Study of the Response by Faith-Based Organizations to Orphans and Vulnerable Children

Preliminary Summary Report

WORLD CONFERENCE OF RELIGIONS FOR PEACE
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Study of the Response by Faith-Based Organizations to Orphans and Vulnerable Children

World Conference of Religions for Peace
United Nations Children Fund - UNICEF

Report compiled by Dr Geoff Foster

Preliminary Summary Report

Please note the findings in this report are preliminary. Data analysis is in some cases incomplete. Views expressed do not necessarily represent those of the World Conference of Religions for Peace or UNICEF.

This report incorporates data and analysis from country reports produced by groups in the six countries participating in this study.

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Cover photograph by Giacomo Pirozzi
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Prepress and Printing by Kenya Litho

"Out of Africa, always something new"
Pliny, 1st Century AD

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acronyms

CI	Community Initiative
CBO	Community-Based Organization
FBO	Faith-Based Organization
HACI	Hope for African Children Initiative
HIV	Human Immuno-deficiency Virus
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PI	Principal Investigator
RCB	Religious Coordinating Body
SAG	Study Advisory Group
SC	Study Consultant
UNICEF	United Nations Children's Fund
WCRP	World Conference of Religions for Peace

introduction 1

International agencies are increasingly recognizing the role of religious organizations in establishing effective HIV/AIDS interventions. Despite some negative perceptions of their role and impact, faith-based organizations (FBOs) are among the most viable institutions at both local and national levels and have developed experience in addressing the multi-dimensional impact of AIDS and its particular impact on children. Religious organizations are prevalent throughout Africa. In the six countries chosen for this Study, the number of local congregations is estimated to be in excess of 150,000. Yet most faith-based responses are small scale and remain undocumented. It is difficult to measure their cumulative impact compared to the more visible project responses of development agencies. Consequently, FBO HIV/AIDS activities remain under-supported.

During 2002 - 2003, the World Conference of Religions for Peace (WCRP) in collaboration with UNICEF carried out a study to survey what religious groups are doing to meet the needs of orphans and vulnerable children (OVC) and to develop an improved and detailed understanding of the responses of religious organizations in east and southern Africa in caring for children affected by AIDS. The Study took place in six countries (Kenya, Malawi, Mozambique, Namibia, Swaziland and Uganda) with a combined population of 85.2 million people. There are currently around 5.8m orphans in these countries, with close to half being due to AIDS. This figure is set to increase to 6.9m by 2010 by which time some 1.4m children (20% of orphans and 3% of the child population) will have lost both parents.

Research teams in the six countries conducted interviews with 686 FBOs, mostly congregations and Religious Coordinating Bodies (RCBs) that coordinate the religious activities carried out by congregations. Over 7,800 volunteers supported more than 139,400 OVC in these initiatives, mostly through community-based initiatives involving spiritual, material, educational and psychosocial support. Though many individual congregational initiatives supported under 100 children, the cumulative results are significant. The overall organizational capacity of local FBOs in terms of governance and financial accountability was on a par with many larger NGOs. Most FBO initiatives receive little or no external technical or financial support and of necessity rely on their own skills and material resources. One of the major recommendations of the study is that donors should support the operation of small grants funds through RCBs to support activities initiated by congregations.

This Study is the first part of a strategy designed to increase the numbers of vulnerable children cared for by religious organizations. The second stage will involve the provision of targeted technical assistance and increased resource mobilization for religious organizations to improve their capacity to care for affected children. This will involve the strengthening of multi-religious collaborative structures in the six Study countries. As a result of the Study, it is anticipated that partnerships between religious organizations and inter-governmental organizations such as UNICEF, donors and other organizations will be strengthened so that the work FBOs are doing at community level to address the needs of children affected by HIV/AIDS can be expanded.

The Impact of AIDS on Children in Africa

The devastating consequences of HIV/AIDS on African societies, and its particular impact on children, is requiring every organization involved in fighting the pandemic to find new strategies to adequately address both the scale of the problem and its duration. The crisis of children left behind by AIDS is a humanitarian, development and human rights challenge of unprecedented proportions. It is estimated that in 41 African countries, the number of children who are orphaned, for any reason, will nearly double between 1990 and 2010. In 1990, AIDS accounted for three percent of deaths that left children orphaned in African countries; by 2010, the proportion will be 48 percent. In seven countries in southern Africa, the most severely affected region, the number of orphaned children who have lost both parents will increase by a staggering 1,250 percent (from 0.2 to 2.7 million). By 2010, orphans will account for at least 15% of the childhood population in twelve countries in Africa; almost three quarters of double orphans in the world will be from Africa. Human Immuno-deficiency Virus (HIV) infection and AIDS are making millions of additional children vulnerable, including those with ill parents, those in poor households that have taken in orphans, and those living in communities impoverished by HIV/AIDS. Current HIV prevalence levels only hint at the much greater lifetime probability of becoming infected. In Lesotho, for example, it is estimated that a person who turned 15 in 2000 has a 74% chance of becoming infected with HIV by his or her 50th birthday.

Although there have been substantial gains in improving overall child survival, these gains are being eroded in African countries hardest hit by the epidemic. The scale of the AIDS epidemic on this continent makes its repercussions qualitatively different from those in other parts of the world. The economic and social effects of HIV infection and AIDS on children include malnutrition, migration, homelessness, and reduced access to education and health care. Psychological effects include depression, guilt, and fear, possibly leading to long-term mental health problems. The combination of these effects on children increase their vulnerability to a range of consequences, including HIV infection, illiteracy, poverty, child labor, exploitation, and the prospect of unemployment.

It has traditionally been said that there is no such thing as an orphan in Africa. Children who lose their parents are normally incorporated into a relative's family. For the most part, relatives treat orphans they care for in the same way as their own biological children. Many go to considerable lengths to keep orphans in school, including borrowing money through informal networks and selling their own assets. But with increased numbers of orphans, reduced numbers of caregivers, and weakened families, the extended family is no longer the safety net that it once was, though it remains the predominant source of care for orphans in Africa. The epidemic is leading to an ever-increasing "caring deficit," as the number of children in need increases while the number of caregivers declines. This erosion of caring capacity has a double impact, because as well as being parents, many of the adults dying are also teachers, health workers and civil servants. Given the scale of the AIDS epidemic in Africa, it is not surprising that children are on the streets, in child-headed households, or working as laborers. What is remarkable is that so few children are slipping entirely through the safety net and ending up in situations of extreme vulnerability. In many other parts of the world, the number of children fending for themselves would almost certainly be higher under these circumstances.

Women are almost invariably left bearing even bigger burdens—as workers, caregivers, educators and mothers. At the same time, their legal, social and political status often leaves them more vulnerable to HIV/AIDS. Over half of the 28.5 million people currently infected with HIV in sub-Saharan Africa are female. The health and life situation of any woman is critical to the health and life chances of her children, not only during pregnancy, childbirth and the early months of life but throughout their entire childhood. A mother's capacity for child care — the time and energy she can devote to her children, the conditions in the home, her material resources, her skills and knowledge — continues to govern a child's passage from childhood to maturity socially, physically and emotionally. Whether or not an HIV-infected mother transmits the virus to one or more of her children, her early death from AIDS will have profound impact on all of them. If she is the key provider of food, clothing and household utilities for all her children, a mother's death has profound social and economic consequences for her orphans and for her husband if he survives.

Families and local communities are the front-line caregivers and they have demonstrated remarkable resilience and creativity in addressing the myriad needs of affected children. Extraordinarily, all the evidence suggests that the traditional fostering systems in Africa, backed up by community programs, will continue to meet most of these children's basic needs, provided that coping mechanisms are not undermined. Because these systems are so effective, they are the ones that need the most support. Indeed, it is somewhat paradoxical that the effectiveness of the traditional African social systems in absorbing millions of vulnerable children has contributed in the past to the complacency of governments and agencies in addressing the orphan crisis. Affected communities need to be strengthened because institutional responses to the crisis, such as orphanages, will never be able to address the scale of the problem, run counter to local traditions and fail to meet children's social, cultural and psychological needs. In this context, proven interventions must be extended widely and expanded deeply through all levels of society to address the multiple dimensions of care required by the children. Though FBO responses to-date have tended to be small scale and localized, in the long run, these groups, which are present in affected communities, are better placed than external agencies to provide appropriate support and deal with complex social issues of children affected by AIDS.

Definitions of Faith-Based Organizations

Four categories of religious organizations were distinguished for this Study:

Congregation: a local grouping of believers such as a church, mosque, temple or synagogue that meet on a regular (usually weekly) basis.

Religious Coordinating Body (RCB): intermediary organizations responsible for coordinating and supporting congregations.

Non-Governmental Organization: faith-based NGOs employ staff, receive external donor support and are answerable to a broader group than a congregation or RCB.

Community-Based Organization (CBO): local groups differentiated from NGOs because they do not employ full-time staff.

Study Methodology

The World Conference of Religions for Peace (WCRP) initiated the Study with support from UNICEF. WCRP appointed a Study Consultant in July 2002 to develop the Study protocol and research instruments and to supervise the Study. In each country, a Study Action Group (SAG) consisting of representatives from WCRP and UNICEF appointed a research team consisting of a Principal Investigator (PI) and data collectors and advised on selection of study sites. The Consultant supervised orientation of SAGs and training of the research teams. Each country developed its own Study plan and was responsible for analyzing data and developing a country report. The PI in each country supervised the study design, training of data collectors, data collection, analysis and report writing.

The Study took place during 2002-3. Interviews were conducted with 686 FBOs consisting of 410 Congregations, 161 RCBs, 63 faith-based CBOs and 52 faith-based NGOs. These were situated in Uganda (193 FBOs), Kenya (171), Mozambique (105), Namibia (91), Malawi (68) and Swaziland (57). Overall, 82% of FBOs were Christian, 15% Muslim, 0.8% Bahai, 0.6% Hindu, 0.6% Traditional and 0.2% Jewish. The Study also involved over 400 children and 100 key informants who were interviewed or took part in focus group discussions (Appendix, Table A).

study findings

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Number of Children Supported by Initiatives

Respondents were asked to estimate the total number of Orphans and Vulnerable Children (OVC) supported by their initiative and the number of beneficiaries who were orphans and non-orphans. Overall, 322 Faith-Based Organizations (FBOs) (out of 505 processed to date) supported 139,409 OVC (Figure 1). Estimates were not obtained from many FBOs because of lack of records, or because respondents were unable to provide estimates; 69% of beneficiaries were orphans and 31% non-orphans.

Congregations and CBOs supported significantly fewer OVC per initiative on average than NGOs and RCBs (217 and 155 vs. 1,270 and 858 respectively). Nonetheless, there were over 80 moderate-sized congregational initiatives supporting 100-1,000 OVC and a dozen large initiatives supporting over 1,000 OVC; 16 NGOs and RCBs had OVC programs supporting over 2,500 OVC (Figure 2).

Volunteers Involved in Initiatives

Most FBOs rely on volunteers to carry out OVC support activities. 193 FBOs (out of 505) involved 7,885 volunteers. The average numbers of volunteers per initiative was greatest for RCBs (106 per initiative) and NGOs (93) and lowest for Congregations (23) and CBOs (15). On average, there was one volunteer for every twelve children supported by the initiatives. Most volunteers providing OVC support were female congregation members aged between 30 and 50 years old. A majority of volunteers involved in HIV prevention activities were youth.

Volunteers managed and implemented OVC projects and offered their services free. Most volunteers received no incentives, though a few received material support, transport and meal allowances from their community or congregation. Other incentives included certificates of appreciation, attendance at workshops or exchange visits to other OVC initiatives. Most volunteers received no training on HIV/AIDS and orphan care. Some gained knowledge about HIV/AIDS through attending workshops, seminars, talks and exchange visits. In some congregations, training was facilitated by RCBs and NGOs covering issues such as the role of committees in program management, child development, home based care, counseling and the impact of HIV/AIDS. Volunteers were motivated by good will, compassion, the plight of seeing vulnerable children, the necessity of helping the needy and a calling to serve God.

Figure 1: Number of OVC Supported by Different Types of FBOs

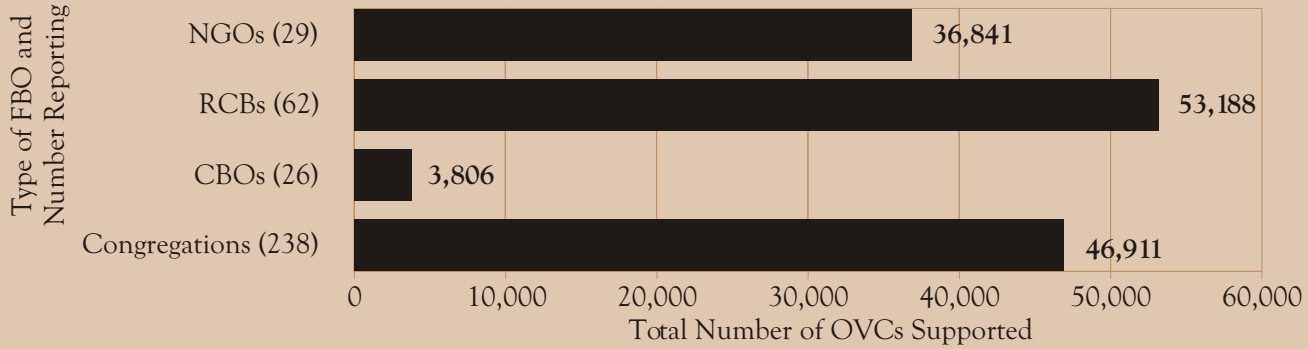
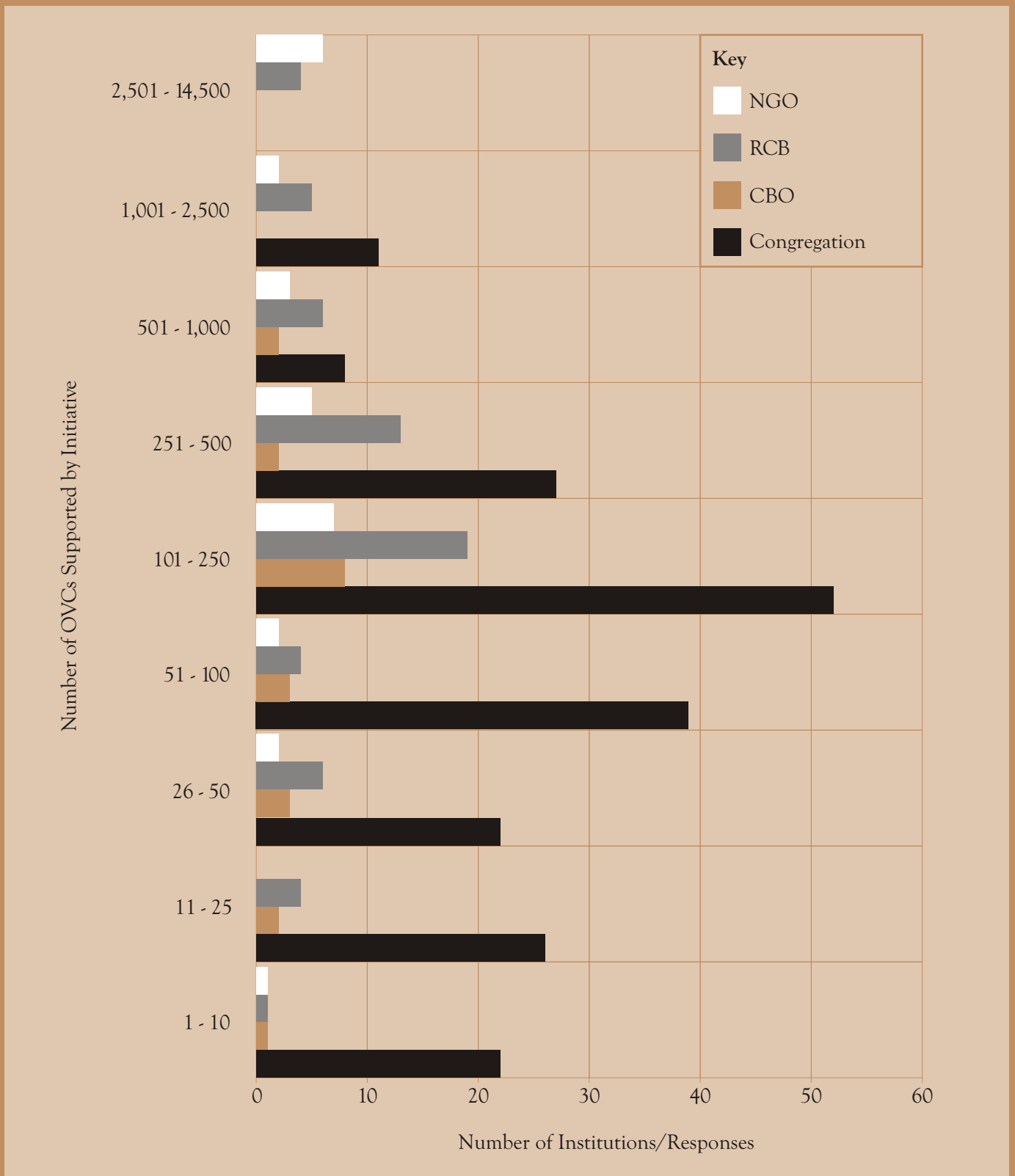


Figure 2: Size of Initiatives by Type of FBO



Date of Establishment of Initiatives

Some of the earliest FBO OVC initiatives were established in the 1960's and 70's, prior to the HIV/AIDS era; these included orphanages, shelters and scholarship programs for underprivileged children. During the mid-90's, FBO responses proliferated as the HIV/AIDS pandemic increased the number of OVC (Figure 3). Almost 50% of the OVC initiatives documented in the Study were established since 1999.

Nature of OVC Support Activities

Almost all faith-based OVC initiatives provide children with religious teaching and spiritual support. The provision of material support and school assistance were other common support activities, followed by HIV prevention activities, the provision of home-based care to chronically ill patients and counseling for children affected by HIV/AIDS (Figure 4).

Figure 3: Date of Establishment of FBO OVC Initiatives

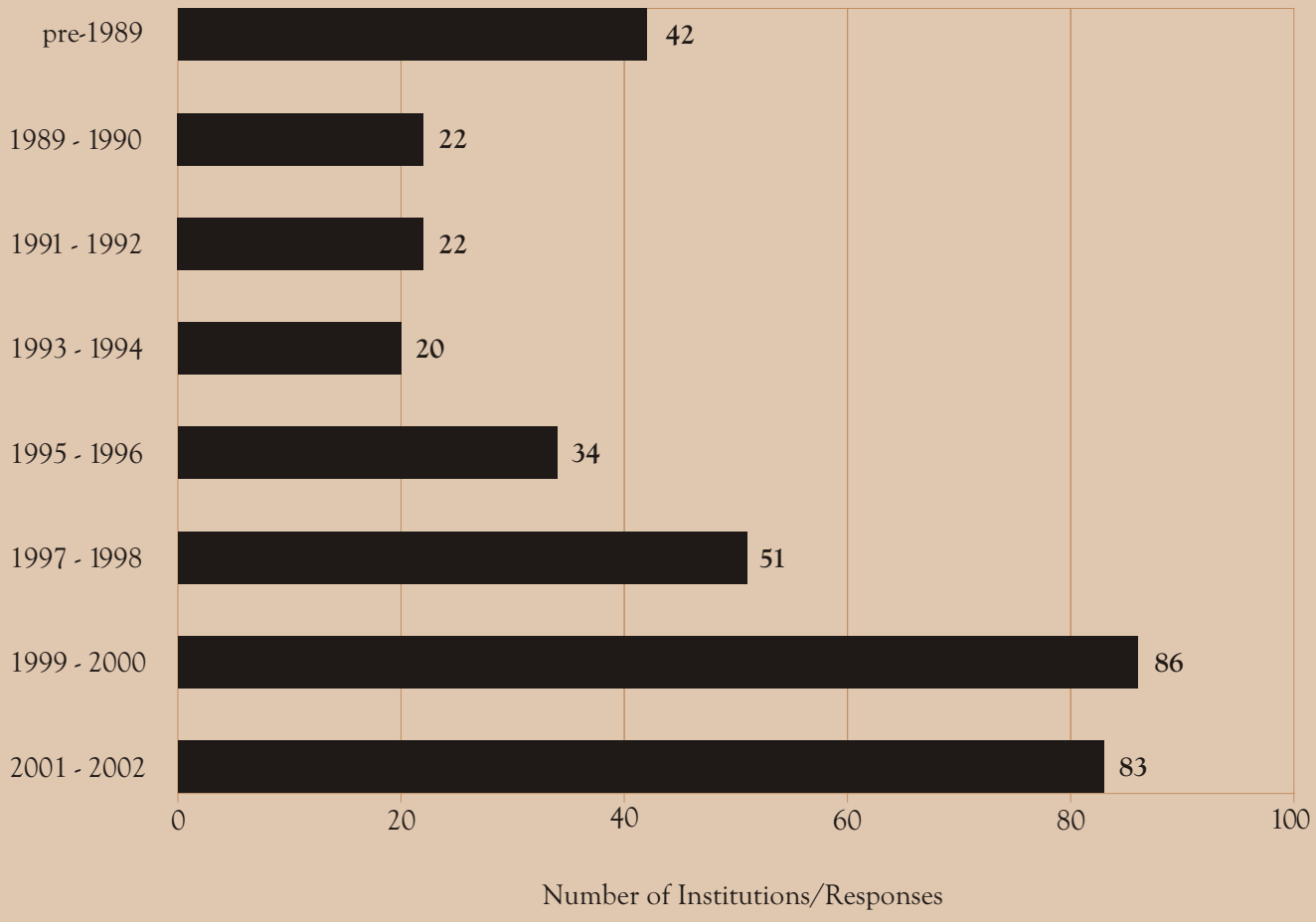
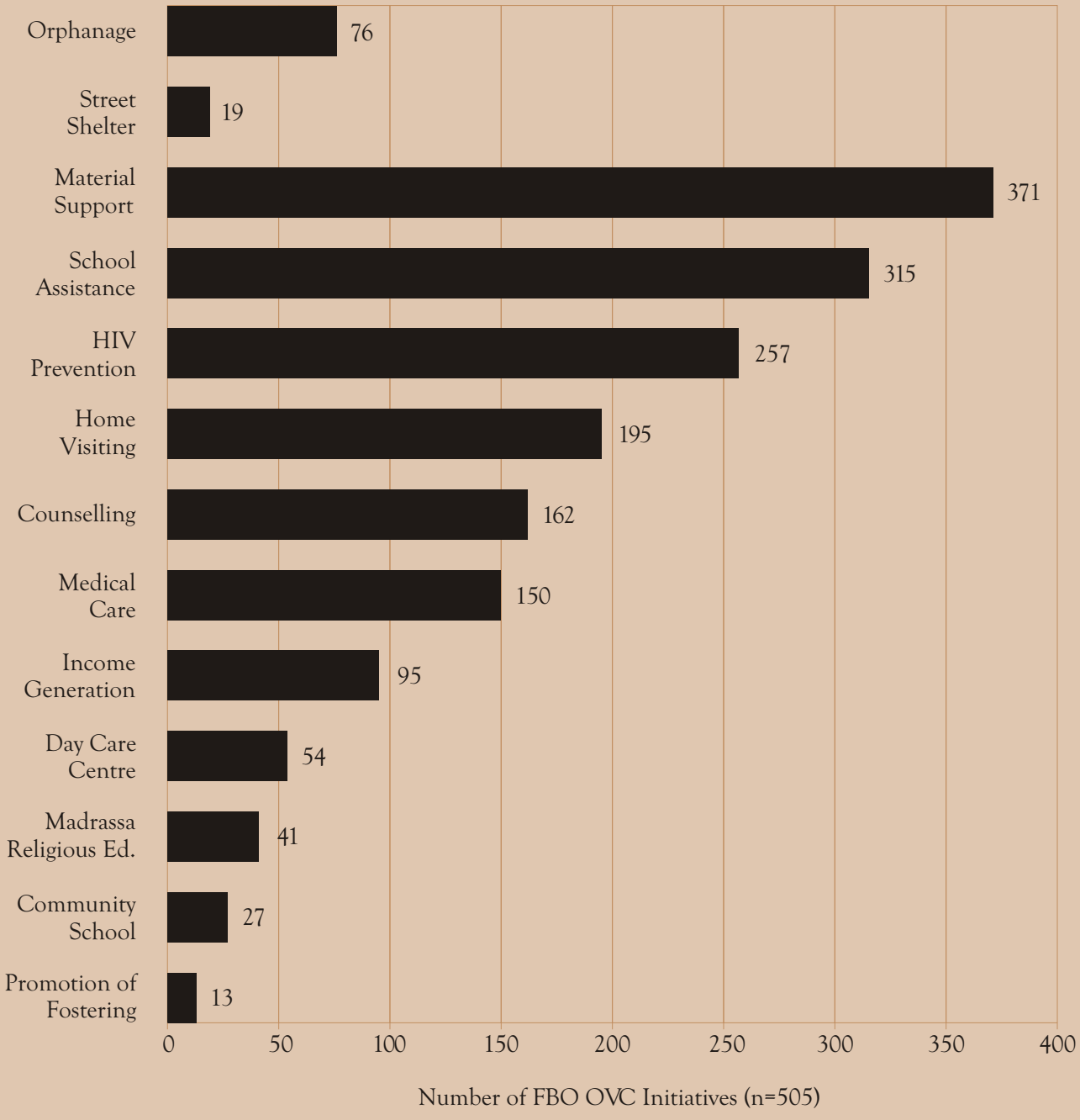


Figure 4: Main OVC Activities of FBOs



A. Community-Based Initiatives by Congregations, CBOs and NGOs

Overall, 82% of OVC responses were community based (Appendix, Table D). Of these, 50% were in urban areas. Community-based responses were commonest in Anglican, Seventh Day Adventist and Catholic groups. Community OVC initiatives have proliferated recently, with 52% established since 1999. The proliferation was strongest in Namibia (78% during 1999-2002) and Malawi (65%). It was also strongest amongst Pentecostal groups (64%) and amongst Congregations (59%). Large numbers of volunteers are involved in community-based responses, suggesting strong community ownership of responses. (Community-based responses are compared to institutional responses in Table 1.)

FBOs provide a broad range of community-based services. Most initiatives provide more than one service. Congregations were more likely to provide material support, home visiting and day care centers. They were less likely to provide HIV prevention, medical care, income generation/vocational training, community schools, madrassa religious education or promotion of fostering compared to other FBO groups. It is evident that RCBs and NGOs are more engaged in school fees support than CBOs and congregations. This is partly explained by the fact that school sponsorship requires relatively large sums of money. CBOs and congregations instead concentrate on support activities that require less financial resources, such as home visits, food support, and counseling. The types of community-based activities carried out by FBOs are described in Figure 4.

Table 1: Comparison of Institutional and Community-Based Responses

	Overall	Institutional Responses	Community-based Responses
No. FBO OVC responses	505	91 (18%)	414 (82%)
Urban	53%	66%	50%
No. OVC supported	139,409	17,567 (13%)	121,842 (87%)
Av. OVC per response	432	241	495
No. Volunteers	7,885	360 (5%)	7,524 (95%)
Established since 1997	47%	31%	52%
Faith groups with highest rates for institutional and community-based responses respectively		Muslim (26%) Pentecostal (26%) Other Protestants (21%)	Anglican (95%) SDA (86%) Catholic (81%)

1. Material Support
Material support was the commonest OVC support activity, provided by 71% of FBOs. This support includes the provision of clothing, food or meals. Material support by FBOs is more prevalent in poorer countries — 96% of FBOs in Malawi and 75% in Uganda provide material support — and is provided more frequently by congregations than by other types of FBOs.

2. School Assistance
In order for children to attend school in the Study countries, fees and levies must be paid. Many FBOs provide vulnerable children with fees, for primary and sometimes for secondary, vocational and tertiary education. Some programs also provide uniforms, equipment, books and boarding fees. Many RCBs and NGOs that operate some distance from affected communities provide educational support to individual children as an isolated activity without the provision of psychosocial support or household economic strengthening activities.

3. HIV prevention
Just over half of FBOs were involved in increasing awareness of HIV amongst vulnerable children and providing moral guidance. It was difficult to assess the effectiveness of HIV prevention activities. Few initiatives provide sexual and reproductive health life skills, or information about the provision of condoms and accessing treatment for sexually transmitted infections. Only a handful of FBOs sought to promote HIV testing as a preventive measure.

4. Visiting / Home-Based Care
Volunteers identify needy families in their neighborhood and regularly visit affected households. Some OVC visiting programs have developed from home-care programs for the terminally ill. Some of the most vulnerable households such as child-headed households are visited several days a month or even daily, with volunteers becoming like surrogate parents. Visitors provide advice and household supervision, prepare meals, eat together with children, help in maintaining dwellings and assist in household agriculture or income generating activities.

5. Counseling and Psychosocial Support
Many FBO initiatives specifically provide counseling and psychosocial support activities to address psychosocial needs of children. Examples of such activities include sports and cultural activities that involve both vulnerable children and other members of the community, or counseling provided to specific children.

6. Medical Care
Some initiatives enable vulnerable children to access essential medical support through the provision of medical fees or medicines.

7. Income Generation and Vocational Training
Some initiatives establish income-generating projects in order to raise money for school fees to support vulnerable children. Projects include nutrition gardens, husbandry projects, manufacturing co-operatives and buying-and-selling initiatives. Many projects also serve an important role by providing children and youth with experience in managing projects and training in specific vocational skills. Additionally, such activities bring together volunteers to discuss their work.

8. Day Care Centers
These provide stimulation, care and food for pre-school children during the day, often whilst caregivers are working

9. Religious Education
A number of Muslim initiatives specifically provided education for OVCs through religious schools (Madrassas).

10. Community Schools and Child Development Centers
Some groups set up education facilities to provide basic education at primary level to vulnerable children who would otherwise be out of school.

11. Promotion of Foster Care
Some programs specifically encourage fostering and adoption by persons unrelated to orphaned children and identify and screen potential foster parents.

B. Institutional Responses

Two main categories of institutional responses were established, predominantly in urban areas (Appendix, Table E):

1. Residential children's homes
Residential institutions, also referred to as orphanages, provide shelter, food, clothing and medical care for vulnerable children. Most provide school fees to enable residents to attend nearby schools, though some provide schooling to residents. Some also provide vocational training and HIV prevention activities.

2. Street Children Shelters
These provide temporary accommodation and food for street children. Some also provide education, vocational training and HIV prevention activities

Institutional responses were commonest in Kenya (33% of initiatives) and Malawi (16%) and least common in Uganda (9%) and Namibia (7%). This may be a reflection of whether there are national policies on institutional care, whether FBOs have connections with religious groups outside Africa and whether strong community-based OVC responses are present in various countries. Institutional responses were most commonly established by Muslim, Pentecostal and "other Protestant" groups. Institutions are being established with increasing frequency, as 35% of those noted in the study have been established since 1999. Proportionately fewer volunteers are involved in institutional compared to community-based responses, suggesting less community ownership of institutional responses (Table 1).

Organizational Capacity of FBOs

A capacity assessment was carried out on 192 Congregations, 34 CBOs, 7 NGOs and 7 RCBs. The assessment consisted of 30 questions in eight areas of organizational development: governance, financial systems, human resources, community ownership, service delivery, administration, financial support, and technical support. Overall differences in average scores between the four categories of FBOs were relatively small. FBOs in Kenya and Namibia had higher capacity scores than Uganda and Malawi (69% & 67% vs. 62% & 57% respectively). Capacity scores for technical and financial support and administration were significantly lower for congregations and CBOs compared to NGOs and RCBs.

Expansion of Activities

Despite resource constraints, nearly all congregations and CBOs expanded their initiatives in terms of range of activities, number of children supported and geographical areas covered. In view of growing numbers of vulnerable children, most FBOs wished to expand their initiatives further but faced constraints.

Lack of funds was the major limitation facing 52% of FBOs. Funds were required to provide direct assistance to children for school uniforms or food, or to provide incentives or transport costs for volunteers. Funds were also needed in some instances for operational costs such as salaries and office equipment. Few FBOs have sufficient human resource capacity to address burgeoning numbers of OVC, and some require salaried personnel to expand their activities.

The need for training on project implementation and on OVC interventions was cited by 21% of FBOs. Members of congregations understand what is needed to support OVC and are eager to respond, but often lack confidence concerning the range of "best practice" activities and strategies. This weakness within FBOs was echoed by interviews with HIV/AIDS personnel at national level. Congregations are well placed to spearhead community responses to OVC, but they need structures and tools to sustain and manage projects. Accountability and monitoring were mentioned as crucial elements of project management needed to develop FBO programs. The provision of training alone was deemed insufficient to expand programming and could lead to community groups' feeling frustrated in their ability to deliver quality services unless the training is accompanied by injections of resources to build the capacity and sustainability of their initiatives.

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conclusions & recommendations

This is the first study of community-level OVC responses in Africa. It is also one of the first to draw attention to the characteristics and distinctive roles of RCBs in responding to HIV/AIDS and orphans and vulnerable children. Analysis of data obtained from the studies led to the following conclusions:

Community-Level Responses

Local Faith-based OVC responses are proliferating
Researchers had little difficulty identifying FBOs with OVC activities. Over 97% of congregations interviewed in the Study countries had OVC activities. Yet these 301 congregations represent less than 0.25% of the estimated 150,000-plus congregations in the Study countries. Faith-based OVC responses are widespread throughout Africa and are more prevalent than was imagined prior to the Study. FBOs are coping with the epidemic by adapting, not simply relying on existing, customary systems but responding to changing situations by developing new approaches. This finding runs contrary to the widespread belief that communities with severe epidemics are disintegrating and support systems are faltering.

Most OVC activities are initiated by community members
Congregations started initiating responses to children affected by AIDS during the 1990's. Recently, the trickle became a flood. Nearly two-thirds of congregational responses were established in 1999-2002. This proliferation occurred without significant external facilitation or financial support. Few congregational responses in this Study resulted from community mobilization as part of OVC projects implemented by RCBs or NGOs. This reflects the motivation of local religious groups who commit their own time and resources to ensure the future well-being of vulnerable children. Responses were initiated after seeing growing numbers of children who were going hungry, lacking adequate clothing, not going to school, lacking spiritual or parental guidance, or were exploited, abused, raped or pregnant.

It is also important to note that while many congregational initiatives begin by targeting children in their own faith, most of them quickly transform to provide support to any family prioritized for assistance by the wider community.

Congregations and CBOs are supporting significant numbers of OVC
In the past, proponents of scaling-up have argued that, in view of their idiosyncratic nature, it is inappropriate to support small-scale OVC initiatives. This has led to community initiatives being overlooked as potential partners by external agencies. In this Study, most congregations and CBOs supported less than a hundred OVC. However, many of the smaller initiatives were established recently and are still expanding. Though most congregations and CBOs support small numbers of children, the cumulative impact of thousands of such initiatives is considerable. In addition, there were 86 medium-sized initiatives supporting between 100 and 999 OVC and 11 large-scale initiatives supporting over 1,000 OVC. The 55 largest congregational responses supported more OVC than the 31 NGOs documented in the Study.

Community-level FBOs are responding in similar ways
Over 85% of recently established initiatives were community-based. Most community responses involve the provision of religious support, material and educational assistance, HIV prevention, home visiting and counseling. Most initiatives are supervised by regularly convened committees. Almost all initiatives rely on volunteers - in some cases, every member of a congregation is involved in OVC support activities. The activities and structures of congregational initiatives were remarkably similar throughout the Study countries. Yet most had never visited or read a description of another congregation's initiatives. Community responses were initiated without literature reviews, situation analyses or fact-finding visits to model programs. The fact that so many different yet unconnected groups have developed similar OVC initiatives suggests that homegrown approaches based around community priorities are the most appropriate and sustainable responses to the crisis.

Community-level FBOs are well organized
One reason why little financial support has been provided to community groups is that such groups are said to lack capacity to manage grants. The Study demonstrates this notion is erroneous. Governance and financial systems of FBOs, including many small, newly established OVC initiatives, were as well-organized as those of larger NGOs and RCBs. Transparent financial administration and clear lines of authority are essential elements of volunteer-driven organizations. Organizations lacking these components are unlikely to succeed in mobilizing communities and maintaining volunteer-driven responses. The fact that religious groups have established and expanded their initiatives despite limited financial and human resources is an illustration of their organizational ability.

Community OVC initiatives probably have limited long-term impact
The main thrust of the Study was to document the nature of FBO OVC responses through collecting data from service providers. FBO community initiatives have improved the situation of thousands of vulnerable children, their families and communities. Positive changes that have been brought about by OVC initiatives and which are observable to community members include:

- increased morale amongst vulnerable households as a result of the provision of spiritual, material and psycho-social support
- the establishment of income-generating projects
- a strengthened community social safety net, through increased support to vulnerable families
- employment provision, assistance with agricultural and domestic tasks or house construction, and in-kind or cash contributions
- reduced stigma through regular visiting of households affected by HIV/AIDS
- a noticeable increase in the number of children who have returned to school
- better adjusted children, involved in social, cultural, educational and sporting activities
- reduction in sexual abuse and physical exploitation through increased child protection.

Though FBO OVC initiatives are prevalent, it is likely that the amount of support provided per affected household is much less than what is needed to enable families to function adequately in meeting children's needs. The desire of most groups to expand their activities is in part a reflection of the limited ability of most community OVC initiatives to substantially improve the situations of destitute households over time.

Community-level FBOs need external financial support
Community members are constantly aware of families that need essential material support. In the poorest situations, the provision of material support by initiatives to destitute households was ubiquitous. This is an indication on the priority placed upon material support as an intervention by congregations and CBOs. Yet, paradoxically, community initiatives that have excessive demands placed upon their philanthropy are also those that have the fewest financial resources.

Many congregations indicated that their only source of support consisted of contributions made by the members of their congregations. Faith-based community groups raise finances and materials to contribute to the families of vulnerable children through congregational collections and contributions from volunteers. Since many of the volunteers are also caring for orphans, it seems that in these self-resourced initiatives, the beneficiaries and donors are virtually identical. As a result, the actual amounts of money raised by many initiatives are small and the ability of initiatives to provide meaningful material support to destitute families is limited. A few congregations received funding from their RCBs but due to inadequacy of resources at RCB level, funds received were minimal and did not meet the needs of the ever-increasing numbers of the OVC.

The Role of Religious Coordinating Bodies

RCBs differ in structure, function and size
The diverse structure, function and terminology of religious organizations poses a problem to agencies trying to understand and work with FBOs. Some congregations, traditional and independent groups for instance, have no bodies responsible for coordinating their activities. Organizations such as some Pentecostal, Baptist and Muslim groups have RCBs that are single-tier networking bodies that function without offices and rely on volunteers to enable coordination of their activities. Larger denominations are often supervised by RCBs responsible for appointing clergy and supporting the religious functioning of congregations. In some cases, these structures are quite complex. Catholic and Anglican denominations, for instance, have hierarchical structures and several tiers of RCBs with national and provincial-level RCBs supervising lower-level RCBs rather than congregations.

RCBs thus differ markedly in terms of their structure, function and the number of congregations they supervise or coordinate. Some groups are responsible for supervising a dozen congregations, while others coordinate several hundred. One reason why RCBs have received little external support in the past is because it is difficult for outsiders to understand their distinctive organizational structures.

Some RCBs have established OVC initiatives
Many RCBs were involved in the provision of support to OVC, though this took several forms.

- Some RCBs implement their own projects that directly support vulnerable children. Activities typically involved scholarship programs or institutions to cater for OVC needs such as schools, orphanages, and baby homes. This mechanism of support frequently was associated with narrowly targeted interventions and limited involvement of affected families, communities and congregations. Many RCB projects do not tap existing community resources to strengthen their own initiatives. The approach of targeting individual children puts these interventions at risk of remaining detached from communities, and thereby communities seeing the OVC problem as a responsibility of external agencies.
- Other RCBs facilitate implementation of programs through their local congregations. In a few cases, RCBs had designated personnel responsible for OVC issues. While congregations implement these responses, they are primarily RCB initiatives, because RCBs negotiate with donors and mobilize congregations as partners to implement projects.
- Relatively few RCBs established OVC programs that recognized the crucial role of congregations as main service providers and that sought to provide congregations with essential technical and material support. However, some of the largest OVC support programs such as Catholic AIDS Action in Namibia (supporting 14,500 OVC) and the Livingstonia Synod AIDS Control Program in Malawi (12,056 OVC) functioned on the basis of working extensively with congregations.

Need for development of RCB HIV/AIDS and OVC programs

Many RCB programs, like their NGO counterparts, lack best practice procedures. Service delivery components such as written plans, monitoring systems, record keeping and reporting were limited in scope. Many FBOs function on the basis of motivation and trust, responses based on a "good heart" to help, rather than on being an effective or efficient organization or program. One common feature of RCBs is the tendency to employ trusted "religious persons" rather than professionally qualified staff in their programs. These approaches favored by FBOs may lead to programs that are no less effective than those of NGOs. However, the Study highlighted the need to strengthen RCB programming through the provision of technical and financial support.

Many RCBs are unaware of their own congregations' OVC initiatives

The main functions of RCBs are to supervise and provide support to religious leaders of congregations, organize meetings to bring together leaders of congregations and administer religious networks. Many RCBs were unaware of the fact that their own congregations were implementing OVC programs. Of those that were aware, most provide little financial and technical support to the congregations that are implementing OVC activities. This was largely a consequence of limited resources since most RCBs have few staff and lack the necessary knowledge and skills to provide technical support to strengthen HIV/AIDS-related activities implemented by local congregations.

RCBs are well situated to provide technical and financial support to congregations

Increasingly, RCBs are establishing committees, appointing full time staff and initiating programs to respond to HIV/AIDS and support vulnerable children. Congregational initiatives are also proliferating and requesting that support be provided from their denominations and religious networks. Yet, surprisingly, a disconnection exists between responses at different levels. External agencies have an opportunity to facilitate OVC responses by enabling RCBs to map their own congregations' initiatives and to provide congregations with appropriate support. The provision of technical support allied with small grants of a few hundred dollars to community groups could help congregations do immeasurably more than at present.

In terms of community development, RCBs have a considerable "multiplier" advantage over NGOs. Most NGO probably have no more than a dozen or so active partnerships with community groups for project delivery. Yet most RCBs have at least a hundred congregations in their network and some of the largest bodies reach thousands of individual congregations. RCBs occupy a strategic position in relation to scaling up OVC responses. Development organizations should partner with inter-religious groups to carry out efficient mapping of these religious networks.

Recommendations

At an end-of-study workshop in May 2003, representatives of the study teams in all six countries, as well as WCRP and UNICEF, developed the following summary recommendations based on the overall findings from the study process.

Donors and External Religious Partners

1. In view of the difficulty of working with strict donor project proposal and reporting requirements, these need to be made more flexible and accessible to FBOs.
2. Donors should recognize and utilize existing faith-based structures and work with the appropriate tier of RCBs to ensure that support reaches communities.
3. Donors should seek to identify the comparative advantages of FBOs and utilize their strengths.
4. UNICEF is well positioned to involve FBOs in networking and training activities alongside other partners with existing FBO networking.
5. Donors that have been more involved in HIV prevention than OVC activities should earmark FBO funding for OVC care/support and capacity building in addition to prevention activities.
6. Congregations have the capacity to implement OVC support activities and receive funds but most receive no external support. Funding should therefore be provided through small grants funds operated by RCBs to support activities initiated by congregations. Donors should ensure that a majority of RCB funding is spent at community level.
7. External support needs to be guided by experience of local religious partners rather than programs being designed by external partners with little local involvement.

Religious Coordinating Bodies and Congregations

1. Since RCBs are often unaware of the existence of effective programs run by RCBs in other religious communities, inter-religious collaboration and networking should be encouraged.
2. RCBs should be enabled to better understand the OVC responses of congregations belonging to their religious network through involvement in mapping exercises.
3. RCBs are well placed to provide technical support and build the capacity of congregational OVC responses through training, resource mobilization and documentation. RCBs may need external assistance to carry out such programs.
4. Leaders of religious organizations are well positioned to influence the practices of their member FBOs as well as government institutions, and they should advocate publicly for child rights, stigma reduction, behavior change, policy development, and increased resource allocation to religious bodies and governmental institutions for OVC programs.
5. FBOs need to recognize and utilize community resources for OVC care and support.
6. FBOS at all levels should increase the participation of children, youth and people living with HIV/AIDS in program design and implementation.
7. FBOs should be encouraged to establish committees to guide the development of OVC and HIV/AIDS initiatives.

appendix

Table A: Details of Study Subjects by Country

	Kenya	Uganda	Mozambique	Malawi	Namibia	Swaziland	Total
Number of Interviews							
RCB Interviews	16	78	33	14	16	4	161
Congregation Interviews	139	71	55	49	52	44(3)	410
CBO Interviews	13	15	14	2	13	6	63
NGO Interviews	3	30	3	3	10		52
Total Organizations Interviewed	171	194	105	68	91	57	686
FBOs without OVC Initiative	0	10 (5%)		1 (2%)	8 (8%)	3 (6%)	22 (4%)
Study Sites Urban	118	94	96	26	27	44	405
Rural	53	100	9	42	39	10	253
% Urban	(69%)	(48%)	(91%)	(38%)	(41%)	(81%)	(62%)
Children: Interviews	57	1					
Focus Group Discussion	10	25	20	24	38		
Informants: Interviews	36	22	43	16			
Focus Group Discussion	3	2					

Table B: Religious Affiliation of RCBs and Congregations by Country

	Kenya		Uganda		Mozambique		Malawi		Namibia		Swaziland		Total	
	R	C	R	C	R	C	R	C	R	C	R	C	R	C
TOTAL	**16**	**139**	**78**	**71**	**33**	**55**	**14**	**49**	**16**	**52**	**4**	**44**	**161**	**410**
Bahai	1	0	0	1	1	0	0	0	0	0	1	1	3	2
Hindu	0	2	0	1	1	0	0	0	0	0	0	0	1	3
Muslim	2	33	15	8	4	7	2	6	0	1	0	1	23	56
Unspecified/ Other	0	1	1	0	4	4	0	0	0	1	0	0	5	6
Total Christian	13	103	62	61	23	44	12	43	16	50	3	42	129	343
Catholic	0	23	18	9	1	17	1	12	5	12	1	3	26	76
Anglican	0	9	32	20	1	2	3	4	1	4	0	1	37	40
Pentecostal	0	17	0	3	11	13	2	10	1	12	0	3	14	58
Other Christian	11	46	8	26	7	10	3	10	6	22	0	26	35	140
Seventh Day Adventist	2	8	3	3	1	2	1	3	0	0	1	2	8	18
Inter-denominational	0	0	1	0	2	0	2	4	3	0	1	7	9	11

R = Religious Coordinating Body C = Congregations

Table C: Religious Affiliation of Faith-based NGOs and CBOs by Country

	Kenya		Uganda		Mozambique		Malawi		Namibia		Swaziland		Total	
	NGO	CBO	NGO	CBO	NGO	CBO	NGO	CBO	NGO	CBO	NGO	CBO	NGO	CBO
TOTAL	**3**	**13**	**30**	**15**	**3**	**14**	**3**	**2**	**10**	**13**	**3**	**6**	**52**	**63**
Muslim	0	4	3	2	0	3	0	2	0	0	0	0	3	11
Unspecified	3	0	8	0	0	2	0	0	3	13	0	0	14	15
Total Christian	0	9	19	13	3	9	3	0	6	0	3	6	35	37
Catholic	0	0	6	8	0	0	1	0	1	0	0	0	8	8
Anglican	0	0	2	3	0	0	0	0	1	0	0	0	3	3
Pentecostal	0	0	0	0	1	4	0	0	1	0	0	0	2	4
Other Christian	0	0	0	1	0	0	1	0	0	0	0	1	1	2
Seventh Day Adventist	0	0	1	0	0	0	0	0	0	0	0	0	1	0
Inter-denominational	0	9	10	1	2	5	1	0	4	0	3	5	20	20

Table D: Community -Based OVCs Responses by Country

	Kenya		Uganda		Mozambique		Malawi		Namibia		Swaziland		Total	
	C	other	C	other	C	other	C	other	C	other	C	other	C	other
Number FBOs	95	21	65	102			40	15	44	32	32	9	276	179
Religious Group:														
Muslim	22	5	6	17			3	1	1	0	1	0	33	23
Anglican	7	0	20	35			4	3	4	2	1	0	36	40
Catholic	16	0	9	23			11	2	12	5	2	0	50	30
Pentecostal	10	0	2	0			9	2	9	2	2	0	3	4
Other Christian	38	14	27	18			13	7	17	9	25	8	120	56
Other	2	0	1	0			0	0	1	0	1	1	5	1
Not defined	0	2	0	9			0	0	0	14	0	0	0	25
Establishment														
pre-1991	17	4	4	18			0	3	0	0	3	0	24	25
1991 - 1994	4	3	5	10			3	0	1	1	0	0	13	14
1995 - 1998	16	5	13	14			7	1	1	7	7	2	44	29
1999 - 2002	49	6	18	13			17	9	20	15	14	7	118	50
Not known	9	3	25	47			13	2	22	9	8	0	77	61
Location														
Urban	60	18	23	55			11	10	18	1	25	8	137	92
Rural	35	3	42	47			29	5	24	11	7	1	137	67
No. children	20,972	6,046	7,002	31,607			10,290	20,056	819	25,050	1,300	516	40,383	83,275
(no. respondents)	(70)	(8)	(43)	(71)			(27)	(2)	(14)	(11)	(26)	(5)	(154)	(92)
No. volunteers	886	59	284	1,896			1,169	175	388	2,667	137	106	2,874	4,903
(no. respondents)			(15)								(15)	(3)		
Av. capacity score	61	64	0	55			49	0	67	60	49	56	58	58
(no. respondents)	(145)	(13)		(11)			(38)		(9)	(12)	(24)	(8)	(192)	(36)
Type of Support Activity Number														
1. Material Support	67	10	55	70			39	14	24	14	31	7	216 (76)	115 (69)
2. School Assistance	71	13	43	67			18	5	15	11	24	4	171	100
3. HIV Prevention	43	13	11	44			34	12	30	25	22	7	140	101
4. Visiting / home-based care	48	10	29	35			10	5	22	18	22	6	131	74
5. Counselling	30	1	20	38			19	5	12	12	16	6	97	62
6. Medical Care	19	4	19	47			6	3	4	11	6	3	54	68
7. Income Generation	15	2	4	28			18	8	0	11	4	2	41	51
8. Day Care Centers	9	0	0	2			11	2	11	12	3	3	34	17
9. Madrassa Rel. Education	5	0	7	11			2	0	0	0	0	0	14	11
10. Community Schools	1	3	0	11			3	0	3	1	2	2	9	17
11. Promotion of Fostering	0	0	5	3			1	2	0	0	6	1	12	6

Other: CBOs, NGOs and RCBs

Table E: Orphanages and Shelters Established by FBOs

	Kenya		Uganda		Mozambique		Malawi		Namibia		Swaziland		Total	
	C	other	C	other	C	other	C	other	C	other	C	other	C	other
FBOs with shelter/ orphanage	44	11	3	14			8	4	2	5	9	4	66	38
Religious Group:														
Muslim	11	1	0	2			3	3	0	0	0	0	14	6
Hindu & Bahai	1	1	0	0			0	0	0	0	0	0	1	1
Christian	32	8	3	10			5	1	2	2	9	4	51	25
Anglican	2	1	0	2			0	0	0	0	0	0	2	3
Catholic	7	0	0	5			1	0	0	1	1	1	9	7
Pentecostal	7	1	1	1			1	1	0	0	0	0	9	3
Other Christian	16	6	2	2			3	0	2	1	8	3	31	12
Not known	0	1	0	2			0	0	0	3	0	0	0	6
Establishment														
pre-1991	8	1	0	7			3	0	0	0	2	1	13	9
1991 - 1994	5	2	0	4			1	2	0	0	0	0	6	8
1995 - 1998	12	2	2	1			2	0	0	0	2	0	18	3
1999 - 2002	13	4	1	1			1	1	1	1	4	3	20	10
Not known	6	2	0	1			1	1	1	4	1	0	9	8
Location														
Urban	30	9	3	9			2	3	2	0	8	3	45	24
Rural	13	2	0	5			6	1	0	1	1	1	20	10
No. children	4,740	2,666	330	7,738			815	830	238	210	405	1	6,528	11,445
(no. respondents)	(42)	(6)	(3)	(9)			(7)	(3)	(2)	(2)	(7)	(1)	(61)	(21)
No. volunteers	173	39	10	51			15	1	10	62	54	2	262	155
(no. respondents)	(19)	(3)	(1)	(4)			(3)	(1)	(1)	(2)	(6)	(1)	(30)	(11)
Av. capacity score	61	69	0	66			61	0	0	78	59	48	61	66
(no. respondents)	(44)	(7)		(1)			(6)			(1)	(9)	(2)	(59)	(11)
% of FBOs with institutional response	33	34	4	11			16	21	4	13			19	17

Other: CBOs, NGOs and RCBs

Table F: Orphan Estimates for Study Countries, 2000 - 2010

	Adult HIV Prevalence%	Population (million)	Number Children 0 - 14 years	Total Orphans as % of all Children	Total Number of Orphans all Causes	Total Number of Orphans due to AIDS
2001						
Kenya	15.0	30.1	13,428,000	12.4	1,659,000	892,000
Malawi	15.0	10.9	6,350,000	17.5	937,000	468,000
Mozambique	13.0	19.7	6,196,000	15.5	1,274,000	418,000
Namibia	22.5	1.7	780,000	12.4	97,000	47,000
Swaziland	33.4	1.0	388,000	15.2	59,000	35,000
Uganda	5.0	21.8	11,852,000	14.8	1,732,000	894,000
2010						
Kenya		35.2	14,708,000	14.3	2,099,000	1,541,000
Malawi		13.9	6,305,000	18.2	1,150,000	741,000
Mozambique		23.1	9,340,000	19.5	1,820,000	1,084,000
Namibia		1.9	851.000	18.3	156,000	118,000
Swaziland		1.3	393,000	22.1	87,000	71,000
Uganda		29.8	16,253,000	9.8	1,554,000	805,000