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Can faith and freedom co-exist? When faith-based health providers and women's needs clash

Jon O'Brien

ABSTRACT

Faith-based health providers are a major component of health services delivery in many developing countries, especially in sub-Saharan Africa. They receive millions of dollars annually from unilateral and bilateral aid agencies to deliver care. At the same time, they often use conservative interpretations of religious teachings to deny access to essential health care, including reproductive health care and HIV/AIDS prevention services. How can we balance the presence of faith-based providers against the rights and needs of women and other vulnerable populations to receive the care they need?

Les prestataires de soins confessionnels constituent une composante majeure de la prestation de services de santé dans plusieurs pays en voie de développement, surtout en Afrique subsaharienne. Pour ce faire, ils reçoivent par an des millions de dollars des organismes d'aide unilatérale et bilatérale. En même temps, ils se servent souvent des interprétations conservatrices des enseignements religieux afin de refuser l'accès aux soins de santé essentiels, y compris les soins de santé reproductive et des services de prévention du VIH/sida. Comment pouvons-nous équilibrer la présence des prestataires confessionnels avec les droits et les besoins des femmes et des autres populations vulnérables de recevoir les soins dont elles ont besoin ?

En muchos países en desarrollo, y particularmente en la región del África subsahariana, los proveedores de salud motivados por la fe juegan un papel importante en la prestación de servicios de salud. Tanto de manera unilateral como bilateral, las agencias de ayuda aportan millones de dólares anuales para contribuir a que este tipo de proveedores puedan proporcionar esos cuidados. Sin embargo, es frecuente que éstos se basen en interpretaciones conservadoras provenientes de su religión para negar el acceso a cuidados básicos de salud vinculados, por ejemplo, a la salud reproductiva y la prevención del VIH/SIDA. Ello genera un dilema en cuanto a la necesidad de equilibrar la presencia de proveedores motivados por la fe con los derechos y la satisfacción de las necesidades de las mujeres y otras poblaciones vulnerables que deben recibir la ayuda pertinente para el cuidado de su salud.

KEYWORDS

Faith-based providers; faith-based organisations; HIV/AIDS; contraception; abortion; health care; sub-Saharan Africa; Catholic; Catholics; secular

CONTACT Jon O'Brien jobrien@catholicsforchoice.org

Introduction

Faith-based health providers are a major component of health services delivery in many developing countries, especially in sub-Saharan Africa. The World Health Organization estimates that 40 per cent of the health-care services in sub-Saharan Africa are provided by the faith-based sector (Bandy *et al.* 2008, 9), and that between 30 and 70 per cent of the health infrastructure in Africa is owned by faith-based organisations (FBOs) (WHO 2007). The prevalence of faith-based providers is even higher in certain African countries. In Kenya, the Kenya Episcopal Conference and the Christian Health Association provide about 65 per cent of all health services in the country; in Rwanda and Tanzania, FBOs provide about 40 per cent of all health care; and in Uganda, the Uganda Catholic Medical Bureau and the Uganda Protestant Medical Bureau provide more than one-third of all clinical care (U.S. President's Emergency Plan for AIDS Relief (PEPFAR) 2012, 14).

In these contexts, many faith-based health-care providers are active in direct provision of clinical care. Many FBOs have long worked in health care and education, and there are thousands of faith-based hospitals in sub-Saharan African alone (Green 2003). Christian missionary hospitals and Islamic hospitals were often the first medical facilities in much of Africa. Because of their extensive networks and infrastructure, faith-based providers are a critical component of health service delivery in many resource-constrained countries where governments lack the funding to provide services, and the private sector is poorly developed. In addition, faith-based providers are often well-respected and offer the most advanced care available in many countries.

Faith-based providers also have the advantage of 'reach' and influence in communities. They are active in public health initiatives such as HIV/AIDS, tuberculosis, and malaria prevention; in maternal and child health initiatives; and in capacity-building programmes such as health-care supply chain development and management. They are often the only genuine non-government organisations (NGOs) in many rural parts of poor countries, and in others, they are the strongest and/or most influential ones. FBOs focusing on health are able to mobilise people and resources and reach rural or isolated areas because of their vast organisational networks. FBOs tend to have a good understanding of local social and cultural patterns, and larger ones have strong, expansive infrastructures.

At the same time, some faith-based providers use conservative interpretations of religious teaching to deny access to critical care, including family planning, abortion, and HIV/AIDS prevention services, particularly condom distribution, and counselling about condom use. This has obvious implications for women and girls in relation to unrealised reproductive and sexual rights and health. Faith-based providers also sometimes discriminate against populations that need particular care and support, like sex workers or men who have sex with men. The benefits of health care offered by faith-based providers must be weighed against their drawbacks, and strategies must be developed to protect access for women and other groups who face discrimination, making it particularly difficult to secure appropriate health care.

This article reviews trends in funding for large-scale and in-country FBO health providers, maps FBO involvement in health care, discusses concerns about FBO involvement in

the provision of health care, discusses FBOs and the provision of contraception and abortion, looks at the role of FBOs in the provision of HIV/AIDS prevention, and presents recommendations to ensure that the needs of women and girls being served by FBOs are met.

Trends in funding for large-scale and in-country FBO health providers

A recent study estimated that in 2013 the amount of development assistance for health projects provided to FBOs amounted to $1.5 billion (nearly 5 per cent more than in 2012). According to one study, development assistance for health to FBOs increased at a rate of 10 per cent per year between 1990 and 2013. The period of fastest growth was between 1999 and 2008, which coincided with the administration of US President George W. Bush (Haakenstad *et al.* 2015, 4). In the 2005 fiscal year, at the peak of the Bush administration, FBOs received about $2.15 billion in funding, including just under $600 million from USAID, representing about 14 per cent of total USAID funding for the period (White House Office of Faith-Based and Community Initiatives 2006, 2).

Following the lead of the United States, other international donors also have expressed increased interest in working with and funding FBOs. In 2006, the UK Department for International Development launched a five-year, £3.5 million religion and development research programme. The Dutch Foreign Ministry, the German Federal Ministry for Economic Cooperation and Development, and the Swiss Agency for Development Co-operation, as well as the World Bank and UN Population Fund, have all launched initiatives to increase co-operation with FBOs with the expectation of increasing funding to FBOs and faith-based providers (Le Moigne and Petersen 2016).

In additional to international bilateral and multilateral funding from public, governmental donors such as USAID and the United Nations, funds for health-care providers are also available from large-scale non-governmental funders such as the philanthropic Bill and Melinda Gates Foundation, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, which draws on a mix of public, private sector, and civil society sources.

The largest share of specific health development assistance to FBOs goes to HIV/AIDS programmes, although spending on 'other' programmes accounts for 60 per cent of all health spending. Development assistance for HIV/AIDS peaked in 2007, then dropped and levelled off between 2008 and 2011 (Haakenstad *et al.* 2015, 9).

Mapping FBOs involved in health care

The scale and scope of faith-based health-care provision in the developing world is large and growing, and there are several categories of FBOs involved. Large international FBOs now account for approximately one-quarter to one-third of all international NGOs; approximately 95 per cent are US-based (Haakenstad *et al.* 2015, 4–6). These organisations have professional staff and highly developed technical capacity. Examples are Catholic Relief Services, World Vision International, and Lutheran World Federation.

A small number of large, international FBOs receive the lion's share of development assistance for health. In 2013, the five largest faith-based recipients of development

assistance for health were Food for the Poor ($782 million), MAP International ($352 million), Catholic Medical Mission Board ($253 million), Catholic Relief Services ($245 million), and Feed the Children ($193 million) (Haakenstad *et al.* 2015, 8).

An analysis of FBOs and USAID funding between 2001 and 2005 by the *Boston Globe* found that Catholic Relief Services (CRS) was the largest faith-based recipient of USAID funding, receiving $638 million over five years, nearly twice as much as World Vision, Inc., the next largest recipient (*Boston Globe* 2006). In addition to funding from USAID, it also receives funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria for HIV/AIDS, tuberculosis and malaria prevention and treatment initiatives, and from the Bill and Melinda Gates Foundation for agriculture, microfinance, and emergency response projects. CRS reported more than $738 million in revenue in 2015. Approximately 35 per cent of this revenue was from US government grants: $263 million in 2015 (Catholic Relief Services 2015, 28).

The large international FBOs have significant variation in geographic distribution. Food for the Poor, MAP International, and the Catholic Medical Mission Board provide most of their services in Latin America and the Caribbean, while CRS is mostly active in sub-Saharan Africa, and Feed the Children's programmes are about equally distributed between the two regions (Haakenstad *et al.* 2015, 9).

In addition to the large international FBOs, there are also the in-country health-care providers mentioned at the start of the article. These faith-based providers typically receive funding from a combination of international donors and private contributors, user fees, and funding from national governments. They are affiliated directly with specific faith traditions, and deliver services directly through networks of hospitals, clinics, and dispensaries. For instance, the Uganda Catholic Medical Bureau operates 27 hospital and 235 health centres in Uganda.

Finally, there are smaller, sometimes informal, health-care programmes operated by churches, charities, faith-groups, and interfaith groups. These often rely on private donations, volunteers, and in-kind donations.

The next sections move to explore the benefits and pitfalls inherent in faith-based provision of health care.

Concerns about the role of FBOs in the provision of health care

There are advantages to faith-based provision of health care – particularly at the level of in-country provision. Many FBOs working on service provision at national level were founded with the intent to provide health services to poor, underserved communities. They have robust infrastructures and funding streams, critical entry points through local congregations, long-standing ties to the communities they serve, and extensive in-country contacts throughout the civil and private sector, all of which make them valuable providers of care in resource-scarce countries.

Because of their robust procurement and distribution networks, FBOs can also play a critical role in delivering pharmaceuticals in many developing countries, which is especially important for people with HIV who require timely delivery of antiretroviral

drugs. A review of faith-based drug supply organisations in sub-Saharan Africa found that they are responsible on average for delivering drugs to 43 per cent of the population (Banda *et al.* 2006, xii). In Uganda, Joint Medical Supplies, which is a partnership of the Uganda Catholic Medical Bureau and the Uganda Protestant Medical Bureau, provides discounted pharmaceuticals and medical equipment to more than 500 hospitals and health centres throughout the country (PEPFAR 2012, 28).

However, as stated at the start of this article, there are significant concerns regarding the imposition of fundamentalist ideologies on populations in need of health care, and failure to provide essential health care.

A widespread concern about FBOs in the provision of essential health care is that they may use their position and influence to try to convert recipients of their services. This concern is understandable; many FBOs have their roots in the missionary tradition of evangelisation. However, most religious charities recognise that such conversion practices would be unethical and have specific guidelines regarding evangelising. For most FBOs, providing health services is an essential part of their mission to help others in need rooted in the tradition of the gospel, and not a means to proselytise.[1]

The other key concern is that some faith traditions will not allow FBOs to provide the full range of appropriate health-care services to their users. This concern is more well-founded for some faith traditions than others. The Roman Catholic Church formally bans the use of all modern methods of contraception, whether for contraceptive or HIV/AIDs prevention purposes, and teaches that all premarital sexual activity is a sin. There are no Protestant churches that follow the Catholic hierarchy in banning contraception, although some conservative evangelical traditions that stress premarital abstinence do not approve of contraceptives counselling or dispensing to unmarried individuals. Similarly, the Muslim faith has no formal ban on contraception, but takes a restrictive view of premarital and extramarital sex that may impair contraceptive counselling for either contraceptive or HIV/AIDS prevention purposes. The Catholic hierarchy bans abortion in all circumstances, even to save the life of a woman. Evangelical and Muslim traditions also take a restrictive view of abortion, but may allow it to save a woman's life or in other extenuating circumstances.[2]

Beyond prohibitions on the provision of certain services, other factors influence the provision of services by FBOs. An analysis of Catholic, Anglican, and Muslim FBOs working in HIV/AIDS prevention in Tanzania found three factors influenced their HIV/AIDS prevention policies and response: the faith structure of the organisation; whether it had formal policies; and the professionalism of the organisation (Morgan *et al.* 2014). Overall, the authors concluded that the presence of FBOs in HIV/AIDS prevention efforts 'can lead to conflicting HIV/AIDS prevention responses on the ground' (*ibid.*, 320) that may be harmful to patients. The Catholic FBO was found to be the most restrictive in terms of having a highly hierarchical faith structure and formal policies banning condoms. However, it also had highly professional staff that understood the value of evidence-based public health policies, especially in the case of couples in which one partner is HIV-positive. As a result, employees of the Catholic FBO sometimes encouraged condom use despite church policy, such as distinguishing between condom 'education' and 'promotion' (*ibid.*).

In contrast, neither the Anglican nor the Muslim FBO answered to a formal hierarchy, or had official policies regarding condoms. As a result, employees of the Anglican FBO responded to HIV/AIDS prevention 'according to their own professional or religion understanding of HIV/AIDS, leading to multiple and conflicting responses to condoms' (*ibid*., 319), while volunteers with the Muslim FBO turned to their faith for guidance and focused on abstinence and marital fidelity.

Faith-based providers and contraception

Few areas of health care are as non-controversial as the promotion and provision of appropriate forms of family planning. NGOs around the world recognise the value of family planning in contributing to the health of women and children through the prevention of child pregnancy, the appropriate spacing of pregnancy, and the prevention of unwanted pregnancy and unsafe abortion. The provision of family planning also provides numerous social and economic benefits, including allowing girls to finish school, and allowing women to contribute to the family income, thereby improving their financial security and the well-being of their communities.

Yet despite the benefits of family planning, there remains a large, unmet demand for contraception around the world. It is estimated that there are 222 million women in the developing world at risk of unintentional pregnancy who are using either a traditional, highly unreliable method of contraception or no contraception (Barot 2013, 18). Filling the unmet need for contraception would prevent 21 million unplanned births, 26 million abortions, nearly 80,000 maternal deaths, and one million infant deaths (*ibid*.).

Numerous faith traditions active in international development and FBOs recognise the benefits of family planning, including the United Methodist Church, Islamic Relief, the Christian Health Associations of Africa, the Adventist Development and Relief Agency, and World Vision, Inc. World Vision recognises 'healthy timing and spacing of pregnancy' (World Vision 2013, 1) as a key maternal and child health goal. It works with community health workers in 36 countries to counsel women about the health benefits of delaying a first pregnancy to age 18 and of spacing pregnancies two years apart. World Vision also works with faith leaders, who are often the most influential members of their communities, to address family planning within the values and belief systems of their faith traditions so that information about the benefits of family planning can be shared throughout the community (*ibid*.).

However, because of conservative religious restrictions, some programmes run by FBOs fail to provide women with access to the full range of contraceptive options, undermining their health and their reproductive autonomy. Some evangelicals consider intra-uterine devices (IUDs) and emergency contraception to be abortifacients and will not promote their use, despite the assurance of the medical community that these methods work before the establishment of a pregnancy. Some FBOs will not work with organisations that provide abortion in addition to family planning, or that provide family planning services to unmarried individuals.

However, only one faith group, the Roman Catholic hierarchy, is opposed to the use of all modern methods of family planning. The encyclical *Humanae Vitae*, issued in 1968 by Pope Paul IV, prohibits all contraceptives, and decrees that Catholics may only use natural family planning (NFP) methods. Pope John Paul II, who was hugely influential on the Catholic Church's development policies, called the promotion of contraceptives in developing countries 'attacks' on the family and part of a 'culture of death' (Pope John Paul II 1995, 2). As a result of this fundamentalist doctrine, Catholic FBOs and health-care providers are banned from counselling about or dispensing modern methods of contraception, including oral contraceptives, barrier devices such as condoms or diaphragms, long-acting methods such as IUDs or contraceptive implants, and contraceptive sterilisation.

Catholic FBOs assert, however, that NFP methods are a viable substitute for modern contraceptives, and have long pressured aid agencies to fund NFP programmes. During President Ronald Reagan's first term, funding for NFP programmes under USAID increased from $800,000 to $7 million (Miller 2014, 148).[3] Yet NFP methods[4] have failure rates ranging between 12 and 24 per cent (Kempner 2015, 1), far higher than modern contraceptives. Such methods can be ineffective for women with irregular menstrual cycles. In addition, these methods are based on attempting to time sexual intercourse to a woman's time of natural infertility during her menstrual cycle, and abstaining from sex during fertile periods. Many women lack the power in their intimate relationship to negotiate in this way. This is especially critical in contexts of poverty and low employment – including many locations in developing countries – where men seek migrant work, and are away from home for long periods. The success of all contraceptive methods, including NFP, depends on high levels of communication and trust between partners who are able to negotiate contraceptive decision-making in an equal relationship, which also appreciates the principles of women being able to control their sexuality and reproductive destinies as autonomous individuals.

An example of use of NFP comes from in Timor-Leste, a country with one of the lowest rates of contraceptive use in the world, where CRS is working with the Ministry of Health and Georgetown University's Institute for Reproductive Health, which developed the Standard Days Method with funding from USAID, to promote Cycle Beads[5],[6] as a method of family planning. According to CRS, nearly 600 couples have been counselled in a method of family planning that is essentially the rhythm method developed in the early twentieth century, instead of more reliable methods of contraception (Aylward and Friedman 2014).

By contrast, the United Methodist Church's Ganta Hospital in Liberia tackled the problem of low rates of contraceptive use and high rates of child and maternal death by training community health workers to counsel women on the full range of contraceptive methods, and to ensure a secure contraceptive supply. As a result, the percentage of women using modern methods of contraception increased from 15 to 61 per cent between 2011 and 2012 (Barot 2013, 19–20).

Faith-based providers and abortion

The provision of safe abortion is no less an essential reproduction health service than access to contraception. Nearly 22 million women experience an unsafe abortion in any

given year (World Health Organization 2008, 1), and about 85 per cent of unsafe abortions occur in the developing world (*ibid*.). As a result, 47,000 women die each year, a full 13 per cent of all maternal deaths (*ibid*.).

Yet Catholic, evangelical, and Muslim FBOs oppose abortion because of religious dictates. Increasingly, they have pushed a narrative to exclude abortion from the full range of reproductive health services that women should have access to, in return for their co-operation in family planning programmes. The emergence of the Zika virus has demonstrated the problem posed by the political power of the Catholic bishops and Catholic control of hospital systems throughout parts of the developing world, especially in Latin America. Abortion is completely illegal in Chile, Nicaragua, El Salvador, and the Dominican Republic, and available only to save a woman's life in Brazil, Guatemala, and Argentina. In El Salvador, women who are suspected of having an abortion can be jailed. Catholic bishops in Brazil, Colombia, Peru, and Honduras condemned suggestions that access to abortion should be liberalised for women facing potentially devastating fetal abnormalities in their pregnancies due to Zika and have remained largely silent on the issue of contraceptive use even after Pope Francis said it would be permissible to prevent pregnancy during the Zika crisis.

Politically powerful Catholic Bishops' conferences in the developing world have been fierce opponents of attempts to liberalise access to abortion services, even in countries where national laws allow it. They have also often worked to conflate abortion and contraception, and to suggest that programmes to expand access to contraceptives are backdoor attempts to promote abortion. When the Nigerian Minister of Health recently announced plans to work with NGOs to expand access to contraceptives, the Nigerian Catholic bishops charged it was a deceptive programme being foisted on the Nigerian people in the name of better maternal health: 'Our country must reject this relentless offer of anti-life incentives under the guise of foreign aid in order not to destroy our beautiful culture', said the bishops (Weatherbe 2016, 1).

Even in countries like Kenya, where access to abortion has been liberalised, the control of most hospitals by faith-based health systems means that as a practical reality, access to safe abortion is limited; most women are forced to resort to unsafe, illegal practitioners.[7]

Secular organisations addressing reproductive health have to operate in this very challenging context. Major funders in international health and development like the Bill and Melinda Gates Foundation have made a major push into funding family planning services, yet the controversy around abortion has led Melinda Gates to suggest that the question of abortion should be dealt with separately, reasoning that the debate about abortion threatens to 'get in the way' of family planning (Gates 2014, 1).

Faith-based providers and HIV/AIDS prevention

Faith-based providers were among the first to open their doors to AIDS patients in the early years of the epidemic, providing compassionate care when others shunned people with AIDS, and have been essential in providing care to generations of AIDS orphans. One in five organisations engaged in providing HIV/AIDS services is faith-based

(Woldehanna *et al.* 2005, 9). Many of these organisations do exemplary work. A review of the role of FBOs in addressing HIV/AIDS (*ibid.*) concluded that FBOs tend to excel in mitigating the impact of HIV/AIDS by providing care, treatment, and support to people infected with HIV, especially in areas with a poor public health infrastructure.

However, no area has demonstrated the shortfalls of faith-based providers more dramatically than the fight to prevent HIV/AIDS in the developing world. Where they tend to fall short is effectively working to change risky behaviours, since many FBOs focus exclusively on abstinence and faithfulness as prevention strategies, and fail to deliver comprehensive prevention messages that include the use of condoms to prevent AIDS. As the Woldehanna *et al.* study points out, they also fall short in addressing women's particular vulnerability to HIV/AIDS because of 'the entrenched inequality' of women within some faith traditions (*ibid.*, 10).

Among FBOs, Catholic providers once again have the most serious shortfalls in the provision of HIV/AIDS prevention services, because the Catholic hierarchy completely forbids the use of condoms, even to prevent HIV/AIDS. As a result, even in circumstances in which other conservative faith-based providers condone condoms, such as with a married couple in which one partner is HIV positive, Catholic faith-based providers are constrained from making sound public health recommendations. This is especially problematic because approximately 25 per cent of HIV/AIDS care throughout the world is provided by organisations affiliated with the Catholic Church (Vitillo 2009, 5).

The Catholic hierarchy has continually reinforced this anti-condom message. When Pope John Paul II visited Tanzania in 1990 as the AIDS epidemic was raging in Africa, he told Catholics that using condoms was a sin (Miller 2014, 212). Another high-profile bishop suggested that condoms were ineffective in preventing AIDS because the HIV virus could pass through them (*ibid.*, 215). Even Pope Benedict's suggestion in 2010 that condoms could be used to prevent HIV/AIDS in certain circumstances, which was widely read to apply to discordant couples or sex workers, had has little impact on official Catholic Church policy.

As noted above, some Catholic FBOs have consciously chosen to support condom use in couples where one partner is positive (Morgan *et al.* 2014). But in many contexts, for instance, in Madagascar, condoms are not in the equation. CRS received $1.5 million from the Global Fund to Fight AIDS, Tuberculosis and Malaria for a programme to test, treat, and counsel about sexually transmitted infections (STIs) as part of an HIV prevention strategy. While condom counselling is an essential part of STI prevention, the programme did not include condoms in the programme, either as a primary STI prevention measure, or as an opportunity to counsel about HIV prevention. Instead, CRS partnered with a group called Youth for Christ on an STI prevention campaign that focused on abstinence and fidelity (Global Fund to Fight AIDS, Tuberculosis and Malaria 2008, 8).

Catholic FBOs are especially prominent in sub-Saharan Africa, which has the world's highest HIV/AIDS prevalence. A recent review of faith-based providers in Kenya determined that FBOs account for 70 per cent of all NGO health facilities in the country and that the Catholic Kenya Episcopal Conference (KEC) owned 37.5 per cent of all faith-based health facilities in the country, making it the largest faith-based provider.

The KEC owned 80 health centres, 48 hospitals, and 25 clinics (Blevins and Griswold 2014, 17). Not surprisingly given its large institutional footprint, the KEC provides by far the largest percentage of care to HIV/AIDS patients, providing nearly 60 per cent of such care in Kenya, followed by the Christian Health Association of Kenya at just under 20 per cent (*ibid*., 18).

The Catholic hierarchy has also lobbied aggressively to have special protections created for its refusal to provide comprehensive HIV/AIDS prevention services. When the US Congress created the historic PEPFAR in 2003, to provide $15 billion for international aid to combat HIV/AIDS in select countries, the US Conference of Catholic Bishops successfully lobbied for the insertion of a 'conscience clause' that exempted FBOs from having to 'endorse, utilize or participate in a prevention method to which the organization has a religious or moral objection' (Miller 2014, 215). This exemption clause gave FBOs the green light to receive millions in public funding for HIV/AIDS prevention strategies that promoted conservative religious ideology, and omitted mention of condoms.

When the PEPFAR programme was reauthorised in 2008, last-minute lobbying by the Catholic bishops and Catholic Relief Services resulted in a delinking of family planning services and HIV/AIDS prevention. It also included an expanded conscience clause that allowed FBOs to refuse to refer patients to organisations that distribute condoms, a contradiction of long-standing US policy that FBOs who refused to provide certain contraceptive services needed to refer to providers that did (Edna 2008).

The very structure of PEPFAR has been criticised as inherently favouring conservative FBOs, as one-third of all funding was directed to programmes that stressed abstinence as a primary prevention strategy, and required grantees to eschew needle-exchange programmes and working with sex workers. Paul Zeitz, former executive director of the Global AIDS Alliance, is on record as stating:

> As PEPFAR was being designed, there was a premeditated plan to make sure that faith groups sharing the administration's ideological perspective would benefit. (Joyce 2010, 15)

Many of the conservative Christian FBOs that have received funding for HIV work were found to be incompetent. There were stories of abstinence-only projects targeted at sex workers and a Ugandan pastor praying over boxes of burning condoms (Joyce 2010).

HIV prevention has focused on the ideologically driven message of abstinence and the devaluation of the known prevention strategy of condom use. Eventually what became known as the 'ABC Strategy' (a successful Ugandan programme that stressed abstinence and fidelity as preferred prevention strategies over condom use, came to permeate the HIV/AIDS prevention agenda, especially where FBOs were concerned. This has resulted in the funnelling of millions of dollars of PEPFAR and other funding to what many called an unproven, ideologically driven approach. A number of problems have been identified with the so-called ABC approach (Murphy *et al.* 2006). One is that it reserves condom promotion and counselling for high-risk populations such as sex workers and men who have sex with men, which further stigmatises these populations as 'dirty' and leaves other populations, such as young adults and women, unprotected. Researchers have also come to

doubt that it alone was responsible for the dramatic decline in HIV infections in Uganda, stressing the importance of other factors, including gender equality:

> ABC-related behavior changes have taken place in Uganda and a small number of other countries not only because fear of AIDS has led to protective action by men and women but because many interventions have also directly addressed gender inequities. Greater openness about the dangers of unprotected sex and challenges to women's subordinate role in sexual decision-making have helped to create an environment in which many more women have found it easier to abstain, reduce their number of partners, and/or negotiate condom use. (Murphy *et al.* 2006, e379)

Public health advocates say that desirable behaviour changes that can help prevent HIV, such as reducing the number of sexual partners and delaying the age that young adults first have sex, can be achieved through non-ideological public health interventions that stress women's empowerment and equality, and provide fact-based sexual education, including counselling about condoms (Murphy *et al.* 2006).

The limitations on the services provided by FBOs, and their insistence on stigmatising certain populations, raises important questions about whether public, taxpayer-funded aid is going to the most effective, proven programmes, or whether they are unfairly being directed to ideologically conservative, but politically powerful, programmes. In reality, funders like PEPFAR tend to defer to FBOs to ensure their own funding streams, which often come from politically conservative sources like the US Congress; and for the simple fact that they are already on the ground and providing services in many developing countries. The co-operation of global aid agencies like UNAIDS with FBOs tends to give the latter legitimacy. Despite the limitations of ideologically based approaches, in September 2015, PEPFAR and UNAIDS launched a two-year, $4 million initiative to strengthen the capacity of FBOs to 'advocate for and deliver a sustainable HIV response' (PEPFAR 2015, 1). In essence, this allows FBOs to qualify for more funding and integrate themselves further into HIV/AIDS service-delivery structures, reinforcing their faith-based policies as the norm in international development assistance.

Little pressure has been brought to bear on FBOs. Of the recommendations made by PEPFAR for working with FBOs, only one focused on the quality of their services: 'Increase FBOs' capacities to develop and implement effective programs or strengthen existing programmes' (PEPFAR 2012, 32–3). This recommendation, however, did not address the need to fund only proven public health strategies, but said only that FOBs should 'improve the quality and scope of their programmes' (*ibid.*).

Recommendations for FBOs working in health

FBOs have the potential to be valuable partners in the provision of reproductive and sexual health services in the developing world, because of their deep roots working in many developing countries, their extensive health-care networks, the trust many communities have in them, and their sincere commitment to working with the poor. But too often, the good they do is compromised by conservative interpretation of religious teachings that are used to deny services and discriminate.

An increased focus on transparency in funding and funding criteria and anti-discrimination policies would ensure that valuable public health finances are being well spent.

It is neither practical nor beneficial to suggest that FBOs should be disqualified from receiving public funding for the provision of health services. There are steps that can be taken to ensure this money is being spent in the best way possible, and that patients and vulnerable populations – including women in need of the full range of reproductive health-care services – are receiving appropriate services.

Transparency in funding

To support transparency in funding, a recommendation is that all public funding agencies should publish annually a list of the organisations they have funded and how much money each received. Do funders require evidence-based interventions from their applicants/recipients as well as disclosure of which interventions applicants will not undertake? (For example, condom distribution and information on use, comprehensive sex education.) Do applicants provide all services to all those who need them? (For example, family planning.) What are acceptable reasons to give money despite gaps in treatment or prevention? What alternatives are created to ensure that those gaps are filled? Who co-ordinates and pays for comprehensive care?

Principles of non-discrimination and human rights

To ensure that FBOs providing health care do not discriminate, funding agencies must ensure that public funding is not used to allow organisations to discriminate in hiring staff, to refuse to provide or find reasonable alternatives for the provision of basic treatment or prevention options, or for the use of proselytising.

A major step forward would be for a conscious effort to support organisations and movements promoting health care for all from a perspective of realising women's and men's basic right to equal access to appropriate health care, including reproductive health care, and the realisation of sexual and reproductive rights. This does not mean refusing to work with FBOs; what it does mean is wherever necessary, choosing to work with organisations whose values chime with the values of equality, justice, and human rights advanced by secular NGOs and enshrined in the Sustainable Development Goals.

An example is the Global Interfaith and Secular Alliance: Working for Reproductive and Sexual Health and Rights (GISA), a coalition of faith-based and secular organisations from around the world working to counter religious extremist forces that seek to curtail global progress on reproductive and sexual rights. GISA was formed in October 2011 as a result of the Global Advocacy Planning Meeting on Religious Fundamentalisms in Yogyakarta, Indonesia, which was convened by Catholics for Choice. GISA creates and presents sound alternatives to religious extremism from a progressive, women-centred, values-based position that advances human rights. GISA's three-point strategic agenda is centred on

- Creating knowledge and generating evidence regarding the negative impact of religious extremism on sexual and reproductive health and rights globally.
- Building the capacity of allies to counter effectively religious extremist opposition to sexual and reproductive health and rights.
- Utilising evidence-based advocacy before international arenas to promote woman-centred, rights-based policies and programmes.

GISA's work is an example of progressive faith and secular organisations identifying that they have a joint agenda, to meet women's full health needs. It is a groundbreaking coalition of faith-based and secular organisations working to ensure that faith-based providers put women's sexual and reproductive health, not conservative interpretations of religious teaching, at the centre of their care.

Notes

1. The US government also provides strict guidelines regarding proselytising for aid recipients. USAID stipulates that grants may not be used for 'inherently religious activities such as worship, prayer, proselytising, or devotional Bible study' (USAID 2016, 1). Grantees also cannot take into account the religious affiliation of the recipient of services and are required to serve people of all faiths and/or no faith in programmes that receive US grants. While FBOs are allowed to offer religious activities with private funding, they must be separated in either time or location from US-funded activities and voluntary for any recipients of services paid for with US funds (*ibid.*).
2. See Maguire (2001).
3. There was a requirement that all organisations receiving USAID funds provide information about all forms of contraception or refer to a provider who will do so (Miller 2014), but this spend on promoting NFP did not meet this requirement.
4. NFP methods include the Standard Days Method, which is based on the 'rhythm' method of counting days in a woman's cycle; the Billings Ovulation Method, in which women track the viscosity of their cervical mucus; and the Sympto-Thermal Method, in which women track changes in their cervix and cervical mucus, and their body temperature.
5. In the Cycle Beads Method, women use a necklace with coloured beads to track the days of their menstrual cycle, to determine their infertile period. Cycle Beads require a full 12 days of abstinence per month to reach an effectiveness rate of 88 per cent (CycleBeads 2013, 1). These issues around abstinence and a shared desire to prevent conception make NFP methods unrealistic options for many, in contexts of gender inequality and social norms which dictate women are junior to men in marriage, as well as high levels of tolerance for violence against women and girls.
6. Cycle Beads are currently included in USAID's contraceptive procurement system and are offered through USAID programmes in low-contraceptive-prevalence countries like the Democratic Republic of Congo, where Cycle Beads are offered in 515 health zones throughout the country (Hook 2013).
7. The law in Kenya changed in relation to abortion in 2010 when Kenya's constitution eased the country's severe restrictions on abortion, legalising safe abortion services when the life or health of a woman is in danger and in cases of emergency (for more information, see www.reproductiverights.org/press-room/kenyan-women-denied-safe-legal-abortion-services, last checked by the author 12 December 2016).

Notes on contributor

Jon O'Brien is President of Catholics for Choice. Postal address: Catholics for Choice, 1436 U Street NW, Suite 301, Washington, DC 20009-3997, USA. Email: jobrien@catholicsforchoice.org

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