Inter-Religious Council of Uganda

Religions for Peace

To what extent are religious leaders effective in creating demand for IRCU HIV/AIDS interventions in Uganda?

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Scriptural Quotes

And the word of the LORD came again to Zechariah: "This is what the LORD Almighty says: 'Administer true justice; show mercy and compassion to one another. Do not oppress the widow or the fatherless, the alien or the po or. In your hearts do not think evil of each other.' (Zechariah 7:8-10)

“Allah, in reality, does not modify the situation of the community, as long as the individuals who form the community do not modify what is wrong in themselves” (Surah 13: 11).

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ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
BAFFE:	Born Again Faith Federation
FBO:	Faith Based Organization
HIV:	Human Immunodeficiency Virus
IGAs:	Income Generating Activities
IPs:	Implementing Partners
IRB:	Institutionalized Religious Bodies
IRCU:	Inter-Religious Council of Uganda
OIs:	Opportunistic Infections
OVC:	Orphans and Vulnerable Children
PACE:	Program for Accessible health, Communication and Education
PHA:	People living with HIV/AIDS
PSS:	Psychosocial Support
ROCOBAO:	Rakai Community Based AIDS Organization
RDSI:	Research, Documentation and Strategic Information
TASO:	The AIDS Support Organization
UNICEF:	United Nations Children's Fund

ACKNOWLEDGEMENT

"Because of the oppression of the weak and the groaning of the needy, I will now arise, says the LORD, I will protect them from those who malign them" (Psalm 12:5)

I am indeed delighted that an operational research has been carried out to determi ne the effectiveness of religious in creating demand for the IRCU HIV/AIDS services. Questions have been persistently asked whether religious indeed accomplish their key roles in the implementation of the HIV/AIDS programme components of Prevention, Care a nd Treatment and Orphans and Vulnerable Children (OVC). These are psychosocial and spiritual support, counseling, resource mobilization, referral of clients to other health facilities, advocacy and initiation of networks and partnerships. From the point of view of IRCU, this was an important study since the role of religious leaders and not least religious structures are pivotal to the delivery of HIV/AIDS services to the God's people. The study was necessitated by the fact that IRCU work and impact were mo re palpable at the macro- and meso- than micro- levels.People have been challenging us different fora to cascade our activities to the local level where the majority of our faith communities live. I am optimistic that the research findings will go a long way to fill gaps that have been identified at the micro level.

In this regard I am grateful to the department of Research, Documentation and Strategic Information (RDSI) that spearheaded the work. In particular, I wish to thank members of RDSI: Manisurah, Aheebwa, programme manager; Kayiso Fulgencio, programme specialist, Evelyn Sseruyange, external researcher; Joan Najinda and Innocent Mwesigwa, IRCU volunteers. Not least, I equally appreciate the work of the IRCU drivers who safely transported to and fro the two research teams to the different study areas. Since research is by nature a collaborative venture, I wish to pay special tribute to all the different categories of people who participated in the study namely; the religious leaders attached to the dif ferent FBOs that were visited; the programme coordinators/managers running IRCU HIV/AIDS services at the FBOs, clients who participated in the study either in Focus Group Discussions or as individual respondents.

May God the Almighty Bless You All.

Joshua Kitakule

Secretary General, Inter-Religious Council of Uganda

FOREWORD

On behalf of the Council of Presidents, I wish to extend my gratitude the IRCU Secretariat for this report. Specifically, I wish to congratulate the IRCU Research and Documentation dep artment for the work well done. Since inception in 2001, IRCU has enjoyed the goodwill and support from all stakeholders; the religious fraternity, government, civic society organizations, development partners and the general public. IRCU has lived to its divine mandate of being a 'voice for the voiceless, poor and marginalized in society' (Matthew 25:34 -40; John 4:20). IRCU has used its established faith network for the mobilization and sensitization of the faith communities, delivery of services and implementation of its programmes. In this context, it need not be overemphasized that religious leaders and institutions are endowed with unparalleled spiritual, social and moral assets for influencing change and social transformation.

Nevertheless, there have been persistent voices questioning the efficacy and efficiency of the IRCU's faith-based model. "Where is IRCU at the grass roots?" "Is it possible to replicate the inter -religious action and dialogue seen at the national level at the grass roots?" "Are re ligious leaders really performing their roles and functions particularly at the lower level where the majority of the faith communities live?" These are some of the challenging questions that people have asked at the different IRCU-organized fora to establish if the organization lives to its mandate. I am sure this was the background that informed the implementation of the study: to answer the 'doubting Thomases'. I am confident that the research findings will go a long way to plug any existing loopholes in order to improve programmatic interventions and service delivery.

The Council of Presidents will carefully study the research conclusions and recommendations with a view to deriving policy options that will catapult the organization to greater heights. I would like to thank USAID for the financial resources without which this research could not have been carried out.

God Bless You All

Metropolitan Jonah Lwanga,

Archbishop, Uganda Orthodox Church and Chairperson, IRCU Council of Presidents

EXECUTIVE SUMMARY

*"To what extent are religious leaders effective in creating demand for IRCU HIV/AIDS interventions in Uganda?" w*as a two-week study carried out by the IRCU Research, Advocacy Strategic Information department between 21 November and 3 December 2011. It covered a total of 253 respondents in eighteen (18) IPs belonging to the Institutionalized Faith Based Organizations (FBOs) namely; the Church of Uganda, the Roman Catholic Church, the Uganda Muslim Supreme Council, the Seventh-day Adventist Uganda Union, the Uganda Orthodox Church, and the Born Again Faith Federation (BAFFE). The targeted respondents were ordained and non-ordained religious leaders, HIV/AIDS clients/patients and beneficiaries of the OVC programme. The study used semi-structured questionnaires and focus group discussions to collect information from the different categories of participants. These methods were triangulated with official documents/reports and publications from the IRCU secretariat and FBOs.

Religious leaders were found to participate actively in the delivery of HIV/AIDS programmes. The majority of them used sermons/khotubas, social functions, radio and personal conversations – during home visits-to communicate HIV/AIDS messages to their congregations. It was noted that , apart from religious leaders, other actors such as health workers, community volunteers, local councilors, friends and relatives played a significant role in the mobilization and sensitization of the communities.

According to the different respondents, religious spoke openly to their congregations about HIV/AIDS, with only a few reluctant to discuss this topic in churches and mosques. Most leaders were active in communities beyond their immediate jurisdiction and were most effective in rural communities. According to the communities, investigators' observations, and the religious leaders themselves, leaders were more effective in mobilization and sensitization, advocacy, counseling and psychosocial and spiritual support and much less effective in resource mobilization and initiation of networks and partnerships. The biggest challenges facing religious leaders were inadequate funding and limited capacity building.

The study recommended regular training of religious leaders in the HIV/AIDS program areas of prevention, care and treatment and orphans and vulnerable children. Further, there is need for more funding to cope up with the large number of people in need of HIV/AIDS services. Building networks and partnerships was considered vital for the rational utilization of resources and increasing sustainability. Through District Inter-Religious Committees, IRCU should roll out its activities to the grass roots to make its presence felt and real on the ground.

1.0 INTRODUCTION

"HIV/AIDS is a crisis of enormous spiritual, social, economic and political proportions. And increasingly, it is a problem of the young. Overcoming HIV/AIDS and the stigma that fuels its spread is one of the most serious challenges of our time. It requires courage, commitment and leadership at all levels especially among religious leaders who can use the trust and authority they have in their communities to change the course of the pandemic"[1].

In many places, religious institutions have been mobilized to make a positive contribution to action against the HIV/AIDS epidemic. The devastating impact of HIV/AIDS in sub-Saharan Africa, where the religious institutions are hugely influential and still growing fast in numbers, calls for a reflection on whether understanding of the word of God has fully tak en account of the social and economic realities of people's daily lives[2]. While scriptural texts do not specifically mention HIV and AIDS, there are number of scriptural principles that help to identify the roles of religious leaders in working with people living with HIV/AIDS[3].There is no doubt, therefore, that religious leaders are bound by their divine call to do something positive to respond to HIV/AIDS that is ravaging the lives of God's people[4]. This divine mandate stems from Jesus' commandment to "Love your neighbor as yourself (Luke 10:27).

Stewardship of religious leaders in the fight against HIV/AIDS is by all means essential. What religious leaders say and do can have an important impact on the faith communities who regularly attend prayer houses; churches, mosques, synagogues etc. Admittedly, the involvement of religious leaders is premised on the following grounds that religious leaders : a) are recognized by the community; b) can give encouragement to members of their religious communities; c) can shape social values; d) promote responsible behavior that respects the dignity of all persons and defends the sanctity of life; e) increase public knowledge and influence opinion; f) support enlightened attitudes, opinions, policies and laws; g) redire ct charitable resources for spiritual

[1] UNICEF (2003). "What religious leaders can do about HIV/AIDS: Action for children and young people"
[2] Lubaale, "Community Action on HIV and AIDS, OAIC, 2008"; IRCU Strategic Plan 2010-2014 pp.13
[3] Tearfund (2005) ibid.
[4] See Olubayo (2010). "The role of religious leaders in curbing the spread of HIV/AIDS in Nigeria" Volume 13, No.3; USAID/Health policy Initiative (2007). "Involvement of religious leaders in the national response to HIV/AIDS: A path-breaking initiative", supported by the President's Emergency Plan for AIDS Relief, Washington DC, USA; UNICEF (2004). "The role of religious leaders in the prevention of HIV/AIDS" http://www.nacp.gov.pk/library/reports/Advocacy%20&%20Communication/Role_of_Religious_Leaders%20(%20English%20).pdf

and social care and raise new funds for prevention, care and support; h) promote action from the grass roots to the national level; i) often have links to other (religious) organizations, people in positions of responsibility in the community, and links to networ ks at the international level; j) are responsible for preaching sermons/khotubas on prayer days (Friday, Saturday and Sunday) and hence have a significant role in teaching about and communicating issues re lated to HIV/AIDS[5].In sum, the roles of religious leaders in HIV/AIDS prevention , care and treatment and management of OVC include mobilization, sensitization, spiritual guidance, education and preaching faithfulness[6].

1.1 Background to the study

The Inter-Religious Council of Uganda (IRCU) is an initiative that brings together different religious organizations to work together along areas of common concern. Currently, the membership of IRCU includes the Institutionalized Religious Bodies (IRBs), namely; the Ca tholic Church in Uganda, the Uganda Muslim Supreme Council, the Church of Uganda, the Uganda Orthodox Church and the Seventh Day Adventist Uganda Union. However, in implementation of its programmes, IRCU works with other faith communities and networks outs ide the five members, namely; the Baha'i, the Born Again Faith Federation (BAFFE), Pentecostals and other faith-based groups.

Over the last decade, the IRCU has used a faith -based approach (FBA) to implement various HIV/AIDS programmes in the country throu gh Institutionalized Religious Bodies (IRBs)of the member organizations and Faith -based Organizations (FBOs) that are affiliated to the IRBs and other independent churches. The FBA is a five-pronged model that entails i) belief in God, ii) use of scientific knowledge;iii) faith teachings based on scriptural texts, iv)religious leaders and faith administrative structures and v) application of self -control skills. Across the country, IRCU has remained an implementer of grassroots project activities, touching the lives of thousands of affected by the HIV/AIDS pandemic. To accomplish this task, IRCU has relied on her well - established faith network for mobilization of communities. The number of FBOs supported by

[5] Tearfund (2005). Ibid; UNDP (2006). "The role of religious leaders in the fight against HIV/AIDS" pp.13; UNICEF (2003). "What religious leaders can do about HIV/AIDS"pp.9; O. Oludoro (2010). "The role of religious leaders in curbing the spread of HIV/AIDS in Nigeria" pp.3 -4; UNICEF (2004). "The role of religious leaders in the prevention of HIV/AIDS" pp.10-12

[6] Tearfund (2005) ibid.

IRCU has grown from 10 to 101 currently, with 11, 097 children supported as OVCs, 39, 464 receiving palliative care and 10,933 on ART[7].

In the next five years, IRCU intends to consolidate and scale-up these activities with focus on more engagement of the established network structures of FBOs through their MotherBodies. IRCU will engage all FBO structures from grassroots to national level to implement HIV prevention. The grassroots FBO structures such as churches, mosques, deaneries and districts will directly implement program activities. On the other hand, FBO secretariats (IRB) will facilitate the planning and coordination of HIV interventions at those levels. The current HIV prevention FBOs affiliated to IRB and those run by independent churches will be further supported to increase their capacity to do HIV prevention work more effectively[8].

1.2 Statement of the Problem

In spite of the IRCU's outstanding performance in contributing to the national HIV/AIDS response, there is hardly any empirical evidence to attest that programme outputs and outcomes are wholly attributable to the mobilization efforts of religious leaders, and to the pervasive structures of the religious institutions. For instance, few IRCU-supported sites have resident religious leaders (chaplains); thus, patients/clients seem to be coming to access services on their own. Furthermore, there is hardly any sufficient evidence to suggest that clients who access IRCU HIV/AIDS services come after having been mobilized by the religious leaders in the communities. Moreover, there are reported cases of loss of patients to follow-up in some supported sites, which could partly be attributed to laxity in mobilization. Besides, it is doubtful that HIV/AIDS messages and a mobilization plan are adequately integrated in the pastoral work.

The thrust of this operational research, therefore, is to assess and determine the role of religious leaders in mobilizing their communities to access HIV/AIDS interventions such as prevention, care and treatment and care for orphans and vulnerable children (OVC).

1.3 Rationale

Currently, the IRCU faith-based HIV/AIDS response is part of the national response. Through FBOs, IRCU provides a range of services: Prevention focussing mainly on promotion of Abstinence and Being faithful; provision of Anti-retroviral treatment, clinical care including

[7] IRCU (2011): "10 Years of dedicated interfaith service delivery" pp.35
[8] IRCU Strategic Plan 2010-2014 pp.21

management of OIs, laboratory strengthening, home-based care, and psychosocial support. Despite the nationwide network of FBO structures and an array of responses, there still exist bottlenecks that compromise the FBO response to the epidemic. These constraints need to be identified, analyzed and redressed if the FBO HIV/AIDS response is to achieve its intended purpose.

This operational research is, therefore, an attempt to interrogate the efficacy, efficiency and effectiveness of the use of religious leaders in a faith-based model to respond to the HIV/AIDS pandemic in the country. The study findings will enable IRCU address the gaps in the delivery of HIV/AIDS program interventions through its religious leadersstructures, and document best practices for replication.

1.4 Scope

The operational research covered the following IRCU-supported FBOs. Under Care and Treatment, the study included: Mengo Hospital, Namungoona Hospital, Kumi Hospital, Iganga Islamic HCIII, St. Francis Buluba Hospital, Lyantonde Muslim HCIII, Ishaka Adventist Hospital and SaidinaAbubaker hospital. For Prevention, the following were visited; SDA Mityana Station, Kapchorwa Evangelical Body of Christ, Bugisu Muslim District, Victory Outreach Churches, Fort Portal Diocese, AMUCA SDA and SDA West Uganda Field. Additionally, the following OVC sites were covered; Kiyinda-Mityana Diocese, Kumi Diocese and Lango Diocese. The study targeted heads of IRBs, bishops/deans/field presidents/district khadis, priests, lay leaders, imams/sheikhs, HIV/AIDS clients, OVC caregivers[9], beneficiaries of OVC[10] and FBO programmecoordinators/managers.

1.5 Objectives

The objectives of the research were;

- To establish a causal link between the uptake of HIV/AIDS services and the mobilization efforts of religious leaders.
- To assess the views of IRCU HIV/AIDS program beneficiaries towards the work of religious leaders and FBOs.

[9] Beneficiaries of socio-economic strengthening interventions
[10] Vocational and apprenticeship training, formal education, psychosocial support, home-care.

- To find out the level of collaboration between IRCU and the FBOs and local religious leaders

1.6 Expected Outputs

- Religious leaders mobilization efforts established
- Faith-based Approach strengthened

1.7 Definition of a religious leader

The terminology 'religious leader' was used in its broad sense to include the ordained and non-ordained (lay) religious leaders. In the context of the IRCU, these include, among others, heads of mothers' and fathers' unions, youth leaders/directors, catechists, women ministries directors, Adventist men, Uganda Orthodox Mothers' Unions, and National Youth Orthodox Associations (NOYA).

2.0 METHODOLOGY

2.1 Sampling frame

A sampling frame was prepared consisting of all 18 FBOs implementing HIV/AIDS programmes of ART and Care and Treatment, OVC and Prevention in all the regions of the country. Selection was based on the following criteria: regional distribution, religious denomination and distance.

Using purposive sampling the following categories of respondents were selected for interviewing; religious leaders (clergy and laity), health workers, counselors, HIV/AIDS coordinators, HIV/AIDS clients, care givers, and OVC.

2.2 Data collection methods

The study used semi-structured questionnaires to collect data from purposively selected categories namely, religious leaders (clergy and non-clergy) and health workers. FGDs were held with OVC and clients (PHA) receiving HIV/AIDS ART Care and Treatment services. For triangulation of information, a document review was carried out featuring reports on the role of religious leaders in combating HIV/AIDS from other parts of the world.

Picture 1: A focus group discussion with Muslim leaders in Iganga

3.0 PRESENTATION OF FINDINGS

"The Churches [and mosques] have strengths, they have credibility, and they are grounded in communities. This offers them the opportunity to make a real difference in combating HIV/AIDS. To respond to this challenge, the Churches [and mosques] must be transformed in the face of the HIV/AIDS crisis, in order that they may become a force for transformation -bringing healing, hope, and accompaniment to all affected by HIV/AIDS"(UNICEF, 2003 parentheses added*)*

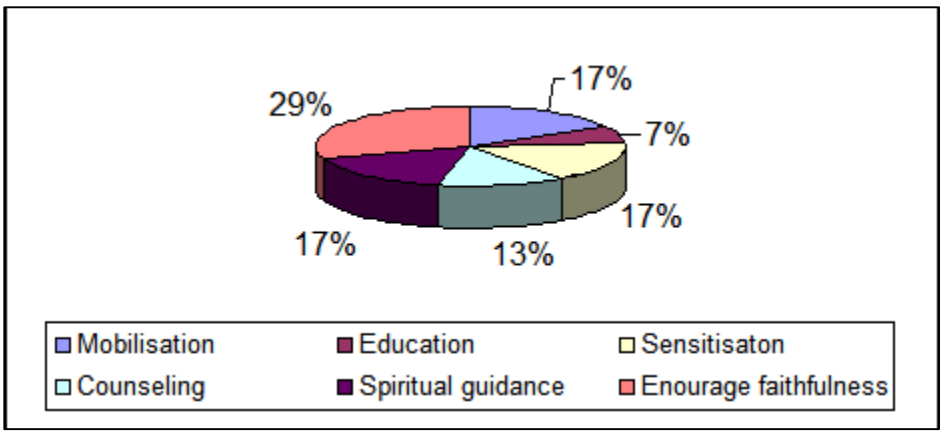
3.1 RELIGIOUS LEADERS - PREVENTION

3.1.1 Role and functions

Thirty religious leaders were interviewed on their role in the HIV/AIDS interventions. Of these about 77% were male and 23% female. The youngest leader was 24 years and oldest 62 years.

Chart 1 below presents the responses of the religious leaders when they were asked to spell out their roles and functions. Preaching faithfulness (to married and unmarried couples) ranked the highest with 29%, followed by mobilization, spiritual guidance andsensitization each at 17%, counseling 13% and education7%.

Chart 1: Role of a religious leader in HIV/AIDS Prevention



The findings above tallied with the StrategicPlan[11] and IRCU Annual reports[12] which observed that IRCU used its structures to mobilize leaders and communities to participate in HIV prevention and AIDS treatment.

3.1.2 Frequency of interacting with faith community

Further, the study endeavoured to establish the frequency of the interaction between religious leaders and the communities. About 59% of religious leaders indicated that they met their communities between once and three times a week. Whereas about 41% indicated that they met their communities four or even more times a week. Ordinarily, religious leaders indicated that they met their communities in prayer houses (churches or mosque) (47%), at their homes (3%) and in church/mosque or other places (50%). That the majority (50%) indicated meeting their communities in prayer houses and other social events implied that they preached beyond the confines of the conventional prayer houses to include unpractising groups of followers.

3.1.3 Channels of communication

According to the religious leaders (n=30), they communicated to their communities through sermons (67%), radio (43%) and notice boards (38%) in that order. Their key behavioural interventions aimed to intensify messages mainly on abstinence among youths and fidelity among

[11] IRCU Strategic Plan, 2010-2014, pp.19
[12] IRCU Annual Reports 2009, 2010

married and unmarried couples[13].That sermons (khotuba) and radio were the most frequently used channels of communication confirmed the religious leaders' pastoral commitment and strategic importance of radio stations to disseminate HIV-related messages to the wider community. HIV prevention interventions remain critical in Uganda's HIV and AIDS response.

3.1.4 Resource mobilization

Religious leaders admitted that they mobilized resources to supplement IRCU funding. Mostly funds were mobilized from places of worship (52 %), some individual contributions (22%) and through training clients to set up money generating activities (15%) . Apparently, FBOs have not adequately embraced the strategy of mobilizing resources through proposal writing. This attestation wasevident in the Performance Review meetingswhere, it was noted, most FBOs survived largely on IRCU funding which posed a challenge to their sustainability[14].

3.1.5 Nature of HIV/AIDS preventive messages

According to Table 1, themost reported messages by religious leaders on HIV/AIDS were faithfulness between partners (56%), abstention (34%), use of condoms (10%). Previous studies indicated that much of HIV transmission in the world occurred as a result of sexual intercourse outside God's plan. Therefore, religious leaders have a role in teaching God 's plan for sex. Preaching faithfulness and abstention between them took the lion's share(90%) which confirmedIRCU's steadfast position of promoting the AB approach vis-à-vis condom use (10%).

Table 1: AB/C Approach to HIV prevention.

No.	Message	Frequency[15]	%
1	Abstain	17	34
2	Faithfulness to one partner	28	56
3	Use of condom	5	10
	Total	50	100

3.1.6 Challenges encountered in working with IRCU

Out of 39 non-ordained religious leaders interviewed , 51% reported that the biggest challenge was inadequate funding. This challenge was echoed in the IRCU Survey on Client Satisfaction Report (2009) and the regularHIV/AIDS programmeperformance review workshops[16]. The study noted

[13] Annual Report, 2010 pp.11
[14]HIV Prevention Performance Review meeting held at Arch Apartments (27 -28 February 2012)
[15] Respondents were free to choose more than one item on the questionnaire
[16] The most recent performance review workshops were held between 6 -28 February, 2012.

that IRCU programs generated huge expectations from the public and faith communities that could not be met due to limited funding[17].

3.1.7 Suggestions for further improvements

According to most respondents, training and capacity building (36%) and funding (about 21%) were the most notable interventions needed to improve their participation in the provision of HIV/AIDS services (see Table 2). This information was in conformity to the key mandates of IRCU which are, among others, capacity building and resource mobilization [18]. Equally, the findings in the IRCU Survey on Client Satisfaction Report pointed out the same gaps; inadequate capacity and limited financial resources on the part of religious leaders at the lower levels.

Table 2: Suggestions for further improvement

No.	Category	Frequency	%
1	Training & capacity building	17	36.2
2	Facilitation/funding	12	20.8
3	More involvement in IRCU program	6	10.3
4	Frequent meetings with leaders	5	8.6
5	More literature on HIV/AIDS	5	8.6
6	Inter-faiths visits	5	8.6
7	Continuous monitoring	3	5.2
8	More manpower	1	1.7
	Total	**54**	**100**

3.2 OVC – CHILDREN IN EDUCATION INSTITUTIONS

Like all children, orphans and other vulnerable children have the right to learn and develop in the structured and supportive school environment [19]. According to the study, the sex distribution of OVC children (n=45) in educational institutions was 62% females and 38% males and their ages ranged between 9 years and 26 years. However, the largest numberof children (22%) were aged 13 years. The duration of living as OVC ranged between 1 year and 15 years. The majority (24%), had lived for two years as OVCs followed by one year (13%), and 4 years (11%).

3.2.1 Role of religious leaders in OVC programme work

Religious leaders played a pivotal role in mobilizing the OVC (44%), followed by the local councilors (31%). The majority of OVCs (36%) reported that they were assisted by religious leaders to make choices on which courses to take. These were followed by the local councilors and

[17] Annual Report, 2010
[18] See Consultancy Report, 2009; IRCU (2011). 10 years…op cit; Annual Report, 2010
[19] UNICEF (2003). "What religious leaders can do about HIV/AIDS".

relatives at 23% respectively. When asked how they learnt of the OVC program 29% mentioned friends, followed by religious leaders at 20%. This proved that IRCU was a framework for religious leaders to work closely with lay religious leaders, local leaders, school/institution administrators and community development officers to mobilize, identify, support and monitor the OVC services[20].

3.2.2 Channels of communication

According to the OVC respondents (n=45) interviewed, religious sermons (58%), social events (36%) and radio (20%) were the most used channels of communication by religious leaders to pass messages relating to the OVC program (see Table 3 below).In IRCU HIV/AIDS program work, religious leaders are encouraged to use their places of worship since they are free of charge and people's attendance is guaranteed at least once a week [21]. 46% of the OVC respondents rated the effectiveness of the preferred channels of communication as 'high', 21% as 'very high' and 'moderate' respectively, 7%as 'low' and 4% said it was 'very low'. Largely, the popularity and effectiveness of the above communication channels were informed by their cost-effectiveness since religious functions are ex-gratia activities.

Table 3: Channels of communication

No.	Channel	Frequency	%
4	Sermons/khotubas	26	57.7
5	Social events (burials, parties	16	35.6
2	Radio	9	20
8	Sign posts	6	13.3
6	Notice boards	5	11.1
3	Newspaper/ magazine	4	8.9
1	Television	3	6.7
7	Leaflets	3	6.7
9	letters	3	6.7
10	Fax	0	0
11	Email	0	0

3.2.3 Assistance from religious leaders

67% of the OVCs indicated that religious leaders assisted them to get enrolled on the OVC programmes. 52% of them indicated that the religious leaders assisted them to get registered,

[20] Annual Report, 2009
[21] Oludoro, O. (2010). Op.cit; UNDP (2006) op.cit

offered themuniforms, books and other materials. Moreover, 77% of the same respondents reported that religious leaders made follow-up visits to the OVC. The level of satisfaction with religious leaders' assistance is captured in the IRCU Survey on Client Satisfaction Report (2009).

3.2.4 Interaction with the religious leaders

When asked where they interacted with religious leaders, 47% of the OVCs reported that they interacted with them when the former visited them at homes (47%), at schools (36%) and other places (18%).As per their divine calling, religious leaders offeredspiritual counseling and guidance to OVC and their care givers. This was done during school and pastoral visits and other religious days/functions[22].

3.2.5 Frequency of interactions with the religious leaders

38% of OVCs reported that they 'often' met with religious leaders. 31% described the encounter as 'fairly often' and 19% described the encounter as 'very often'. It is significant to note that the frequency of the interaction was corroborated by the responses of religious leaders on the same question.

3.2.6 Assessing performance of religious leaders in psychosocial support and health care

The provision of psychosocial support was aimed at restoring the mental wellbeing of OVC who faced psychosocial challenging situations like loss of parents, domestic violence, sickness and others.[23] Such children were often desperately in need of compassion and support from those around them[24]. 71% of the respondents termed as 'good' the performance of religious leaders in offering health care and psychosocial support. This observation gives a true picture of the core role of a religious: provision of psychosocial support and spiritual guidance.

3.2.7 Assessing performance of religious leaders advocacy and resource mobilization

IRCU carries out training aimed at equipping religious leaders with knowledge and skills in developing and carrying out advocacy and coordination strategies[25]. When OVC were asked to comment on religious leaders' capacity for advocacy, 53% classified it as 'good', 23% as fair, 17% as poor and 7% as very poor. The above percentages indicated that religious leaders' knowledge of and capacity for effective advocacy work was slightly above average. On the question of resource

[22]IRCU Annual Report, 2010 pp.21
[23]IRCU Annual Report, 2010 pp.21
[24] UNICEF (2003),op cit.
[25]IRCU (2011): 10 years....op.cit.

mobilization, 3% ranked it as 'very good', 27% as 'good' and 'fair' respectively; 18% termed it 'poor' and 24% were not sure.Although resource mobilization was a key mandate of the IRCU, the performance of religious leaders on this account fell far below average . This problem continually surfaced at virtually all the past and recent performance review meetings for all the HIV/AIDS programmes. Although 52% of the religious leaders reported that they mobilized resources from their places of worship, it is most probale that this amounted to little money given the prevailing poverty levels in the rural areas.

3.2.8 Initiation of networks and partnerships

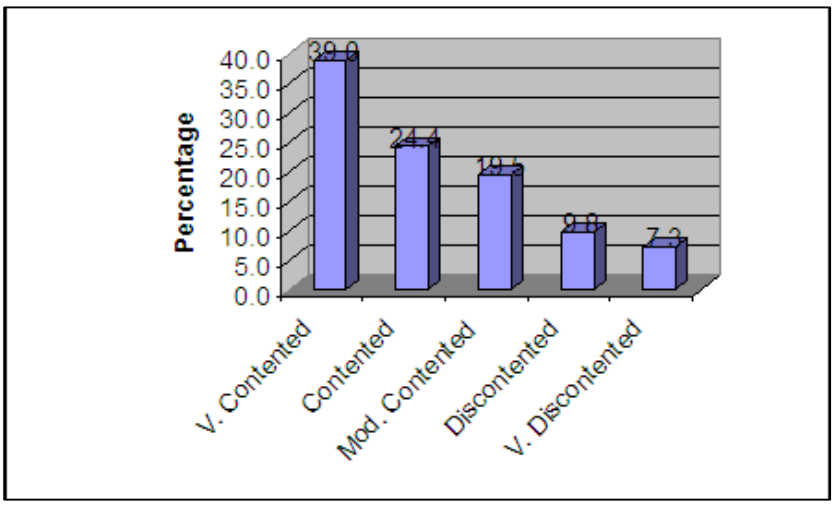
Over the years, IRCU has built a strong foundation through its partnerships with both international and local organs. Religious leaders `are urged to work in partnership with national governments and non-governmental organizations in HIV prevention and alleviation of the suffering of AIDS[26].Most of the OVC respondents (71%) termed as 'good' the role of religious leaders in initiating networks and partnerships in the fight against HIV/AID S. However, previous studies seemed to contradict this observation; for instance, the Client Satisfaction Survey and the Mid-term Review indicated low levels of coordination and partnership building at the regional and district levels[27]

3.2.9 Attitude of OVC towards the performance of religious leaders

From Chart 2 below, 39% of the OVC indicated that they were 'very contented' with the performance of the religious leaders, 24 percent were 'contented' and 20 percent were 'moderately contented'. On the whole religious leaders were held in high esteem by the OVC, since they invariably endeavoured to play their roles against all odds.

[26]UNICEF, 2003 op cit; IRCU (201). "10 years…", op.cit
[27] IRCU: "Operational Guidelines for District Inter -Faith Committees, October 2011 pp.6

Chart 2: Level of satisfaction with performance of religious leaders



3.2.10 Knowledge about the IRCU

The majority of OVC (60%) indicated that they had ever heard about the IRCU, whereas 40% indicated they had never heard about it. Of those who had heard about IRCU, 26 % knew about it from the religious leaders, 22% from community-based monitors, 22% from head of schools/institutions, 13% from local councilors, 4% from coordinators HIV/AIDS programs, 4% from care takers. 9% of the respondents did not answer the question. Generally, the performance of religious leaders' role in scaling up the image of IRCU is appreciably above average. Nevertheless, there is still room for religious leaders to redouble their efforts in increasing the visibility of IRCU at the grass roots being the largest constituency of the faith communities.

3.2.11 Challenges faced in pursuit of HIV/AIDS OVC programme

Whilst 38% of the OVC did not report any challenges, 63% of them mentioned the various challenges they faced. 23% reported balancing studies with family affairs to be the main challenge, followed by financial problems (13%), inefficient facilitation (8%), inadequate scholastic materials (6%) and others (see Table 3 below). That the majority reported challenges despite the assistance provided by religious leaders,vindicated the need to scale up mobilization of additional resources and initiation of networks in order to build synergies to achieve better service delivery . Moreover, this underscores the issue of sustainability of the faith-based work once external sources roll back.

Table 4: Challenges facing the HIV/AIDS OVC programmes (n=45)

No.	Challenge	Frequency	%
1	None	18	37.5
2	Balancing studies with family	11	22.9
3	Financial problems	6	12.5
4	Inefficient facilitation	4	8.3
5	Inadequate scholastic materials	3	6.3
6	Psychosocial torture from relatives	2	4.2
7	Jealousy due to assistance	1	2.1
8	Shortage of food	2	4.2
9	Allocation of materials to other people	1	2.1

3.3 OVC – CARE GIVERS

The biggest number of care givers were female (85%, n=25), aged between 30 and the 74 years. The duration of service of a care giver ranged between 3 and 15 years, with those who had served 3 years being the majority (23%), followed by the four, five, and 15 years of service at 15%, respectively.

3.3.1 Knowledge about IRCU HIV/AIDS OVC program

Table 5 below indicates that the majority of care givers (38%), learnt about the IRCU programs through religious leaders. In addition, radios (15%) and schools (15%) were also useful sources of information. Further, 92% of care givers observed that they received assistance from religious leaders to enroll children on the IRCU HIV/AIDS OVC program.The prominent position played by religious leaders in the recruitment of care givers on the OVC programwas corroborated in the responses by the religious leaders themselves and the OVC attending both formal and informal education.

Table 5: Sources of information for OVC programs

No.	Sources of information	Frequency	%
1	Religious leaders	11	44
2	Friends	7	28
3	Community meetings	5	20
4	Radio	5	20
5	School	4	16
6	IRCU	3	12
7	Seminars	2	8

3.3.2 Channels of communication

Care givers were asked the most popular channels used to communicate HIV/AIDS information by religious leaders and other stakeholders. Religious sermons were ranked highest (85%), followed by radio and social events both 62%(see Table 6). They were then asked to comment on the effectiveness of the different channels of communication. The majority of care givers (46%), ranked the effectiveness of the preferred channels as 'high' and 23% of them indicated that the effectiveness was 'very high'.

Table 6: Indicating channels of communication (N=13)

No.	Channel	Frequency	%
1	Religious sermons	11	84.6
2	Radio	8	61.5
3	Social events	8	61.5
4	Television	4	30.8
5	Leaflets	4	30.8
6	News papers	4	30.8
7	Letters	4	30.8
8	Notice board	3	23.1
9	Sign posts	3	23.1
10	e-mail	0	0
11	Fax	0	0

3.3.3 Mobilization and sensitization of care givers

86% of the care givers mentioned religious leaders as the most active participants in mobilizing and sensitizing them.69% of the respondents indicated that religious leaders visited them in their homes. The majority of them (60%) described the frequency of the visits by the religious leaders as 'moderately high'. This was supported by other interviewed categories such as religious leaders themselves and the OVC- children assisted to pursue formal and informal education. Table 7 below attempts to assess the care givers' interpretation of the religious leaders' sensitization messages/actions.The first eight messages fall within the religious leaders' psychosocial and spiritual roles which seem to be performed fairly well as previously reported. For message number nine, the majority of respondents (46%) observed that they were not listened to by the religious leaders. This is most likely given that religious leaders' messages (in sermons) are unidirectional. Ten to thirteen are negative messages which only a minority of respondents attributed to religious leaders.

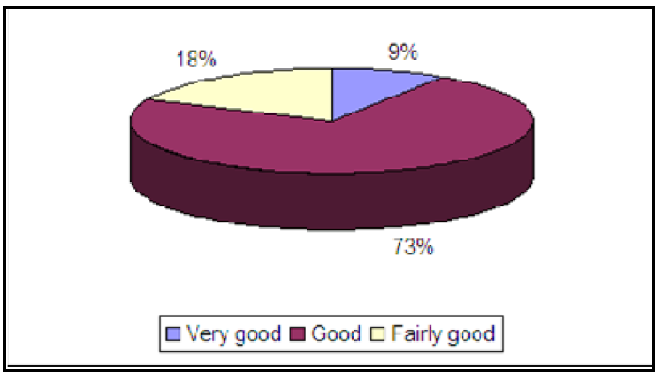
Table 7: Messages/actions of religious leaders

No.	Messages/actions	Yes %	No %	Not sure %
1	Gives me words of advice and encouragement	80	20	0
2	Encourages me to join OVC income-generating activities	77	0	23
3	Encourages me to use preventive methods against HIV/AIDS	77	0	23
4	Carries out bible/Quran study	62	15	23
5	Encourages me to help the OVC	62	15	23
6	Encourages me to help the OVC	62	15	23
7	States that helping OVC is one way of fighting HIV/AIDS	62	15	23
8	Encourages me to live positively	62	15	23
9	Talks to me but does not listen to me	46	31	23
10	Blames all those affected by and infected with HIV/AIDS	31	46	23
11	Discriminates me	31	46	23
12	Threatens me with God's punishment	12	69	19
13	Insults me	10	90	0
14	Donates food stuff and/or money	8	69	23

3.3.4 Rating performance of leaders in mobilizing IGA for care givers

Chart 4 below gives the rating of the performance of the religious leaders in the mobilization of IGA for care givers with 73% of respondents indicating that the performance was 'good' compared to 9 % who rated it as 'very good' and 18% who categorized it as 'fairly good'. In the area psychosocial support (PSS), 8 % of the care givers described religious leaders' performance as 'very good', 69% as 'good', 15% as 'fair', and 8% as 'poor'. On this religious leaders fared well since PSS was their niche activity. For their role in mobilizing people for income generating activities (IGA) activities, religious leaders were rated as 'good' (54%), 'fair' (15%)and 'poor' (15%) respectively. The good performance of religious leaders in the area of PSS was least surprising sine it was their niche activity.

Chart 3: Rating performance of religious leaders in IGA programs



3.3.5 Rating general performance of religious leaders by care givers

Care givers were asked to rate the performance of religious leaders in their different roles and functions (see Table 8).58% described as 'good' the performance of religious leaders in offering psychosocial support, mobilization of people for HIV/AIDS services and resource mobilization. 92% and 75% of them described as 'good' advocacy and initiation of networks and partnerships. In all their work, religious leaders' performance was rated as 'good'. It is important to note that in psychosocial support, mobilization for HIV/AIDS services and resource mobilization the average score is 54% which is slightly above average performance. It is intriguing , though, to note that advocacy (92%) and initiation of networks and partnerships (75%) have such high scores. This contradiction is hard to explain given that religious leaders have limited skills to address advocacy campaigns and initiate networks and partnerships.

Table 8: Rating performance of religious leaders in their different roles

No.	Roles	V. Good	Good	Fair	Poor	Not sure
1	Psychosocial support	0%	53.8%	15.4%	15.4%	15.4%
2	Mobilization for HIV/AIDS services	7.7%	53.8%	15.4%	15.4%	7.7
3	Advocacy	7.7%	92.3%	0%	0%	0%
4	Resource mobilization	7.7%	53.8%	15.4%	30.8%	7.7
5	Initiation of networks & partnerships	0%	75.1%	8.3	8.3	8.3%

3.3.6 Knowledge of the IRCU

77% of the care givers had heard of IRCU as opposed to 23% w ho had not heard about it. W hen asked about what they had benefited from the IRCU, 30% me ntioned medical care, 30% scholastic materials, 20% education for children, 10% unity among care givers and 10% food stuffs. That 77%

of the care givers had heard about the IRCU is an achievement largely attributable to the faith infrastructure that stretches all from the national to the local levels.

3.3.7 Challenges

The care givers (n=25) gave their challenges as financial constraints (4 4%), accommodation (16%), drug delays (16%), inadequate beddings and treatment (8%), delays in release of funds (8%). The remaining 8% did not report any challenges. Basing on interviews of other categories of respondents, it was evident that financial constraints were the biggest challenge facing IRCU HIV/AIDS programs. This was caused by the overwhelming expectations arising from the increasing number of people (infected and affected) enrolling on the HIV/AIDS programs. As a consequence, this constrains the capability of the religious leaders to cope with such rising demand for the HIV/AIDS OVC services.

3.4 CARE AND TREATMENT

3.4.1 Role of religious leaders

All the religious leaders confirmed that clients were aware of the care and treatment services at IRCU-supported FBOs. The religious leaders' role in the IRCU HIV/AIDS Care and Treatment Programme included mobilization and sensitization, resource mobilization, psychosocial and spiritual support, advocating for improved HIV/AIDS services and initiation of networks and partnerships.

Table 9 below indicates the channels of communication that religious leaders use to mobilize and sensitize their faith communities. It is evident from the table that that most commonly used channels of communication religious leaders used for sensitization and mobilization for HIV/AIDS care and treatment services were: sermons/khotubas (100%), social events (100%), and personal conversations (100%).

Table9: Indicating channels of communication [28] (N=8)

No.	Channel	Frequency	%
1	Religious sermons	8	100
2	Social events	8	100
3	Personal conversations	8	100
4	Telephone	4	50
5	Leaflets	3	37.5
6	Sign posts	3	37.5
7	Notice board	3	37.5
8	Radio	3	37.5
9	News papers	2	25
10	Letters	1	12.5
11	e-mail	1	12.5
12	Fax	1	12.5
13	Television	1	12.5

These channels conformed to the IRCU requirements of a religious leader i.e. using prayer houses to convey HIV/AIDS related messages. On the question of effectiveness of preferred channels, 12.5% said they were 'very effective' and 87.5% called them 'effective'. The effectiveness of these preferred channels is largely attributed to the fact that they have least cost implications.

3.4.2 Psychosocial and spiritual support

Further, religious leaders administered psychosocial and spiritual support. They carried out pastoral visits as a means of reaching the people affected and infected by the HIV/AIDS pandemic. On the question of frequency of their pastoral visits, 13% of the religious leaders qualified them as 'very frequent' and 88% referred to them as 'frequent'. Box 1 below lists down the issues/topics that religious leaders discussed with their faith communities living with HIV/AIDS.

[28]Each respondent was free to select more than one channel depending what s/he found convenient and cost-effective.

Box 1: Issues/Topics discussed

- Keeping a clean (home) environment
- Correct use of ARVs
- Drinking safe water
- Good nutrition
- Leading spiritual and holistic lives
- Fidelity/faithfulness between couples
- Socio-economic empowerment
- Blood tests
- Abstinence from sex
- Discordance

Religious leaders remarked that the choice and depth of the topics depended on other factors such as; age, HIV status, socio-economic status, education level and religiosity of the spouses. Such visits are important because they demonstrate the caring and compassionate spirit of the religious leaders. Besides, religious leaders admitted that they referred HIV/AIDS clients to other health facilities in the event where their FBOs were short of drugs or lacked specialized services. Certainly, making referrals was a core responsibility of the religious leaders.

3.4.3 Attendance of meetings at the FBOs

All the religious leaders considered it very important to attend meetings at their FBOs. 40% noted that they learnt a lot about health issues through such meetings; 30% stated that such fora enabled them to share and acquire new ideas and approaches required in delivering the HIV/AIDS response. The remaining 30% noted that meetings were good to improve service delivery.75% of the religious leaders described theirworking relationship with FBO staffas 'very cordial' and 25% called it 'cordial'. Then they termed their relationship with clients as 'very cordial' (50%) and 'cordial' (50%) respectively. This confirmed the divine mandate of a religious as per the Holy Scriptures (Matthew 25:34-40; 1 john 4:20; Surah Al-Baqarah:17)

3.4.4 Resource mobilization, networking and advocacy

Religious leaders are expected to participate in the mobilization of resources for their FBOs. On this issue, 12.5% described their role as 'very successful', 37.5% as 'successful' 25% as moderately successful and 25% as 'unsuccessful'. This indicates that religious leaders' capacity in mobilizing resources is still wanting. That aside, they have not fa red well in their efforts to initiate networks and build partnership to enhance resource mobilization, joint planning and implementation of

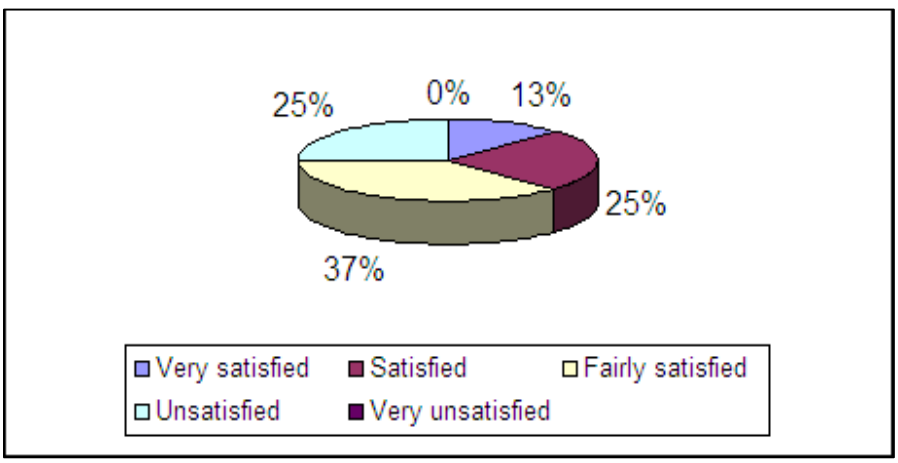
activities.On the question of advocacy, religious leaders outlined the following as the advocacy issues;

- Abstinence
- Faithfulness
- Counseling and testing
- Treatment for opportunistic infections
- Condom use
- Additional resources and support.

3.4.5 Individual assessment

When asked to comment on their individual contribution to the HIV/AIDS ca re and treatment programme, 13% of the religious leaders said they were 'very satisfied', 25% were ' satisfied', 37.5% were 'fairly satisfied' and 25% were 'unsatisfied' (See Chart 4 below). Even with self-assessment, it is evident that the performance rating of religious leaders is not sign ificantly different from the observations made by other respondents.

Chart 4: Judging individual contribution to HIV/AIDS care and treatment program



3.4.6 Challenges

Religious leaders were asked the challenges they faced i n their contribution to the HIV/AIDS care and treatment services. Table 10 below indicates the responses of the respondents.

Table 10: Challenges of the HIV/AIDS care and treatment program (n=8)

No.	Challenges	Frequency	%
3	Limited funding	5	62.5
4	Poverty of clients	2	25
5	Increase of HIV in married couples	2	25
6	Lack of office space for religious leaders	2	25

Interestingly, the majority of the religious leaders (63%) mentioned limited funding as the major obstacle that impacted their performance in the HIV/AIDS care and treatment programme. They argued that they worked in an environment characterized by poor people, who looked to them for (financial) assistance in form of contributions to, say, transport sick persons to referral health facilities or contributing fuel to a local ambulance. Further, they found increased HIV prevalence rates among married couples a challenge because for they had been preaching the gospel of faithfulness for a long time. "Are our efforts rewarded by increased HIV among the marrieds? Is our gospel falling on deaf ears?" asked one Anglican priest. On the question of lack of space, religious leaders noted that they needed more space to handle increasing numbers of people in need of counseling sessions.

Having highlighted the above challenges, religious leaders were asked to make suggestions to improve HIV/AIDS service delivery within their FBOs. Table 11 below indicates their suggestions which are more or less direct remedies to the challenges mentioned in Table 10.

Table 11: Suggestions to improve HIV/AIDS service delivery

No.	**Challenges**	**Frequency**	**%**
1	Facilitation for transport	3	37.5
4	Increase funding	5	62.5
6	Provide more space	2	25

4.0 PROGRAMME COORDINATORS/MANAGERS

4.1 Role of religious leaders in the HIV/AIDS care and treatment programmme.

Twelve programme coordinators/managers were interviewed in order to seek their opinions on the work of religious leaders who, according to the IRCU constitution are supposed to oversee the operations of their respective FBOs. Box 3 below outlines the roles of religious leaders in HIV/AIDS care and treatment.

Box 2: Role of religious leaders

- Psychological and spiritual healing
- Advice to clients to start treatment
- Counseling
- Advocacy for HIV/AIDS services

92% of respondents reported a good working relationship with the religious leaders in mobilizing people to access the HIV/AIDS care and treatment services at the F BOs. 50% of them found religious leaders 'very cooperative', 33% as 'cooperative' and 17% as 'moderately cooperative' respectively.

4.2 Assessing performance of religious in mobilizing HIV/AIDS care and treatment services

Program coordinators/managers gave their assessments on the performance of religious leaders in mobilizing people to access HIV/AIDS care and treatment services. 25% termed it as 'very high', 50% as 'high', 17% as 'moderately high' and 8% as 'low'. Table 13below indicates the assessments made by program coordinators/managers over the specific roles of the religious leaders in the delivery of HIV/AIDS care and treatment services.

Table 12: Rating performance of religious leaders (n=12)

No.	Role	Good	Fair	Not sure	Poor
1	Psychosocial support	91.7%	8.3%	0%	0%
2	Mobilization of clients	66.7%	33.3%	0%	0%
3	Advocacy	16.7%	66.7%	0%	0%)
4	Resource mobilization	33.3%	50%	8.3%	8.3%
5	Initiation of networks and partnerships	25%	41.7%	25%	8.3%

It is interesting to note that there is a discrepancy between the relatively higher level of 'cooperation' in 4.1 above and the lower performance rate in 4.2. While in 4.1 50% of the respondents described religious leaders as 'very cooperative' only half them (25%) later described their performance as 'very high'. This seems to imply that whereas religious leaders love to help their people as per their divine calling; their capacity to perform is not commensurate to their responsibilities. Hence the need for capacity development programmes to boost their performance levels. On the outset, there is an obvious discrepancy between ratings of the care givers and programme managers. Whereas the former gave religious higher ratings for the performance of religious leaders in advocacy and initiation of networks and partnerships, programme managers, on the other hand, rated highly PSS and mobilization of people.

4.3 Challenges

Programme managers noted the challenges facing their FBOs as lack of capacity development, lack of drugs and testing kits, inadequate funding and overexpectations of their clients. There is no doubt, these challenges have a direct bearing on the performance of religious leaders. In the first, place limited capacity development will result into lower performance rates of staff including religious leaders themselves. Further, it would not make much sense for religious leaders to mobilize people to go for health services when in reality there are no drugs, nor testing kits. In the same vein, overexpectations seem to imply a scenario where people's demands outstrip the capacity to supply.

5.0 FOCUS GROUP DISCUSSIONS (FGD)

Focus group discussions were held in three of the study areas; Kumi hospital, Saidina Abubaker hospital and Ishaka hospital. As clients at the receiving end, it was expected that FGD responses would help to triangulate information given by other categories of respondents.

5.1 Role of religious leaders

Through FGD, clients reported that religious leaders visited them in their local communities and mobilized them to access HIV/AIDS services at the IRCU-supported sites. The visits were qualified as 'fairly' frequent and if circumstances did not allow them to come by themselves, they sent lay leaders to represent them. They observed that such visits brought them happiness since they demonstrated that religious had compassion and care for the people in need.

On prayer days, religious leaders used sermons/khotubas to sensitize their followers on matters related to HIV/AIDS. According to the information obtained in the FGD, religious leaders specifically talked about 'faithfulness among married couples',' leading spiritual lives', 'the need for testing to assess one's sero status', 'abstention', 'good nutrition', 'keeping a clean environment' and 'correct use of ARVs'. It was further noted that religious leaders referred those in need of more specialized health services to other health centres.

It was pointed out that apart from making direct visits, religious leaders used other channels to communicate with their followers. These were FM radio stations, social events (such as wedding parties, baptismal parties and funeral rites). Although focus group members commended the role of religious leaders in mobilizing them, they pointed out other sources of information such as community-based health workers, counselors, local councilors, friends and relatives.

Commenting on the roles and functions of the religious leaders, focus group members rated highly the latter's performance in mobilization and sensitization. However, they observed that they were more successful in mobilizing women than men who proved more 'resistant and stubborn'. In the area of advocacy, focus group members remarked that other than talking about advocacy issues in prayer houses, religious leaders did not make any deliberate efforts to work with other local organizations to formulate a common advocacy agenda. Nevertheless, they commended religious leaders' role in initiating networks and partnerships. For instance, they

mentioned Finca, Brac and Pride as examples of organizations which religious leaders had recommended to them for microfinance to better their livelihoods.

Focus groups members noted that resource mobilization was the area where religious leaders performed worst. They argued that other than the meager offertories and local contributions, they were not aware of any attempts made by their religious leaders to mobilize for resources.

The information obtained from focus group discussions was considered a vital and authentic reflection of the role of religious leaders. This is because people respect religious leaders and hold them in high esteem as they live within local communities and are, therefore, the first point of reference for people in need.

6.0 Lessons learnt

- Apart from religious leaders, there were other key players on the ground who participated in the mobilization of people for HIV/AIDS services such health workers, community volunteers, relatives and friends of people infected and/or affected by HIV/AIDS.
- In some cases ordained religious leaders delegated their responsibilities to non-ordained religious leaders which made the former's role appear less prominent. Since the latter are part of the laity, there was a tendency to consider them as lay people and not religious leaders.
- Scaling up partnerships and networks will go a long way to offset financial constraints and human resource inadequacies.
- Performance of religious was ranked high in activities that required minimal funding namely; sermons in prayer houses and at social events, counseling, school and pastoral visits.

7.0 Challenges

It was generally noted that the performance of religious leaders in mobilization and sensitization, counseling, advocacy, psychosocial and spiritual support was rated 'good'. However, they performed 'poorly' in the area of resource mobilization and initiation of networks and partnerships. All respondents interviewed reported challenges of inadequate funding and capacity building as the most acute. The study observed that even other lesser challenges had a direct

bearing on resource mobilization, that is, inadequate financial and human resources. The cure for HIV/AIDS is still eluding all scientific endeavours; and the disease is not limited to one group, sex, race, ethnic or religious group. Christians, Muslims and people of other faiths are living with and affected by HIV/AIDS. There is still room, therefore, for the inter-religious action if the HIV/AIDS scourge and its consequences are to be mitigated.

8.0 Conclusions

8.1 Prevention

Generally, it was observed that religious leaders understood their roles and functions in the IRCU HIV/AIDS prevention program. They preached messages on HIV/AIDS to the faith communities whom they met in prayer houses, social functions and home visits. This was corroborated by program coordinators/managers and then clients. By using these channels of communication, theymanaged to reach out to those members of their faith communities who did not frequently attend religious sermons. Of the many channels of communication available, it was established that religious sermons, radios, social events and notice boards were the most popular. They performed counseling sessions and preached faithfulness and abstinence to spouses, and encouraged people test themselves. It was noted, though, that local leaders, community volunteers, relatives and friends of clients supplemented the efforts of the religious leaders. All in all the services of religious leaders in the HIV/AIDS prevention programme was rated 'good'.

8.2 Orphan and Venerable Children (OVC)

Although religious leaders came second to friends as source of information to those in need of OVC services, religious leaders took a lead in other aspects such as helping OVC making choices of courses, giving them assistance, and visiting them at home, schools and vocational/apprenticeship institutions. OVC respondents reported religious sermons/khotubas and social events as the highest and second highest channels of communication. They appreciated the frequency of the visits from religious leaders and the spiritual and pshycosocial support they offered to them.On their part care givers, too, also appreciated the role of religious leaders in so far as making visits, providing counseling and spiritual guidance, and rendering other forms of assistance to them. The major constraints reported were financial constraints and limitations in initiating networks and partnerships. All in all, religious leaders' performance was generally average given the nature of constraints which impacted their work.

8.3 Care and Treatment

Under care and treatment religious leaders delivered psychological and spiritual healing, counseled and advised clients to start treatment, and advocated for HIV/AIDS services. During pastoral visits they talked to spouses about testing, keeping a clean (home) environment, correct use of ARVs, drinking safe water, good nutrition, leading spiritual and holistic lives, fidelity/faithfulness between couples, socio-economic empowerment, abstinence from sex, safe sex among discordance couples. The study noted that religious leaders did not hesitate to make referrals to clients to seek treatment in other health facilities in the event where such serves were not locally available. Further, it was observed that there were other actors, apart from religious leaders, who played a key role in the mobilization and sensitization of clients on HIV/AIDS services. These were community volunteers, health workers[29], relatives and friendsof the clients and who provided them with information.The role of these diverse groups tended to eclipse the work of religious leaders.

8.4 Role of IRCU

The study noted that there was a good working relationship between IRCU and the FBOs and religious leaders. Whereas some religious leaders talked about IRCU and its work to the different categories of the HIV/AIDS program beneficiaries of IRCU servicers, there was still a fairly sizeable number (40% among OVC school and out-of-school) of people who did not know IRCU. There is need for religious leaders to scale up IRCU's visibility at the lower level structures since they are the core base of the faith communities.

9.0 Way forward

Religious leaders should continue working with government, other faith-based organizations, NGOs, media and other well-intentioned individuals to halt the spread of the pandemic- a common challenge.On a positive note, the study noted that given proper training, religious leaders can become strong allies in HIV/AIDS prevention and control programs focused on awareness creation, behavioral change, and the elimination of stigma and discrimination against people living with the virus. IRCU should intensify efforts to bring the organization closer the grass roots where people who are in most need of its services live. The launching of the district inter-religious committees was a move in the right direction.

[29] These are counselors and clinicians based at other health facilities (government/public health facilities, private clinics and other HIV/AIDS organizations such as TASO)

10.0 Recommendations

- Continued capacity building of religious leaders in the areas of HIV/AIDS prevention, care and treatment, counseling and psychosocial support.
- Equipping religious leaders with accurate information on HIV/AIDS will enable religious leaders pass equally accurate information to their congregations.
- Faith-based organizations can support the campaign against the HIV/AIDS epidemic through distribution of information in local languages about H IV/AIDS
- Religious leaders should scale up building partnerships with other faith -based organizations and community leaders in order to find common beliefs, spiritual teachings and moral, legal and social standards that can prevent HIV and alleviate the suf fering of those affected by AIDS.
- Challenge the economic and social systems that increase the vulnerabilities of people and be agents of changeby mobilizing government to play its role in terms of rights, resources and institutions.
- Continued awareness and support should be given to people infected and affected by HIV/AIDS
- Scale up the advocacy agenda for promotion of PMTCT, elimination of stigma, denial, rejection and discrimination, to influence decision -making processes on HIV/AIDS and above all to be a voice for the voiceless.
- Using the structures of the District Inter -Religious Committees, IRCU should spread the spirit of inter-religious dialogue and action. It is only then that presence of IRCU will become concrete at the grass roots.

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APPENDIX 1: Questionnaires

Inter-Religious Council of Uganda
Religions for Peace

RESEARCH, ADVOCACY AND STRATEGIC INFORMATION

Questionnaire

This questionnaire seeks information from you for the purpose of understanding the role of religious leaders in creating demand and furthering IRCU HIV/AIDS interventions in Uganda. Therefore, you are kindly requested to candidly provide the required information in order to enable IRCU Secretariat assess its capacity to deliver services through its religious structures. You are assured that your responses will be treated in confidentiality.

Target groups
Religious leaders

Name.....
Sex.....
Age..... .....
Religion/denomination.....
Village/.....
Diocese/Deanery/Field/.....
County..... .....
District.....
Date.....

PREVENTION

What is your role as a religious leader in the HIV/AIDS prevention programme?
.....
.....
How often do you interact with your faith community?
A: Once a week B: twice a week C: three times a week D: four or even more times a week
Where do you meet your faith community?
A: only in church or mosque B: only at their homes C: only at their places of work D: in church or mosque and at all social events in the community
Do you talk to them about HIV/AIDS? A: Yes B: No
If yes, what different methods do you tell them to use to remain HIV/AIDS free?.....
.....
....

What changes in the people's behavior do you encourage them to adopt to avoid getting infected by HIV/AIDS?

……
……
…… ……

a) Which of the following channels of communication do you use to pass your HIV/AIDS messages? (tick more than one)

	Channel	Tick
1	Television	
2	Radio (FM stations)	
3	Newspapers/magazines	
4	Sermons/khotubas	
5	Notice boards	
6	Leaflets	
7	Sign posts	
8	Letters	
9	e-mails	
10	Fax	

Rank each of the above channels depending on the frequency of use

	Channel	Frequency				
		Very high	High	Moderate	Low	Very low
1	Television					
2	Radio (FM stations)					
3	Newspapers/magazines					
4	Sermons/khotubas					
5	Notice boards					
6	Leaflets					
7	Sign posts					
8	Letters					
9	e-mails					
10	Fax					

a)Do you think people follow and sti ck to your HIV/AIDS messages?
A: Yes B: Sometimes C: No
b) If yes above, does this translate into lower HIV prevalence rates in the area?
A: Yes B: sometimes C: not sure D: no
c) Explain

……
…… ……

a)Do you provide counseling services to individuals and couples on HIV prevention in the family setting?
A: Yes B: No
b)If yes above, do often?

A: very often B: often C: average D: rarely E: very rarely

Describe your performance in mobilizing resources to supplement IRCU funding.

……

……

……

A) How frequently do you organize project review meetings to inform other stakeholders?

……

……

b) What do you discuss at such meetings?

……

……

Name the stakeholders to whom you submit your general reports (ask for samples).

……

……

How do you feel about your individual contribution to the fight against HIV/AIDS in your community?

A: very satisfied B: satisfied C: fairly satisfied D: unsatisfied E: very unsatisfied

a)Are the faith communities aware of IRCU's contribution in the HIV/AIDS prevention programme?

A: Yes B: Not sure C: No

b) If yes above, explain how……

……

……c) If no above, explain why

……

……

What challenges do you encounter in working with IRCU to sensitize the faith communities on HIV/AIDS prevention?

Explain……

……

……

Do you have any suggestions to make further improvement in the IRCU/FBO relations?

……

……

Inter-Religious Council of Uganda
Religions for Peace

RESEARCH, ADVOCACY AND STRATEGIC INFORMATION
Questionnaire

CARE AND TREATMENT

This questionnaire seeks information from you for the purpose of understanding the role of religious leaders in creating demand and furthering IRCU HIV/AIDS interventions in Uganda. Therefore, you are kindly requested to candidly provide the required information in order to enable IRCU Secretariat assess its capacity to deliver services through its religious structures. You are assured that your responses will be treated in confidentiality.

Target groups
Religious leaders

Name.....
Sex.....
Age..... .....
Religion/denomination.....
Village/.....
Diocese/Deanery/Field/.....
County..... .....
District.....
Date.....
What is your role as a religious leader in the HIV/AIDS Care and Treatment programme?
.....
.....
a)Are clients aware of the care and treatment services offered in the health facility?
A: Yes B: Not sure C: No

Table 1 below indicates the different channels of communication. Tick any that you mostly use to mobilize people for HIV/AIDS care and treatment. (You can tick more than one)

Table 1: Channels of communication (from 1=very infrequently to 5= very frequently)

	Channel	Frequency				
1	Television	1	2	3	4	5
2	Radio (FM stations)	1	2	3	4	5
3	Newspapers/magazines	1	2	3	4	5
4	Sermons/khotubas	1	2	3	4	5
5	Social events (e.g. funerals, parties, anniversaries)	1	2	3	4	5
6	Personal conversations	1	2	3	4	5
7	Notice boards	1	2	3	4	5

8	Telephone	1	2	3	4	5
9	Leaflets	1	2	3	4	5
10	Sign posts	1	2	3	4	5
11	Letters	1	2	3	4	5
12	e-mails and/or fax	1	2	3	4	5
13	Fax	1	2	3	4	5

How effective are the communication channels you use in passing information to the faith communities?

A: Very effective B: effective C: moderately effective D: ineffective E: very ineffective

How frequently do you carry out pastoral visits to the communities to talk about HIV/AIDS services?

A:Very frequently B:frequently C:fairly frequently D: infrequently E: very infrequently

Write down the different activities you do when you make a visit to a home of PHAs.

……

……

……

What advice would you give to a family that is HIV/AIDS negative?

……

……

What do you do in case you discover a patient needs services that are not available in your FBO?

……

……

What do you do in case you discover that after HIV testing one member of a couple is HIV positive and the other is negative?

……

……

Do you think it is important to attend meetings with FBO staff?

A: Yes B: Not sure C: No

Explain

……

……

……

How do you describe the relationship between you and

the health staff? A: very cordial B: Cordial C: fairly cordial D: uncordial E: very uncordial

Clients? A: very cordial B: Cordial C: fairly cordial D: un-cordial E: very un-cordial

Describe your rate of success in mobilizing extra funding for the HIV/AIDS care and treatment services for the FBO.

A: very successful B: successful C: moderately successful D: unsuccessful E: very unsuccessful

A: Yes B: sometimes C: No

Joining networks and partnerships is part of your responsibility. Indicate below the different organizations you have networked with and/or partnerships created.

.....
.....
.....
Indicate below HIV/AIDS issues you have advocated or intend to advocate for as a religious leader.
.....
.....
Are the faith communities informed of IRCU's role in the HIV/AIDS Care and Treatment programme?
A: Yes B: Not sure C: No
b) If yes above, explain how.....
.....
.....
c) If no above, explain why
.....
.....
How do you feel about your individual contribution to the HIV/AIDS care and treatment programme?
A: very satisfied B: satisfied C: fairly satisfied D: unsatisfied E: very unsatisfied
What challenges do you encounter in the pr ovision of the HIV/AIDS care and treatment services? Explain.....
.....
Do you have any suggestions to make further improvement in HIV/AIDS care and treatment services?
.....
.....
.....

Inter-Religious Council of Uganda
Religions for Peace

RESEARCH, ADVOCACY AND STRATEGIC INFORMATION
Questionnaire

CARE AND TREATMENT

This questionnaire seeks information from you for the purpose of understanding the role of religious leaders in creating demand and furthering IRCU HIV/AIDS interventions in Uganda. Therefore, you are kindly requested to candidly provide the required information in order to enable IRCU Secretariat assess its capacity to deliver services through its religious structures. You are assured that your responses will be treated in confidentiality.

Target groups
FBOs (coordinators, head of counseling services)

Name.....
Sex.....
Age.....
Religion/denomination.....
Village/.....
Diocese/Deanery/Field/.....
County.....

What is your role in the HIV/AIDS Care and Treatment programme?
.....
.....
....
What is the role of the religious leader in the running of the health facility?
....
....
.....
a)Do you have a working relationship with the local religious leader(s) in running th e HIV/AIDS care and treatment programme?
A: Yes B: Not sure C: No
b)If yes above, describe the quality of the working relationship with the local religious leader(s)?
A: Very cooperative B: cooperative C: moderately cooperative D: uncooperative E: very uncooperative
c) If no above, explain why
.....
.....
According to you, who should mobilize the clients before they come to you for HIV/AIDS care and treatment?
A: religious leaders B: local councillors C: LCV chairpersons D: impossible to tell

How do you rank your level of satisfaction with the performance of the local religious leader(s) in running the health facility?

A: very high B: High C: moderately high D: low E: very low

What is your assessment of the religious leaders' performance on the following?

i)Psychosocial support

……. …….

…… ……

ii)Mobilization of people for HIV/AIDS services

……

…… ……

iii)Carrying out advocacy

……

…… ……

iv)Resource mobilization

……

…… ……

v)Joining networks and partnerships

……

…… ……

How do you feel about your individual contribution to the HIV/AIDS care and treatment programme?

A: very satisfied B: satisfied C: fairly satisfied D: unsatisfied E: very unsatisfied

What challenges do you face in delivering HIV/AIDS care and treatment services?

……

……

……. …….

Do you have any suggestions to make further improvement in HIV/AIDS care and treatment services?

…… ……

…… ……

…… ……. …….

Inter-Religious Council of Uganda
Religions for Peace

RESEARCH, ADVOCACY AND STRATEGIC INFORMATION
Interview guide
CARE AND TREATMENT

This FGD seeks information from you for the purpose of understanding the role of religiou s leaders in creating demand and furthering IRCU HIV/AIDS interventions in Uganda. Therefore, you are kindly requested to candidly participate in the discussion with a view to providing information that will enable the IRCU Secretariat to assess its capaci ty to deliver services through its religious structures. You are assured that your responses will be treated in confidentiality.

Target groups
FGDs (groups of clients)

1. How do you learn of the HIV/AIDS care and treatment services?
2. Name the communication channels used to pass messages?
a) Are they effective?

3. Who assisted you to enroll on HIV/AIDS care and treatment?
4. Do religious leaders offer psychosocial support to HIV/AIDS clients?
a) How often?
b) Is it effective?
5. Other than religious leaders, are there any other sources of information on HIV/AIDS care and treatment?

6. Have religious leaders succeeded in doing the following?
Mobilization of people for HIV/AIDS services
Carrying out advocacy
Resource mobilization
Making referrals
Initiating networks and partnerships

7. Are there chances for people who do not go for Juma, Saturday or Sunday prayers to know of HIV/AIDS care and treatment services?
8. Do religious leaders visit HIV/AIDS clients?
a)How often?
b) Are the visits effective? Describe how you feel before and after the visits?
9. Have you heard about IRCU? If yes, through who? What does it do?
10. What challenges do you face as a client in accessing HIV/AIDS care and treatment?
11. Do you have any suggestions to offer to improve HI V/AIDS care and treatment services?

Inter-Religious Council of Uganda
Religions for Peace

RESEARCH, ADVOCACY AND STRATEGIC INFORMATION
Questionnaire
OVC

This questionnaire seeks information from you for the purpose of understanding the role of religious leaders in creating demand and furthering IRCU HIV/ AIDS interventions in Uganda. Therefore, you are kindly requested to candidly provide the required information in order to enable IRCU Secretariat assess its capacity to deliver services through its religious structures. You are assured that your responses will be treated in confidentiality.

Target groups
Children in education and vocational institutions

Name.....
Sex.....
Age.....
Religion/denomination.....
Village/.....
Diocese/Deanery/Field/.....
County.....
District.....
Date.....

How long have you been living as an OVC?
.....
.....
a) What course are you pursuing?
.....
.....
b) Who assisted you to make that choice ?
A: A religious leader B: a local councilor C: a relative D: a friend E: none of these
How did you learn of the HIV/AIDS OVCprogramme?
.....
.....

Basing your answer on the table below, indicate with a t ick the channels of communication mostly used to convey messages on OVC programme in your area.

	Channel	Tick
1	Television	
2	Radio (FM stations)	
3	Newspapers/magazines	
4	Sermons/khotubas	
5	Social events (e.g. funerals, parties, anniversaries)	

6	Notice boards	
7	Leaflets	
8	Sign posts	
9	Letters	
10	e-mails and/or fax	
10	Fax	

How do you rank the level of effectiveness of the selected channels of communication? A: very high B: High C: moderately high D: low E: very low

a)Did your religious leader assist you in any way to get enrolled?

A: Yes B: not sure C: No

b)If yes above, describe the nature of assistance you received.

b) If no above, explain why

…… ……

…… ……

According to you who participated most in mobilizing the OVC ?

A: religious leaders B: local councillors C: LCV chairpersons D: impossible to tell

a)Once enrolled on the OVC programme, does the religious leader pay you fol low-up visits?

A: yes B: Not sure C: No

b)If yes above, how often?

A: Very often B: often C: fairly often D: rarely E: very rarely

What is your assessment of the religious leaders' performance on the following?

i)Psychosocial support

…… ……

ii)Mobilization of people for HIV/AIDS service s

…… ……

iii)Carrying out advocacy

…… ……

iv)Resource mobilization

…… ……

v)Initiating networks and partnerships

…… ……

How do you rank you level of satisfaction with the performance of religious leaders in the running of OVC programme?

A: very contented B: contented moderately contended D: discontented E: very discontented

Have you heard of the Inter-Religious Council of Uganda (IRCU)?

If yes, state how you came to know about it

.....
.....
.....
What challenges do you face in pursuit of the OVC programme?
.....
.....
.....
Do you have any suggestions to make further improvement in the OVC programme
.....
.....

Inter-Religious Council of Uganda
Religions for Peace

RESEARCH, ADVOCACY AND STRATEGIC INFORMATION
Questionnaire

This questionnaire seeks information from you for the purpose of understanding the role of religious leaders in creating demand and furthering IRCU HIV/AIDS interventions in Uganda. Therefore, you are kindly requested to candidly provide the required information in order to enable IRCU Secretariat assess its capacity to deliver services through its religious structures. You are assured that your responses will be treated in confidentiality.

Target groups
Care Givers
Name.....
Sex.....
Age..... ...
Religion/denomination.....
Village/.....
Diocese/Deanery/Field/.....
County.....
District.....
Date.....

How long have you been a Care giver?
.....
....
How did you learn of the IRCU HIV/AIDS programme?
....
....
a)Did you religious leader assist you in any way to get enrolled on the programme?
A: Yes B: not sure C: No
b)If yes above, describe the nature of assistance you.
b) If no above, explain why
.....
.....
....
....

Basing your answer on Question 3 above, indicate with a tick in the table below the channels of communication frequently used to convey messages on OVC programme.

	Channel	Tick
1	Television	
2	Radio (FM stations)	
3	Newspapers/magazines	
4	Sermons/khotubas	
5	Social events (e.g. funerals, parties, anniversaries)	
6	Notice boards	

7	Leaflets	
8	Sign posts	
9	Letters	
10	e-mails and/or fax	
10	Fax	

How do you rank the level of effectiveness of the selected channels of communication?
A: very high B: High C: moderately high D: low E: very low
According to you who participated most in mobilizing you and other care givers?
A: religious leaders B: local councillors C: LCV chairpersons D: impossible to tell
a) Do religious leaders visit you in your home?
A: Yes B: sometimes C: No
If yes above, how frequently?
A: very often B: often C: moderately D: rarely E: very rarely
Tick any of the activities below that a religious leaders does when he visits you

No.	Activity	Tick
1	Gives me words of advice and encouragement	
2	Threatens me with God's punishment	
3	Carries out bible/Quran study	
4	Insults me	
5	Donates food stuff and/or money	
6	Encourages me to help the OVC	
7	Blames all those affected by and infected with HIV/AIDS	
8	Discriminates me	
9	Talks to me but does not listen to me	
10	Encourages me to join OVC income-generating activities	
11	States that helping OVC is one way of fighting HIV/AIDS	
12	Encourages me to use preventive methods against HIV/AIDS	
13	Encourages me to live positively	

How do you rate the performance of religious leaders in the running of IGA for care givers programme?
A: very good B: good C: fairly good D: poor E: very poor
What is your assessment of the religious leaders' performance on t he following?
i)Psychosocial support
.....
.....
ii)Mobilization of people for HIV/AIDS IGA services
.....
.....
iii)Carrying out advocacy
.....
.....
iv)Resource mobilization
.....
.....

v)Initiating networks and partnerships

a) Have you ever heard of the IRCU?

A: Yes B: not sure C: No

b)If yes above, how do you benefit from the IRCU and its programmes?

.....

.....

.....

What challenges do you face as a care giver under the IRUC HIV/AIDS?

.....

.....

Do you have any suggestions to improve the IGA for the care givers?

.....

.....

Inter-Religious Council of Uganda
Religions for Peace

RESEARCH, ADVOCACY AND STRATEGIC INFORMATION

Questionnaire

This questionnaire seeks information from you for the purpose o f understanding the role of religious leaders in creating demand and furthering IRCU HIV/AIDS interventions in Uganda. Therefore, you are kindly requested to candidly provide the required information in order to enable IRCU Secretariat assess its capacity to deliver services through its religious structures. You are assured that your responses will be treated in confidentiality.

Target groups

OVC (Head/coordinator of Institution)

Name..... ....

Sex.....

Age..... .....

Religion/denomination..... .....

Village/..... ....

Diocese/Deanery/Field/..... .....

County.....

District.....

Date..... ..

How long have you been providing services t o OVC?

.....

....

What services to you give out to OVC?

....

....

Which category of people in the table below do you consider most useful to work with in providing services to OVC?

No.	Category	Tick
1	Religious leaders	
2	Care givers	
3	Police men	
4	Magistrates	
5	Local councillors	

Who assists you in identifying and enrolling candidates for the OVC programme?

A: a religious leader B: a local councilor C: a local police officer D: None of these

Who pays you for the services rendered?

....

....

....

a)Do local religious leaders visit your institution to check on performance of OVC?

A: yes B: not sure C: No

b)If yes above, how frequent are the visits?
A: very frequent B: frequent C: average D: infrequent E: very infrequent
State what, in your opinion, a religious should do when he/she comes to visit your institution
a)..... .....
b).....
c)..... .....
d)..... .....
e)..... .....
f) .....
What is your assessment of the religious leaders' performance on the following?
i)Psychosocial support
....
....
ii)Mobilization of people for HIV/AIDS OVC services
....
....
iii)Resource mobilization
....
....
iv)Initiating networks and partnerships
....
v) identifying other service providers
....
How do you rate the level of cooperation from religious leaders in the running of your institution?
A: very good B: good C: fair D:poor E: very poor
a)Have you heard of the Inter-Religious Council of Uganda (IRCU)?
A: Yes B: not sure C: No
b)If yes, state how you came to know about it
....
....
....
What challenges do you face in rendering the OVC programme services?
.....
....
Do you have any suggestions to make further improvement in the services you deliver ?
....
....

Inter-Religious Council of Uganda
Religions for Peace

RESEARCH, ADVOCACY AND STRATEGIC INFORMATION
Questionnaire
OVC
This questionnaire seeks information from you for the purpose of understanding the role of religious leaders in creating demand and furthering IRCU HIV/AIDS interventions in Uganda. Therefore, you are kindly requested to can didly provide the required information in order to enable IRCU Secretariat assess its capacity to deliver services through its religious structures. You are assured that your responses will be treated in confidentiality.

Target groups
Religious leaders

Name.....
Sex.....
Age.....
Religion/denomination.....
Village/.....
Diocese/Deanery/Field/.....
County.....
District.....
Date.....

What is your role as a religious leader in the OVC programme?
.....
.....
.....
.....
Do you mobilize OVC in your community for them to access services?
A: Yes C: No

b)If yes above, which channels you use to infor m them? (Tick more than one)

	Channel	Tick
1	Television	
2	Radio (FM stations)	
3	Newspapers/magazines	
4	Sermons/khotubas	
5	Social events (e.g. funerals, parties, anniversaries)	
6	Notice boards	
7	Leaflets	
8	Sign posts	
9	Letters	

10	e-mails and/or fax	
10	Fax	

How effective are the communication channels you use in passing information to the faith communities?

A: Very effective B: effective C: moderately effective D: ineffective E: very ineffective

What exactly do you do to ensure tha t OVC secure training/education opportunities at the different institutions?

……
…… ……
…… ……

a) Do you visit the OVC at the different training/education ins titutions?

A: Yes B: No

b) If yes above, how frequently?

A: Very frequently B: frequently C: average D: infrequently E: very infrequently

c) State exactly what you do during and after your visits at the OVC training/education/vocational institutions

a)……
b)…… ……
c)…… ……
d)…… ……
e)…… …..
g)…… ……
h)…… ……

a) Do you make home visits (outreaches) to the OVC ?

…… ……
……
…… ……

b) What is the purpose of such visits?

……
…… ……
…… ……

How successful have you been able to mobilize extra funds for the OVC

……
……
…… ……
…… ……

Do you provide spiritual counseling to the OVC?

A: Yes B: No

If yes, how frequently?

A: Very frequently B: frequently C: average D: infrequently E: very infrequently

What do you do to ensure smooth implementation of the OVC project?

……
……

Have you succeeded in establishing links between t he OVC programme in your area and other service providers?
A: Yes B: Not sure C: No

If yes above, name the different service providers you have linked to the OVC programme?
…… ……
……
…… ……
a)Do you attend quarterly project review meeting at the FBO level?
A: Yes B: No

b) If yes above, how frequently?
A: Very frequently B: frequently C: average D: infrequently E: very infrequently
c)Explain benefits of attending quarterly project meeting
…… ……
…… ……
…… ……
How do you feel about your individual contribution to the OVC programme?
A: very satisfied B: satisfied C: fairly satisfied D: unsatisfied E: very unsatisfied
What strategies have you used to popularize IRCU among the OVC?
…… ……
…… ……
…… ……
What challenges do you encounter in th e provision of knowledge and vocational skills to the OVC programme?
……
…… ……
…… ……
…… …… ……
Do you have any suggestions to make further improvement in HIV/AIDS care and treatment services?
…… …..
…… ……