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Faith-based organizations (FBOs) have a long tradition of providing HIV/AIDS prevention and mitigation services in Africa. The overall response of FBOs, however, has been controversial, particularly in regard to HIV/AIDS prevention and FBO’s rejection of condom use and promotion, which can conflict with and negatively influence national HIV/AIDS prevention response efforts. This article reports the findings from a study that explored the factors influencing the HIV/AIDS prevention policy process within faith-based non-governmental organizations (NGOs) of different faiths. These factors were examined within three faith-based NGOs in Dar es Salaam, Tanzania—a Catholic, Anglican and Muslim organization. The research used an exploratory, qualitative case-study approach, and employed a health policy analysis framework, examining the context, actor and process factors and how they interact to form content in terms of policy and its implementation within each organization. Three key factors were found to influence faith-based NGOs’ HIV/AIDS prevention response in terms of both policy and its implementation: (1) the faith structure in which the organizations are a part, (2) the presence or absence of organizational policy and (3) the professional nature of the organizations and its actors. The interaction between these factors, and how actors negotiate between them, was found to shape the organizations’ HIV/AIDS prevention response. This article reports on these factors and analyses the different HIV/AIDS prevention responses found within each organization. By understanding the factors that influence faith-based NGOs’ HIV/AIDS prevention policy process, the overall faith-based response to HIV/AIDS, and how it corresponds to national response efforts, is better understood. It is hoped that by doing so the government will be better able to identify how to best work with FBOs to meet national HIV/AIDS prevention targets, improving the overall role of FBOs in the fight against HIV/AIDS.

Keywords HIV; prevention; policy process; faith-based organization; non-governmental organization; religion
Introduction

Faith-based organizations (FBOs) have a long tradition of providing HIV/AIDS prevention and mitigation services in Africa (Byamugisha et al. 2002; Liebowitz 2002; Chikwendu 2004). In Africa, it is currently estimated that one in five HIV/AIDS organizations is faith-based, and 30–70% of all healthcare provision and education is provided by FBOs (Olivier et al. 2006; Casale et al. 2010). FBOs, however, are not a homogenous group and FBOs’ overall response to HIV/AIDS has not been without controversy. While many have recognized FBOs’ positive contribution to HIV/AIDS, particularly in the area of HIV/AIDS care and support, some FBOs’ response to HIV/AIDS has been criticized for undermining overall response efforts (Liebowitz 2002; Tiendrébeogo and Buyckx 2004; Dilger 2009; Casale et al. 2010; Dilger et al. 2010). Such criticisms have predominantly focused on FBOs’ role in HIV/AIDS prevention (Tiendrébeogo et al. 2004; Casale et al. 2010).

According to Casale et al. (2010), FBOs’ involvement in HIV prevention has been limited compared with HIV/AIDS-related care, and arguably less effective. One explanation for these limitations are the theological and health challenges inherent in issues surrounding sexual behaviour, particularly around condom promotion and use and sex outside marriage—each essential for HIV prevention, which have led to different responses to HIV/AIDS prevention among FBOs (Casale et al. 2010). Some FBOs, for example, are depicted as condemning condom use completely, advocating instead for abstinence and fidelity, whereas others are depicted as accepting of, and sometimes promoting, condoms. These diverse messages found among FBOs can lead to confusion within the community about effective and appropriate HIV/AIDS prevention strategies, particularly around the use of condoms (Casale et al. 2010).

Generalizations about FBOs’ HIV/AIDS prevention responses are unhelpful as they create an inaccurate picture of FBOs’ HIV/AIDS response efforts. Responses are influenced by a number of inter-related and sometimes conflicting factors, particularly issues surrounding ‘religious doctrines, ethics, morality and the official positions of religious hierarchies’ (Tiendrébeogo and Buyckx 2004, p. 8); in addition to wider contextual factors such as the socio-cultural environment, biomedical discourse, availability of resources and locally identified needs (Parker and Birdsall 2005; Casale et al. 2010). As a result, to understand the faith-based response to HIV/AIDS, and how this might affect national and international prevention and mitigation efforts, there is a need for a more detailed understanding of FBOs’ response towards HIV/AIDS and the factors and processes influencing this response.

This article reports the findings from a study that explored the factors influencing the HIV/AIDS prevention policy process within faith-based non-governmental organizations (NGOs) of different faiths within Dar es Salaam, Tanzania, with the aim of developing a better understanding of FBOs’ HIV/AIDS prevention responses (Morgan 2011). By understanding these factors, it is hoped that a better understanding of how the faith-based response to HIV/AIDS relates to the national HIV/AIDS response in Tanzania can be developed. It is also hoped that the findings will have wider applications to contexts outside of Tanzania, such as FBOs within different countries or within secular organizations with similar processes or factors influencing their response efforts. The article begins by providing an overview of the methods and the study context, including a description of each organization studied. The article concludes with a discussion of the key factors found to influence the organizations’ HIV/AIDS prevention policy processes and responses, the way these factors interact to influence their responses, the reasons for the different responses found within the organizations, and how these responses relate to national response efforts.

Methods

Study setting

Within Tanzania, Christian and Muslim communities are each estimated to account for 30–40% of the population, with the remaining population made up of members from other faiths and traditional indigenous religions (Bureau of Democracy, Human Rights, and Labour 2007, 2008; Zou et al. 2009; World Factbook 2011). According to the International Religious Freedom Report, however, ‘recent information suggests that 62% of the population is Christian, 35% is Muslim, and 3% percent are members of other religious groups’ (Bureau of Democracy, Human Rights, and Labour 2009). While there is a lack of information regarding Christian and Muslim involvement in HIV/AIDS, there is evidence to suggest that Christian
FBOs are the most active (among FBOs) in HIV/AIDS prevention and mitigation, and Muslim FBOs are increasingly becoming more involved (Tiendrebeogo and Buyckx 2004).

FBOs play a major role in health service provision in Tanzania. Christian FBOs have traditionally played a more prominent role in Tanzania than Muslim FBOs. According to the Annual Health Statistical Abstract 2008, there are 223 hospitals, 565 health centres and 4940 dispensaries in Tanzania. The government is the main provider of health services, providing ~67% of all health services, the remaining 33% being provided by Christian FBOs, parastatal organizations and private organizations (MOHSW and WHO 2007; DPP 2008; MoFA and GoT 2009). According to data from the Annual Health Statistical Abstract, the government and FBOs each own 40% of hospitals (DPP 2008). At the highest level of health care, there are four referral and four specialized hospitals. Government owns and operates six of these hospitals—the remaining two are owned and operated by Christian FBOs (MOHSW and WHO 2007). All Christian FBO health facilities in Tanzania are co-ordinated by the Christian Social Services Commission (CSSC). It is estimated that there are ~700 hospitals and dispensaries currently under CSSC in Tanzania. Muslim involvement in health care and HIV/AIDS is much more minimal. Compared with Christian organizations, there are very few hospitals or healthcare facilities that are run by Muslim organizations in Tanzania, particularly locally run organizations. According to Leurs et al. (2011), for example, BAKWATA (the National Muslim Council of Tanzania) runs 110 dispensaries within Tanzania.

Tanzania’s HIV prevalence rate is estimated to be 5.7% (TACAIDS et al. 2008); however, this national average masks the variation within the country. In Zanzibar, the HIV prevalence rate is reportedly below 1.0%, whereas on the mainland the prevalence rates range from 2 to 13% (TACAIDS et al. 2008). The HIV/AIDS prevalence rate in Dar es Salaam, the study site, is estimated to be 9.3% (TACAIDS et al. 2008). Tanzania’s national HIV/AIDS response has evolved since 1983 when the first AIDS cases were reported. Currently, it is framed around the National Multi-Sectoral Framework (NMSF) on HIV/AIDS (the main policy document) and the National Policy on HIV/AIDS.

The first priority of the NMSF is the reduction of new HIV infections (URT-PMO 2007). The NMSF outlines nine prevention areas, the strategies of which aim to decrease the risk of infection among the general population. These include:

1. Promotion of abstinence, delayed sexual debut, partner reduction and consistent condom use among young people in and out of school.
2. Reduction of risk of HIV infection among the most vulnerable populations.
3. Expansion of workplace interventions, with special attention for mobile and migrant workers.
4. Prevention, treatment and control of other sexually transmitted infections.
5. Promotion and expansion of HIV testing and counselling services.
6. Prevention of mother-to-child transmission (PMTCT) of HIV.
7. Promotion and distribution of condoms.
8. Prevention of HIV transmission through blood transfusion, exposure to contaminated body fluids and contaminated instruments.
9. Introduction of new prevention interventions such as male circumcision.

The role of civil society, including FBOs, within HIV/AIDS prevention is recognized within the NMSF. According to the NMSF, civil society is made up of NGOs, FBOs and community-based organizations, of which there are several thousand involved in the HIV/AIDS national response in Tanzania (URT-PMO 2007). The NMSF recognizes that state actors cannot implement the national response alone, and that civil society organizations (CSOs) ‘across the country are important implementation partners and complement the government driven intervention initiatives’, already having made substantial contributions to the national response (URT-PMO 2007, p. xv).

Although the potential role of civil society is recognized within the NMSF, the policy also recognizes that the rapid development and increase in CSOs, as witnessed throughout the last two decades, has at times created challenges with regard to the control and quality of services and interventions, as well as the supervision of CSOs. According to the NMSF, improving adherence to the national guidelines and improving the standards of quality among CSOs continue to remain a challenge.

While the NMSF recognizes the involvement of FBOs in the national HIV/AIDS response, it is clear that the government is critical of FBOs’ involvement in HIV prevention, especially with regard to some FBOs ‘disabling’ views regarding commercial sex activities and condom promotion (URT-PMO 2007). For example, the NMSF identifies unbalanced condom messages regarding their effectiveness in the prevention of HIV infection as a challenge to overall prevention efforts, as it leads to confusion among the population. The role of condoms with regard to discordant couples, where one or both partners is HIV/AIDS positive, is particularly recognized, as it is the only available method to reduce HIV infection apart from abstinence. Advocacy with religious leaders to be more tolerant towards condom use, especially in relation to discordant couples, is identified as a key strategy within the NMSF. The NMSF recognizes that overall more advocacy work is needed with FBOs ‘to provide greater understanding of the dynamics of the epidemic as well as the promoting of interventions that are evidence-based, culturally accepted and scientifically valid and with which they may not always agree with’ (URT-PMO 2007, p. 86). While all FBOs working in the area of HIV/AIDS have to operate within the framework, the NMSF does recognize that not all FBOs will support all recommended strategies due to their own convictions and mandates. According to the NMSF, in such cases, organizations are permitted to select their own preferences but are asked to ‘refrain from contradicting other elements of the NMSF’ (URT-PMO 2007, p. 86).

Data collection

This article presents findings from a wider study exploring the HIV/AIDS policy processes of faith-based NGOs (Morgan 2011). The research used a qualitative, comparative case-study approach and employed Walt and Gilson’s (1994) health policy
framework, which examines context, actor, process and content, and how they interrelate within the policy process. In particular, attention was given to the role of faith or religion within each of the above factors within the organizations’ HIV/AIDS prevention policy process and response. Walt and Gilson’s health policy framework was therefore used as a guiding framework to explore the factors that influenced the organizations’ HIV/AIDS prevention policy process and response, how faith or religion played a role within this process, and how the inter-relationship between the factors influenced the policy process and response.

Data collection took place from June 2009 to November 2009 in Dar es Salaam, Tanzania, and included 72 semi-structured interviews, document review and observation. Interviews included contextual interviews with governmental officials, NGO organizations, FBOs and donor officials. Interviewees were chosen based on their affiliation to HIV/AIDS NGOs or FBOs within Tanzania. In total, 44 interviews were conducted within the organizations. A breakdown of the interviews is presented in Table 1.

The number of interviews was informed by the number of key informants within each organization. Respondents were asked about the policy-making structures within the organization and the factors involved in decision-making within the HIV/AIDS prevention policy process and organizational response in relation to context, content, process and actor-related factors as outlined in Walt and Gilson’s health policy framework. Respondents were also asked about the role of faith or religion within each of the four factors. For example, respondents were asked about the role of the Church (where applicable), the role of national policy documents, the role of their own religious beliefs, the role of donors, and the HIV/AIDS prevention messages they discussed with clients or the community. Organizational policy documents were also analysed where applicable and available; these included organizational policies, constitutions and reports. In addition, observations of organizational meetings and environment were recorded and analysed. Both document and observations were analysed for influencing factors, in relation to context, process, actors and content.

Framework analysis was used to analyse the data (Ritchie and Spencer 1993; Spencer et al. 2003). Using the analysis steps outlined within framework analysis (e.g. indexing, charting, mapping and interpretation), the findings discussed below emerged from examining and comparing the different factors (and their inter-relationships) that were found to influence each organization’s HIV/AIDS prevention policy process and response. Through examining the data, these factors were interpreted by the authors as the three key factors which, through their inter-relationship, influenced the three organizations’ policy processes and responses.

Within this article, policy refers to organizational policy and refers to any policy that has to do with HIV/AIDS prevention. Here, policy is defined as both ‘formal and informal, explicit and implicit, [including] written documents, as well as reported intentions, promises and practices’ (WHO 2007, p. 23), including actors’ intentions and decisions not to act on a particular issue. This definition, therefore, includes both written and unwritten policy, which is expressed at the point of implementation. Response refers to the practice and actions of individuals within each organization at the point of implementation.

### Ethical approval

Ethical approval was granted from the Leeds Institute of Health Sciences Ethics Sub Committee and the National Institute for Medical Research in Tanzania. In addition, research clearance was granted from the Commission for Science and Technology in Tanzania. All participants received detailed information about the study, were informed their participation was voluntary and signed a consent form prior to participation.

### Study limitations

There are three main methodological limitations of this study. The first limitation is the lack of generalizability or representativeness typically found in case study research. As a result, the factors found within these organizations may be different from other faith-based NGOs working in the area of HIV/AIDS, which may make comparisons difficult. Along these same lines, we recognize that while the case studies selected are all faith-based NGOs working in the area of HIV/AIDS, organizational differences existed between the three cases, which affected comparison across the three cases. Second, it is possible that due to the nature of the topic, some respondents may not have informed the interviewer that they contravened organizational policy in practice, due to potential repercussions, which may have affected the study results.

Finally, data collection and analysis was restricted due to varying organizational access between the three organizations, which affected the role of observation as a data collection method and the organizational documents that were available. For example, only those events and documents that access was given to could be observed or analysed. With regard to organizational documents, the Catholic organization had many more documents than either the Anglican or Muslim organizations. At the same time, however, not all relevant documents were made available within each organization, while others simply lacked written policy documents. The level of access within each organization will, therefore, have affected the scope and depth of analysis within and between each organization.

The findings presented here are based on the interpretations made through data analysis. While this process was made as robust as possible, the authors recognize that due to the nature of qualitative research, alternative explanations due to emphasis placed on influencing factors, such as the role of donors or organizational environment, are possible.

### Table 1 Breakdown of interviews

<table>
<thead>
<tr>
<th>Type</th>
<th>Number</th>
</tr>
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<tbody>
<tr>
<td>Contextual</td>
<td>28</td>
</tr>
<tr>
<td>Catholic NGO</td>
<td>24</td>
</tr>
<tr>
<td>Anglican NGO</td>
<td>10</td>
</tr>
<tr>
<td>Muslim NGO</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>72</td>
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</tbody>
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Description of case studies
As stated earlier, three faith-based NGOs were included within this study. Organizations were selected based on the criteria below. To be considered faith-based, the organizations had to meet one or more of the following characteristics: (1) defined themselves as faith-based in their mission statement or objectives, (2) were formally affiliated with a religious body and/or (3) had a 'governance structure where selection of board members or staff is based on religious beliefs or affiliations and/or decision-making processes based on religious values' (Bano and Nair 2007; Jayasinghe 2007, p. 624). To be considered an NGO, the organizations also had to be non-profit and have aims and objectives developed to 'promote and realize collectively articulated ideas about the public good' (Berger 2003, p. 16). In addition, they had to be actively working in HIV prevention at the time of data collection. Only those organizations working at the local level were included in the study, meaning those organizations working at the regional or international level were excluded.

Catholic organization
The Catholic organization is a social service agency operating under the Roman Catholic Archdiocese. The organization provides care and support to people infected and affected by HIV/AIDS such as voluntary counselling and testing (VCT), home-based care (HBC), PMTCT, tuberculosis services, antiretroviral treatment (ART), care and support to orphans and vulnerable children and preventive services. With regard to HIV/AIDS prevention, the prevention services that the organization was involved in, as outlined in the NMSF earlier, included promotion of abstinence, delayed sexual debut and partner reduction; outreach to the most vulnerable populations, such as commercial sex workers and men who have sex with men; promotion of HIV testing and counselling services; and PMTCT of HIV. The organization is 100% donor funded, and its services are offered to all individuals irrespective of religion. The organization had 150 professional staff and more than 700 volunteers from different religious denominations.

Anglican organization
The Anglican organization is a registered NGO operating under the Anglican Diocese. The organization provides core and support to people infected and affected by HIV/AIDS such as voluntary counselling and testing (VCT), home-based care (HBC), PMTCT, tuberculosis services, antiretroviral treatment (ART), care and support to orphans and vulnerable children and preventive services. With regard to HIV/AIDS prevention, the prevention services that the organization was involved in, as outlined in the NMSF earlier, included promotion of abstinence, delayed sexual debut and partner reduction; outreach to the most vulnerable populations, such as commercial sex workers and men who have sex with men; promotion of HIV testing and counselling services; and PMTCT of HIV. The organization is 100% donor funded, and its services are offered to all individuals irrespective of religion. The organization had 150 professional staff and more than 700 volunteers from different religious denominations.

Muslim organization
The Muslim organization is a non-governmental Islamic organization. The organization is not accountable to any coordinating body or structure. Its main aim is to fight the HIV/AIDS pandemic by empowering Muslim communities and individuals to fight against HIV/AIDS through promoting Islamic values. The organization’s activities have included life skills training for Muslim leaders, Community Mapping and Theatre about HIV/AIDS, formulation of and participation in Council Multicultural AIDS Committees, training of trainers for Muslim Family Health Life Education, stigma and discrimination education to sheikhs, madrasa teachers and the Muslim community, and HBC support. At the time of data collection, many of the above activities had been completed, and the organization was relying solely on members’ contributions with no external donor support to conduct their activities. The organization’s main activities appeared to be support for people living with HIV/AIDS through HBC, and ad hoc HIV/AIDS prevention education. With regard to HIV/AIDS prevention, the prevention services that the organization was involved in included promotion of abstinence, delayed sexual debut partner reduction and promotion of condoms (within marriage only). Membership is voluntary and numbers vary between the different branches throughout the country. Data collection took place at two of the organization’s branches; one had ~25 members and the other had ~100 members.

Findings
Three main factors were found to influence the organizations’ HIV/AIDS prevention policy processes and responses: (1) the faith structure in which the organizations are a part, (2) the presence or absence of organizational policy and (3) the professional nature of the organizations and its actors. The interaction between these factors, and how actors negotiate between them, was found to shape the organizations’ HIV/AIDS prevention policy processes and responses. Each factor is discussed below.

Faith structure
Each organization works within a specific faith structure, which influences its HIV/AIDS prevention policy process and response. Faith structure refers to the religious structure or network, and related values, that the organizations are a part of. The faith structures that the organizations work within can be described as controlling, flexible or permeating. The Catholic organization works within a controlling faith structure with clear delineations of authority through which top-down policy directives are employed. Subsidiary organizations are expected to follow the position and policies of the Roman Catholic Church—a structure that spans across the local, national and international level. The Catholic organization was no exception and, as explained by the following respondent, was expected to follow the position of the Catholic Church, particularly around the issue of condoms:

[The organization] being one of its [Catholic Church’s] agencies, one of its institutions has to follow the Church’s
instructions on the issue of, only on this issue of condoms where the Church doesn’t actually encourage condoms (respondent, Catholic Organization).

The Catholic Church’s position on condoms was outlined within the organization’s community educators’ tool:

The Catholic Church has always been firm on condom use even before the HIV pandemic. Condom use as a method of HIV prevention is not allowed by the Church. HIV, which is mainly spread through sexual intercourse, cannot be controlled by using condoms. Behaviour change and observance of religious teachings on the sanctity of sex before and after marriage is the only way that can significantly reduce the spread of HIV (Community Educator Tool, Catholic Organization 2007).

The organization was, therefore, not permitted to promote condom use as an HIV/AIDS prevention strategy. In comparison, the Anglican organization works within what is described here as a flexible faith structure. The structure is flexible in that by choosing to remain silent on issues of sexuality and HIV prevention, and allowing the organization a degree of separation from the Church, the organization is not restricted by religious directives. While the Anglican Church in Tanzania is, as a whole, against condom promotion (interview respondent, Anglican Organization), at the time of data collection there was no HIV/AIDS policy within the Anglican Church and, according to respondents, the Church had chosen to remain silent and not direct the organization in its HIV/AIDS prevention approach:

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

Compared with the Catholic organization, the Anglican organization was, therefore, not under the direction of the Church.

The Muslim organization, in comparison, works within what is described here as a permeating faith structure. Although the organization is not a subsidiary of a larger religious organization (like the two other organizations), it is part of a larger religious context or structure. The structure is permeating in that, in the words of Balogun (2011, p. 459), ‘Islam is not only a religion but also a way of life which can regulate most aspects of an adherent’s life – political, economic or social activities, and personal, inter-personal or inter-group relations’. According to respondents, the Islamic discourses used within HIV/AIDS prevention within the organization were interpreted from the Quran and other Islamic texts, and included beliefs about the cause of HIV/AIDS being ‘zinaa’ (adultery and fornication), adhering to Islamic teachings about abstinence outside of marriage and marital fidelity as being the only solutions to HIV prevention, and condoms being permitted only within marriage. These discourses were found to greatly influence and direct the HIV/AIDS prevention messages within the organization, which did not include any messages that were not promoted within or accepted by Islam. The influence of Islam and Islamic discourse within the organization is exemplified by the following two quotations:

The main cause of AIDS transmission is adultery, sex. But then when you go back to the Quran, it restricts people from engaging, from practicing adultery. So we look at what the Islamic religion says about AIDS (respondent, Muslim Organization).

**Ways to protect ourselves from AIDS**

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

**What does committing zinaa mean?**

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

While not a subsidiary of a larger religious organization, the Islamic organization was nevertheless heavily influenced by Islam and Islamic discourse.

While the faith structure influenced each of the organizations in different ways, each of the faith structures shared a similar position regarding condom use within HIV/AIDS prevention, namely, that condom use was not permitted as a form of HIV/AIDS prevention. The Islamic faith structure differed in that condom use was permitted only within marriage, whereas the Catholic and Anglican faith structures were against condom use in all instances. This position differed from national policy within Tanzania, which saw condom use and promotion as an important and essential component of HIV/AIDS prevention.

Whether the position of the faith structure was ‘implemented’ within the organizations themselves, however, depended on other factors within the policy process, in particular the type of faith structure, as discussed earlier, the presence or absence of a formal or informal organizational HIV/AIDS policy, and the professional or non-professional nature of the organization and its actors, which are discussed below.

**Presence or absence of organizational policy**

Due to its faith structure, the Catholic organization had a clear organizational policy in relation to HIV/AIDS prevention, which all employees were expected to follow. The organization’s HIV/AIDS prevention response was therefore expected to be in line with this policy, which was to, in addition to other less contentious prevention issues, follow the Catholic Church’s position and not promote condom use. In comparison, the Anglican organization not only lacked direction from the Anglican Church but there was also no policy within the organization itself outlining how staff were to respond to HIV/AIDS, and, as a result, actors were found to respond to
HIV/AIDS in conflicting ways according to their own religious or professional understanding of HIV/AIDS, which is discussed below.

Compared with the Catholic and Anglican organizations, although the Muslim organization lacked a co-ordinating body or structure and a formal HIV/AIDS policy, what was common throughout the policy process within the organization was the overall objective of responding to HIV/AIDS through Islam, which in itself has a strong position regarding HIV/AIDS. As a result, despite having no formal policy, due to its strong statement of faith and non-professional nature, the organization was found to have a uniform approach to HIV/AIDS based on Islamic principles and regulations.

Professional/non-professional nature of organization
The professional or non-professional nature of the organizations was found to influence each organization’s HIV/AIDS prevention policy process and response. Both the Catholic and Anglican organizations are professional organizations, they employ staff based on their professional qualifications and expertise, as opposed to their faith or interest. Staff within these organizations were mainly health professionals, and therefore according to respondents held professional understanding of HIV/AIDS and HIV/AIDS prevention related to their profession:

You have people who are professional, have more professional people, and people who come because of the skills and education that they have (respondent, Catholic Organization).

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

At times, their approach to HIV/AIDS prevention conflicted with the organizations’ religious position on the use of condoms in HIV/AIDS prevention. This was particularly the case with regard to more sensitive topics, such as HIV prevention among discordant couples, where one is HIV positive and one is negative, men who have sex with men, and commercial sex workers. Within the Catholic organization, some respondents openly disagreed with the Church’s position on condoms, while others would find ways to assert their professional understandings and encourage condom use at the point of implementation. Such strategies included, for example, distinguishing between condom ‘education’ and ‘promotion’, emphasizing individual choice, and framing issues in a way that circumvented religious moral or ethical arguments. Within the Anglican organization, due to the absence of Church direction and organizational policy, as discussed earlier, actors were found to respond to HIV/AIDS prevention according to their own professional or religious understanding of HIV/AIDS, leading to multiple and conflicting responses to condoms in relation to HIV/AIDS prevention within the community, where messages included both the promotion and condemnation of condoms.

Compared with the Catholic and Anglican organizations, the Muslim organization is a non-professional volunteer organization: it is comprised of non-professional volunteers within the community. Respondents, therefore, did not have the same professional understanding of HIV/AIDS that was found within the Catholic and Anglican organizations. Due to the organization’s focus on Islam and HIV/AIDS, most respondents’ decision to join was religiously motivated, and, as a result, volunteers shared Islam as a religion. This created a common religious understanding of HIV/AIDS and HIV/AIDS prevention within the organization:

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

The professional or non-professional nature of the organizations was, therefore, found to relate to actors’ overall understanding and approach to HIV/AIDS prevention. It was the interaction between the faith structure, presence or absence of organizational policy and the professional or non-professional nature of the organizations that was found to influence the organizations’ HIV/AIDS prevention policy processes and responses, particularly in relation to condoms. This interaction, and the organizations’ resulting responses, will be discussed in greater detail below.

Discussion—explaining the diverse faith-based HIV/AIDS prevention response
The above has shown that all three FBOs had diverse HIV/AIDS prevention responses. While there is currently a lot of literature discussing FBOs’ contribution to HIV/AIDS prevention and mitigation (see, e.g. Liebowitz 2002; Tiendrebeogo and Buyckx 2004; Parker and Birdsall 2005), there is a lack of literature exploring the factors that influence individual organizations’ response efforts. As a result, this section does not seek to examine where the organizations in the study fit within FBOs’ overall contribution to HIV/AIDS prevention but instead to analyse the different responses found within the organizations. In addition, as mentioned previously, Walt and Gilson’s health policy framework was used as a guiding framework to explore what influenced the organizations’ HIV/AIDS prevention policy process and response and how the factors interrelated to influence this process. While this framework was useful in identifying the different factors and their inter-relationships, the discussion below draws on the literature in an attempt to analyse the reasons for the different responses to HIV/AIDS prevention found within the organizations. As a result, it adds to the health policy analysis field by exploring not only the
factors that influence the organizations’ policy process and response but also the processes and subsequent tensions that can exist within FBOs as a result of these factors, of which actors working within these environments must navigate.

As a result of the interaction between the three factors discussed earlier, the practice of actors within the three faith-based NGOs differed. Whether these factors complemented or contradicted one another, and how actors navigated between the different factors, influenced the organizations’ overall HIV/AIDS prevention policy process and response. Within the Catholic and Anglican organizations, both professional FBOs, conflict was found between religious and professional discourses. In a study about Catholic and non-Catholic NGOs working in HIV/AIDS, Ferrari refers to such competing discourses as ‘frames’, which she defines as ‘templates that perceivers use to determine which information is important in a given situation and how to proceed with discourse on the topic’ (2011, p. 86). According to Ferrari, religious and scientific (in this case professional) frames ‘build competing visions of the AIDS crisis, and lead to quite different strategies for addressing the epidemic’ (2011, p. 101). While Ferrari’s distinction between scientific and religious frames, and how they can lead to different response strategies, was made between Catholic and non-Catholic organizations, it is useful as it helps to explain the different prevention responses found within the organizations.

As the findings from this study suggest, discrepancy or consistency between policy and policy implementation will depend upon whether actors’ frames, and therefore strategies, correspond to the organization’s frame. As the staff’s professional understanding of HIV/AIDS, or frame, within the Catholic organization did not correspond with the organization’s frame, there was a discrepancy between policy and practice. Within the Anglican organization, as there was no organizational frame, staff employed their own individual frames within their HIV/AIDS prevention response, and different approaches to HIV/AIDS prevention were found. In contrast, policy and practice within the Muslim organization was consistent due to a similarity of frames between the volunteers and the organization.

The use of competing medical and religious frames, or discourses, by health professionals has also been found in other studies. In a study about nurses’ motivations in delivering ART in South Africa, Stein et al. (2007) illustrate how service providers appropriate different discourses during implementation. They found that nurses used religious metaphors alongside ‘medical notions of effective treatment and care to help them and their patients negotiate, and make sense of, the difficult terrain of HIV/AIDS and the possibilities offered by lifesaving ART treatment’ (2007, p. 962). The use of different discourses was found to enable nurses to create and sustain hope for both patients and themselves when faced with the burden of HIV/AIDS and the constraints of the health system (Stein et al. 2007). Although their study did not relate to FBOs, FBOs work within similar constraints and challenges, due to the religious nature of the organizations themselves. Stein et al.’s study provides evidence that staff working within organizations providing HIV/AIDS services within highly religious contexts, will have to mediate between different conflicting discourses similar to those found within the organizations within the study, which can lead to conflicting HIV/AIDS prevention responses on the ground.

The conflicting responses found within the Catholic and Anglican organizations were, therefore, the result of tensions created by competing factors within the policy process. Similar tensions have also been reported by Casale et al. (2010) in their analysis of the complexities confronting an FBO in its delivery of an abstinence-focused HIV prevention programme. Such tensions create an interesting dynamic within organizations working within a wider context where both medical and theological challenges are present. On the one hand, these tensions are not helpful in that they add to the confusion surrounding HIV/AIDS prevention. Such confusion has implications for both patients, who may be given conflicting advice and are unsure how to act, and staff, who may not only worry about their job security if they do not follow religious guidelines, but may also feel it unethical to not provide all HIV/AIDS prevention options to patients. At the same time, these challenges may not exist within all FBOs, as witnessed by the Muslim organization, leading to diverse faith-based responses to HIV/AIDS prevention.

Aligning faith-based and national responses?

Due to the diverse, and sometimes conflicting, responses to HIV/AIDS prevention found within the organizations, and given the key role that FBOs play within HIV/AIDS prevention and mitigation within Tanzania and beyond, how might Government respond? There is no straightforward answer to this question. First, as demonstrated earlier, FBOs are not an homogeneous group and, therefore, will not have consistent HIV/AIDS prevention responses. Second, the Tanzanian Government is working within a resource-constrained setting and is currently unable to provide universal health coverage. As a result, they must find alternative ways to ensure that healthcare services and programmes are delivered to the population. In such settings, FBOs and other non-governmental actors typically provide services that the government is unable to provide. While the approach of FBOs may be different from government, they continue to remain important actors in HIV/AIDS and healthcare service delivery. Therefore, in such settings, an inherent conflict exists between ensuring national policies are followed consistently without jeopardizing a significant actor/set of actors that provide these services.

Within Tanzania, the NMSF recognizes the role and contribution of FBOs within HIV/AIDS prevention and mitigation. Given the diverse response of FBOs to HIV/AIDS prevention, the best way forward may be to continue with what the NMSF advises, which is to encourage FBOs to engage in open dialogue about HIV/AIDS. The aim of such dialogue could be to provide greater understanding of the dynamics of the epidemic and encourage FBOs to promote interventions which are consistent with, or at least non-contradictory to, national HIV/AIDS strategies and interventions, as was stated in the NMSF. Until government is able to effectively provide HIV/AIDS and healthcare services, or is effectively able to regulate CSOs, due to the theological and health challenges inherent in issues surrounding HIV/AIDS prevention, aligning faith-based and
national responses to HIV/AIDS will prove to be difficult and compromises will have to be made.

Conclusion

FBOs play an important role in the overall HIV/AIDS response. However, the faith-based response to HIV/AIDS is often seen as incompatible with more secular and evidence-based approaches to HIV/AIDS. If the overall faith-based response to HIV/AIDS prevention and how it relates to national response efforts is to be better understood, it is important to explore the factors influencing FBOs’ responses to HIV/AIDS prevention. This research compared the factors influencing the HIV/AIDS prevention policy process within three faith-based NGOs. It found that FBOs’ HIV/AIDS prevention response varies between organizations depending on the faith structure of which they are a part, the presence or absence of organizational policy and the professional nature of the organizations and their actors. It also found that it is the interaction between these factors and how actors negotiate between them that shape how individual organizations respond to the epidemic.

By exploring the factors and processes that influence the HIV/AIDS prevention response of faith-based NGOs, this research has contributed to a greater understanding of the overall faith-based response to HIV/AIDS, the tensions that can exist within such organizations, and how the faith-based response relates to national response efforts. It is hoped that by doing so the government will be better able to identify how to best work with FBOs to meet national HIV/AIDS prevention targets, improving the overall role of FBOs in the fight against HIV/AIDS.

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Conflict of interest

None declared.

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