between the FBOs and Civil Society Forum (CSF) of the SANAC. But such dialog should be deepened and made regular in order to address some of the noted predilection of the FBOs in responding to the pandemic including using holy water in place of ARV [8]. In fact, as cursory observation would show, FBOs in the continent (not only South Africa) have often promoted the use of such commodities as holy water, holy oil, holy sand, and anointed spiritual items in perceived treatment of the pandemic. These items are usually seen as general spiritual agencies of miracle cure.

Before enumerating ways through which the FBOs can be repositioned and strengthened in terms of further contributing to the HIV/AIDS response, there is a need to point out that the beginning of effective mainstreaming and integration of the FBOs into the national response framework should be against the appreciation of the variety of FBOs operating in the country. In other words, there is a need to take cognizance of the peculiarities, denominational/religious bends, and defining characteristics of these groups. Thus, a one-size-fits-all approach would not suffice. Therefore, there is a need for tailored engagements that aim at creatively harnessing the strengths of these FBOs as mass organizations. Strategies to be considered include the following:

1. Facilitating the FBOs to reconcile liturgical stands with the reality of the pandemic. Specifically, in this regard, efforts would include the acceptance of condom and the unavoidable reality of premarital sex and marital infidelity.
2. Improving the awareness creation of the FBOs—while huge success has been achieved on awareness in general in the country as a whole, the FBOs lag behind, and often a good number of them avoid the topic of AIDS altogether and adopt a more or less ostrich approach. Therefore, there is a need to take awareness to the church and the pulpit. But even more critical is to ensure that awareness messages whether captured in main liturgical modes or in the communication outlets of the church need to be informed by a good knowledge of the pandemic and location of South Africa within the global response.
3. Empowering the churches to establish formal organs within the church hierarchy dedicated to the HIV/AIDS pandemic response. Such organs should be manned by members who have good knowledge of the pandemic and have the time to dedicate to the response. Members of such church organs would need to be empowered through capacity training by the agencies of the state in charge of the response to the pandemic.
4. Partnership and networking: The partnership and networking envisaged here should be between the FBOs and state agencies on one hand and a form of triple network involving the FBOs, state agencies, and NGOs/CSOs engaged in intervention programs at various levels of the response.

5. Given the ubiquity of FBOs in South Africa, there is no gainsaying the fact that these organizations have the reach and presence even in the remotest areas of the country where the impact or presence of the state and its agencies are almost invisible. The reach of these FBOs can be critically harnessed especially in creating and sustaining awareness about the pandemic and even in functioning as first responders to those affected by the pandemic. FBOs would be critical in the coverage of rural areas and even densely populated urban townships.

As Keikelame et al. [27] have rightly opined, “South African FBOs need to engage more vocally in advocacy to address the social and contextual factors that increase HIV vulnerability, such as poverty and gender inequality.” In other words, these organizations should use the good will and acceptance they enjoy among the people to engage in actions and dialog that aim at whittling down and eradicating practices and values which engender or perpetuate both poverty and gender inequality especially gender-based violence which has in recent years become a social plague in the society. When women and minorities are treated as second-class citizens or as inferior members of the society, they are easily denied or deprived the opportunity to make informed decisions, oppose sexual predation, and abuse in the communities.

Equally worth noting is that even though most FBOs in South Africa are opposed to both premarital and extra-marital sex by members, the messages given out often vary between churches or sects [37]. In this case, there is a difference since the approach in Zionist and mainline churches seems to be that while promiscuity is bad, abstinence is unrealistic and that premarital sex with only one partner is admissible (which contrasts with the loud and clear directives against premarital sex and the condom among Pentecostal and Catholic churches) [37]. Thus, the messages between FBOs may differ and call for the acute realization of this difference in the process of interfacing and integrating FBOs response as a whole and within the broader state-wide response.

As Mash and Mash [6] have contended, there is a need for the church to take up the challenge of empowering young women and recognize the need to protect their sexually active youth members. This challenge should go beyond the orbits of the church membership to include all spheres of influence of the church in the lives of both members and non-members. The call to evangelize should now embody the call to add value to the national response in an integrated and systematic manner that does not denigrate, devalue, or distort the philosophy and knowledge foundation of the national response.

Author details

Edlyne Eze Anugwom

Address all correspondence to: eanugwom@uwc.ac.za

University of the Western Cape, Cape Town, South Africa

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