ABSTRACT

Comparing Secular and Christian-Based Organizations' Efforts Towards the HIV/AIDS Epidemic:
Case Study of Uganda

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The Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) epidemic is considered to be one of the largest and worst epidemics to surface, especially within the developing world. While there has been much progress made in terms of research, prevention programs, and medicine to help combat the spread of the epidemic, there has yet to be a cure. Furthermore, the devastating effects of the virus have left many regions, such as Africa, crippled and is attributed to one of the major obstacles in further development. Various actors are involved in efforts to reduce HIV/AIDS prevalence through a number of projects and programs. From the different organizations, faith-based organizations (FBOs) are considered to important actors due to their influence within the local communities and their ability to build social capital. Due to their influence within the communities, FBOs may be more equipped to reduce stigma and discrimination against those affected by the epidemic as well as influence behavior change. A case study in Uganda was conducted to better

understand the influence and role of FBOs in HIV/AIDS treatment and prevention. The case study compares a Christian development organization, World Vision, to the World Bank and PEPFAR, other large organizations with projects focused upon the epidemic and helps to display the need for greater partnership between FBOs and secular organizations for sustainable impact.

Keywords: faith-based organizations; social capital; Uganda; HIV; AIDS
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CHAPTER 1 – INTRODUCTION

1.0 INTRODUCTION

The Human Immune Deficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) virus remains one of the largest obstacles to development on the continent of Africa. The impacts of the HIV/AIDS epidemic are witnessed across both the social and economic factors of development inclusive of education, gender issues, health, and agriculture. Compared to other diseases or epidemics that have occurred across Africa, HIV/AIDS is considered to be one of the newest, yet most devastating. Although other regions such as Asia have also experienced an HIV/AIDS epidemic, Africa still remains the hardest hit and negatively impacted. The magnitude of HIV/AIDS in Africa has resulted in a worldwide effort by other countries outside of Africa as well as international organizations to partner together and focus funding and projects for HIV/AIDS prevention and treatment. From the various actors involved in fighting against the epidemic, faith-based organizations (FBOs) have started to gain prominence due to their ability to connect and be committed to the communities.

As Uganda is considered to be a success-story in their treatment and response to HIV/AIDS, the country provides an interesting case to analyze various organizational efforts. Furthermore, as a country with a high religious participation, it also provides a basis in which the concept of faith and religion within the realm of development and healthcare can be studied to a further extent. While many faiths are represented within Uganda, this study

focuses more upon Christian-based organizations because of greater prominence as well as better access to information and resources on their efforts and impacts.

1.1 HISTORY OF AIDS IN AFRICA

While the exact origin of the HIV virus remains unknown, scientific research shows that one of the earliest cases to mark the existence of the virus occurred in 1959 in Kinshasa, Democratic Republic of Congo (which was then known as the Belgian Congo).[1] Much information cannot be gleaned from these findings other than to show that the virus existed at this time and that it was uncommon. However, while it is impossible to be certain the origin of the virus, researchers and scientists have reasons to believe that the dominant form of the virus originated from western equatorial Africa. The first reason given to justify this assumption is based on the findings that "HIV clearly results from the transmission to human beings of the ancient and related simian immunodeficiency virus (SIV), an infection of African monkeys that had also spread to chimpanzees."[2] SIV is not the first disease to be transferred from monkeys to humans, and it is possible that the disease was transferred through a blood infection during hunting. Through this transmission, there have been two forms of the virus that exist in humans: HIV-1 and HIV-2, the former being responsible for the global epidemic. The HIV-1 strand is also divided into several subgroups: M, N, O, and all three originated from different SIV strands. The second reason to believe western Africa

[1] Iliffe, John. *The African AIDS Epidemic: A History* (2006), p. 3
[2] ibid., p. 4

as the origin for HIV is because this region harbored the three groups of HIV-1, but also the subgroups of the most dominant from, M.[3]

Despite concluding that the virus existed in the 1950s, an epidemic was not visible or realized until many years later. Three characteristics of the virus can be cited as reasons why it took a considerable amount of time before an epidemic surfaced. The first characteristic is the difficulty in transmission—compared to other diseases, HIV is considered to difficult to transmit because it can only be contracted through blood, genital fluids, or milk from an infected human body.[4] Unlike airborne diseases, special situations or circumstances are required for HIV to be contracted, and the main means of transmission in Africa has been through sexual intercourse. This very nature of transmission of the virus plays a key role in the creation and implementation of policies, programs, and prevention efforts by governments and organizations. The second reason given for delayed visibility of an epidemic is that the development of the virus is gradual where the incubation period can be up to several years. Due to a long incubation period, it is possible for the virus to go unnoticed until it is too late. The third reason is the fact that the HIV and AIDS virus does not kill itself, but rather attacks the immune system making the body more vulnerable and susceptible to other diseases and viruses. As the immune system is compromised, the likelihood of contracting other existing diseases, such as tuberculosis, is increased and the body's ability to fight against it is also weakened, thus resulting in death. Due to this nature

[3] ibid., p. 5
[4] ibid., p. 8

of HIV, it may have been difficult recognize the existence of the virus until a greater number opportunistic infections of other diseases started to appear in greater number.[5]

While there are a variety of factors that contributed to allowing the HIV-1 virus to become an epidemic, one major reason is believed to be the demographic context of Africa in the 1980s. During this time there was large-scale urbanization due to high population growth, which in turn provided the environment and conditions for the virus to flourish.[6] Once the epidemic was realized, governments as well as international organizations were slow to create programs to adequately respond to the severity of the issue. The HIV/AIDS virus was vastly different than other epidemics that the region had encountered, and proposed a large challenge to both state governments as well as the international community. Rather than simply being confronted with a virus or disease and sub sequential death, HIV posed an even larger threat and imposed greater devastation because it was like four epidemics: "first the virus, then disease, next death, and finally societal decomposition, each superimposed upon its predecessors."[7] For the larger international organizations—usually headed by Western powers—it was unlike the situation with the virus that they were facing at home. HIV in the West at the time was on a smaller scale isolated to minorities, and therefore programs that were able to target and address the issues at home were inadequate to address the scale of the issue in Africa. On the other hand, the African governments found themselves inept to deal

[5] ibid., p. 9
[6] ibid., p. 60
[7] ibid., p. 112

with the HIV epidemic because the nature of the virus required long-term care, unlike other diseases that required urgent, short-term care, as well as the governments facing economic and structural issues. Non-governmental organizations (NGOs) filled in the gap left by the governments, and played a large role in prevention and support for those with HIV.[8]

1.2 PROBLEM – MULTI-SECTOR IMPACT OF AIDS

While HIV/AIDS is a leading health issue, the effects of the epidemic reach much further into other sectors as well. The epidemic is seen as a major obstacle towards development for many countries where there is a high prevalence rate, especially within Africa. The epidemic puts heavy restraints upon the health sector in terms of the quality and availability of healthcare, but the negative impacts can also be witnessed within the education, economic, and social sectors as well as government stability.

The two major ways in which the negative economic effects can be seen is a reduction in the labor supply and increased costs.[9] The reduction in labor supply is one of the most immediate effects of HIV/AIDS as many young adults, or those who make up a large part of the workforce, either become too sick to continue working or die as a result of the virus. The loss of labor results in less economic output and has large impacts upon the economy if the pattern continues over a period of time. For example, this negative economic

[8] ibid., p. 98
[9] Bollinger, Lori; John Stover, Vastha Kibrige. (1999). "The Economic Impact of AIDS." The POLICY Project, p.3

impact can be witnessed within the agriculture sector where studies conducted in several African countries show the adverse effects on agriculture. More specifically, the Zimbabwe Farmer's Union (ZFU) showed how an AIDS related death of an agricultural worker cuts the output of maize in small-scale farming by 61%, and a similar effect can be seen with other crops as seen in the figure below.[10]

Crop	*Production loss (Percentage)*
Maize	61
Cotton	47
Vegetables	49
Ground nuts	37
Cattle	29

Source: Kwaramba, *The Socio-economic Impact of HIV/AIDS on Communal Agricultural Production Systems in Zimbabwe* (Harare, Zimbabwe Farmer's Union and Friederich Ebert Stiffung, 1997).

In addition to the negative economic impacts seen through the agriculture sector or decrease in productive workforce, HIV/AIDS also places a strain upon the education sector. Oftentimes children will stop attending school when the number of productive workers decreases, especially if one of their parents fall ill to the virus. In order to help provide for their household, children will have to forego an education in order to work to contribute to the family. This negative impact upon education is multi-faceted as the availability of

[10] ibid., p. 5

teachers declines due to the virus, as well as student withdrawal. This is a large concern especially in rural areas because it may be more difficult to replace teachers in rural communities. Also, there is the possibility that there will be an increasing proportion of children who will become orphans who may be unable to afford to continue education.[11] In general, as access to education is decreased with also the possibility of a decline in the quality of education available, the development of AIDS affected communities can be greatly hindered.

While there are many other negative consequences as a result of HIV/AIDS within communities, it can be clearly seen that the virus has devastating impacts upon nations, especially those considered as third-world or developing nations. As the workforce is greatly hindered and reduced, strain is put upon the economy and even government institutions to help make up for the lack of productivity. This in turn poses a multi-sector threat to the nation as whole. For this reason, it is important that governments as well as non-state actors are able to come up with effective ways to both treat and prevent the spread of HIV/AIDS.

1.3 RESEARCH OBJECTIVE

The main research objective of this paper is to:

i. Analyze the ability of faith-based organizations (FBOs) to build social capital and subsequently analyze how this can help in reduced stigmatization, behavior change,

[11] Haacker, Markus. (2002) "The Economic Consequences of HIV/AIDS in Southern Africa." IMF Working Paper. p. 13

and overall effective prevention efforts.

1.4 RESEARCH QUESTIONS

i. Do the FBOs in Uganda demonstrate greater levels of social capital in comparison to other NGOs or international organizations (IOs)?

ii. How effective have been the efforts of FBOs to reduce stigmatization of HIV/AIDS and encourage behavior change in comparison to other actors?

CHAPTER 2 - LITERATURE REVIEW

2.1 CONCEPTUAL REVIEW

When there is a gap left by the government in providing basic needs, NGOs and civil society organizations (CSOs) will tend to step up and provide services to fill the gap left by the state. This can often be seen in the area of healthcare where various health services are entrusted to these non-state actors. For many developing countries in Africa, there is much state instability thus leaving the state unable to provide basic services for the people, and therefore leading to a high presence of NGOs and CSOs. A subgroup of NGOs—FBOs—are considered to be highly important actors due to their presence and reputation within communities. Furthermore, their intrinsic motivation and value system helps them to reach the hardest, or most unreached communities, as remain committed. The presence of FBOs also presents the idea that faith can play an important role in the development of communities. This idea of a common faith or value system can help to strengthen and solidify networks

within communities, thus building higher levels of social capital.

Connected to the idea of faith-based organizations alongside the increase of social capital within communities is the empowerment theory where empowerment is referred to as "the process by which people use these individual, organizational, and neighborhood building blocks to gain mastery over their lives."[12] The empowerment theory can also be seen through a faith-based lens where the assets of individuals, FBOs, and communities can solve problems and reach desired results rather than being focused upon their own shortages. In addition, one can connect the idea of the empowerment theory to the first principle of the Paris Declaration on Aid Effectiveness—ownership. Though ownership in the Paris Declaration mainly refers to governments or countries setting up their own strategies for development, such as reducing poverty, tackling corruption, and improving state institutions, empowerment on the local level can help the idea of ownership to reach to the top in a bottom-up transition. As individuals, FBOs, and communities are empowered to realize and utilize their assets towards development, or in this specific case, fighting against HIV/AIDS, they are able to take greater ownership over the various projects and programs.

In order to see HIV/AIDS prevalence rates decline in communities, there is a need to provide moral and social support alongside basic healthcare services. This can be done through the presence of social capital as trust is built within the networks and reciprocity between actors comes into existence. Therefore, empowerment and social capital become

[12] Wallace, John M., Valerie L. Myers, Jim Holley. (2004). "Holistic Faith-Based Development Toward a Conceptual Framework." The Roundtable on Religion and Social Welfare Policy, p. 7

vital elements to effectively respond to the HIV/AIDS epidemic.

2.1.1 CONCEPTUAL FRAMEWORK

According to the conceptual framework, the intrinsic motivation and values of FBOs—usually based on religious morals and scriptures—allows volunteers and workers of these organizations to remain committed and invested into the various projects, development, and well-being of those within the community in which they operate. The longstanding presence, involvement, and commitment of FBOs in communities allow greater trust to be built, therefore leading to high levels of social capital. The social capital that FBOs are able to build lead to reciprocity in relationships where their programs and various project implementations can have greater impact as community members are more receptive to FBO efforts and can lead in a change in perception of HIV/AIDS as well as in behavior. Decreased stigma and a decrease in risky behavior are major contributors to decline in HIV/AIDS prevalence rates. In this way, FBOs may have greater advantages in reaching communities in providing holistic care to effectively respond to needs. In addition to filling in the gap to provide basic services and meet needs, there exists the ability for faith-based empowerment that can allow individuals, FBOs, and communities to utilize their resources to bring about outcomes. As the individuals and communities are empowered, they can take greater ownership over HIV/AIDS prevention initiatives, leading to greater levels of sustainability.

When attitudes and beliefs towards HIV/AIDS are shifted, there is a greater chance in seeing prevalence rates reduced. As misconceptions are confronted about the virus, people

have access to more and better information, thus allowing them to make better decisions that could impact the spread of the disease. This can be observed through behavior change efforts in countries where there is high HIV/AIDS prevalence as governments and organizations work to influence behavior through greater education and information.

2.1.2 FAITH-BASED ORGANIZATIONS

Among the many different NGOs that have contributed to HIV/AIDS response, prevention, and care, are FBOs. The type of actors that fall under the FBO category can be quite large because the definition of what is considered to be an FBO is quite broad. For this paper, the understanding of what is considered to be an FBO is an organization whose "mission and identity are 'self consciously derived from the teachings of one or more religious spiritual traditions.'"[13] By this definition, therefore, large organizations, such as World Vision International or Catholic Relief Services, are considered to be faith-based as well as smaller entities such as local churches that participate in development or health care efforts in the communities. Though efforts of different international organizations—such as the World Bank, Global Fund, UNAIDS—as well as different NGOs have played a major role in trying to alleviate the HIV/AIDS situation, FBOs are believed to be of particular importance and a major actor in prevention and care efforts. In order to effectively fight

[13] Lipsky, Alyson B. (2010). "Evaluating the Strength of Faith: Potential Comparative Advantages of Faith-Based Organizations Providing Health Services in Sub-Saharan Africa." *Public Administration and Development*, p. 25

against HIV/AIDS, there is a need for coordination among three levels: the political level, the institutional level, and the community level[14]. In this regard, FBOs are significant actors because of their prominence and influence in the community. Furthermore, due to their presence in local communities, they oftentimes have a greater understanding of local needs and how to connect to the community.[15] The importance and power of FBOs in the arena of development has been gaining greater recognition in the international community in recent years as organizations such as the World Bank have stated "we cannot fight poverty without tending to people's spiritual dimension and its many manifestations in religious institutions, leaders and movements."[16]

There are many organizations that operate on the grassroots level of developing nations and have prominence within the local communities. NGOs as wells FBOs are oftentimes cited as having greater advantages in providing care and assistance than the state (or government) itself because of their ability to connect with locals. Furthermore, NGOs and FBOs tend to fill in the gap left behind in the case of instability and corruption of the state. The question that is asked, therefore, what makes FBOs different and possibly more influential and effective than other civil society organizations? While both NGOs and FBOs play similar roles in the arena of development and health care, FBOs are credited with some

[14] Okaalet, Peter. (2001). "Reducing Poverty by Combating AIDS." *Faith in Development: Partnership between the World Bank and Churches in Africa*, p. 138
[15] Lipsky, "Evaluating the Strength of Faith", p. 26
[16] Olarinmoye, Obobolaji Ololade. (2012). "Faith Based Organizations and Development: Prospects and Constraints." *Transformation: An International Journal of Holistic Mission Studies*, p. 3

comparative advantages over other organizations. The table below displays the relative advantages between both NGOs and FBOs, showcasing areas in which one might be stronger than the other.[17]

Table 1. Relative advantages between NGOs and FBOs

Comparative advantages	NGOs	↔	FBOs
Organizational traits			
Moral and ethical standing	●○○	<	●●○
Understanding of local context	●○○	<	●●●
Increased flexibility	●○○	<	●●●
Increased transparency and accountability	●○○	>	○○○
Roles			
Speak on behalf of disenfranchised	●○○	≤	●○○
Deliver quality services	●○○	–	●○○
Mobilize energy and resources	●○○	<	●●●
Provide feedback to donors and government	●○○	>	○○○
Contribute to consensus-building	●○○	=	●○○
Beneficiary empowerment			
Build constituency	●○○	>	○○○
Help communities form their own representative bodies	●○○	>	○○○
Connect local communities with higher authorities	●○○	=	●○○
Foster joint learning	●○○	=	●○○

○○○ = Not likely to have this advantage.
●●● = Very likely to have this advantage.

As seen from the table, the areas in which FBOs tend to demonstrate greater advantages over other NGOs are that of moral and ethical standing, understanding of local context, increased flexibility, and the ability to mobilize energy and resources.

A strength attributed to FBOs that may not be found in other NGOs and international organizations (IOs) is moral and ethical standing—or in other words, intrinsic motivation to work and stay committed in the poorest and least-reached areas.[18] This moral and ethical standing helps to enhance their influence in the communities in which they work, as they are able to call on people's moral duty such as helping and providing for the poor and

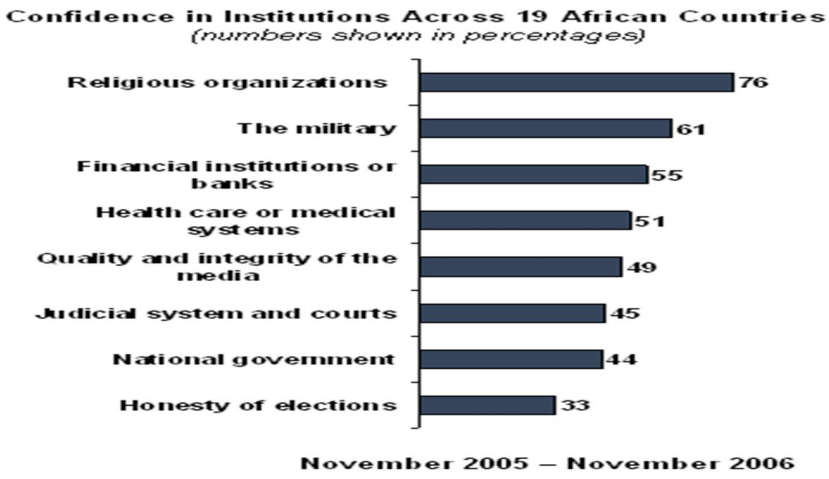
[17] This table displays relative advantages between NGOs and FBOs as displayed in Alyson B. Lipsky's article.
[18] Lipsky, "Evaluating the Strength of Faith", p. 26

sick.[19] Most research and literature related to the topic of faith—or religion—and development seems to encompass this idea of intrinsic motivation where for many religious organizations, "the motivation to engage in development work is not based on economic maximization, or improved living conditions, or growth…the driving force of religious NGOs is social justice, interpreted broadly and inclusively."[20] While other organizations and governments may be more interested in achieving certain goals such as poverty reduction or greater access to healthcare, FBOs are more interested in seeing justice upheld. What this may look like for each organization may differ, but the different aims of projects and programs may not be to simply reach various development goals and see improved livelihood, but to see those they are working with have their rights upheld.

Another area in which FBOs tend to have a greater advantage than secular NGOs is in understanding of local context. Though many NGOs try to operate on the grassroots level and try to incorporate themselves into the society, they still tend not to carry as much influence as FBOs or other religious organizations. A reason for this is because of the long history of FBOs within the community as well as established relationships with marginalized members, which "allow them to access additional information and advocate or implement programs with cultural sensitivity and greater effectiveness."[21] Since the definition of what constitutes a FBO is fairly broad, it can include churches or religious groups that also

[19] ibid., p. 29
[20] Occhipinti, Laurie. (2013). "Liberating Development: Religious Transformation of Development Discourse." *PDGT* p. 428
[21] Lipsky, "Evaluating the Strength of Faith", p. 30

participate in providing healthcare, education, or other services of need within the community. These religious institutions, therefore, have already been intricately woven into the community as key actors contributing to greater levels of trust and allowing them to better reach the members of the community. The graph below displays the level of confidence that local people have in various social and political institutions in their countries. As seen from the graph, 76 percent stated that they had confidence in the religious institutions, which was the highest among the eight institutions.[22] Therefore, because there is a higher level of confidence and trust in religious entities, there is a greater chance of projects, programs, campaigns, and other prevention efforts of FBOs or other religious institutions to be more effective in reaching the community.



(*Source: Gallup Poll, "Africans' Confidence In Institutions. 2007)*

[22] Gallup Poll "Africans' Confidence in Institutions, Jan 18 2007; poll conducted in 19 sub-Saharan countries. Sample size was 19,002 people aged 15 and older.

In the similar stream of having a greater understanding of the local context, FBOs are attributed to having greater level of flexibility than NGOs and other organizations because they "may have stronger community relationships that are not compromised by reliance on traditional funding streams such as international donor agencies and governments."[23] While FBOs do partner with large donor agencies and governments such as the World Bank, United States Agency for International Development (USAID), Global Fund, as well as other organizations, they also may receive funding from within their own religious community. They may have access to a different source of support and funding through the local community, or the wider religious body. However, this flexibility usually applies to the smaller, indigenous FBOs compared to the larger international faith organizations. Although the local FBOs may not have access to the same funding as the larger FBOs or other international organizations, they are able to create and implement their projects and efforts to fit the needs they see within the community, as they are not as restricted to donor conditions. Furthermore, the flexibility of FBOs is related to their ability to mobilize energy and resources. As previously mentioned, FBOs oftentimes may have a greater network with whom they can receive support for their initiatives outside of formal donor agencies and governments. While they may receive less funding at times, there are certain advantages to having access to alternative funding sources such as less vulnerability to losing organizational identity and they are less likely to change their goals, vision, and priorities to meet donor

[23] Lipsky, "Evaluating the Strength of Faith", p.30

agendas.[24]

Although FBOs are involved in various areas of development efforts within a country, the two sectors in which they are the most are heavily involved are healthcare and education. As previously mentioned, FBOs oftentimes help to fill in the gap left by governments in their inability to reach different communities whether due to a lack of resources, corruption, instability, or a mixture of these various reasons. The relevance of FBOs in the healthcare sector continues to grow, especially when confronting epidemic diseases spreading throughout the continent of Africa, such as HIV/AIDS. A World Health Organization (WHO) report released in 2004 found that one if five organizations actively engaged in HIV/AIDS programming is faith-based, thus showing both the importance and relevance of FBOs.[25]

2.1.3 EMPOWERMENT THEORY

The empowerment theory, adapted to a faith-based perspective, "examines the processes by which people of faith, their organizations and their neighborhoods gain control over their lives and the outcomes of empowering processes."[26] The empowering processes are processes where different actors—individuals, organizations, as well as communities or neighborhoods—become empowered, and it is this very empowerment of these groups that

[24] ibid., p. 32
[25] Global Health Council. (2005). "Faith in Action: Examining the Role of Faith-Based Organizations in Addressing HIV/AIDS " p. 9
[26] Wallace, John M., Valerie L. Myers, Jim Holley. "Holistic Faith-Based Development Toward a Conceptual Framework." p. 7

allow for positive change. The faith-based empowerment theory can be analyzed from three levels: the individual, FBOs, and neighborhood, with each level increasing in its scope. The table below demonstrates the empowering process and the outcomes of the different levels of analysis.

Table 2: Faith-Based Empowerment Processes and Outcomes Across Levels of Analysis

LEVEL OF ANALYSIS	EMPOWERING FAITH-BASED PROCESS (How faith empowers individuals and families, organizations, neighborhoods and beyond)	EMPOWERED FAITH-BASED OUTCOMES (The results of empowering faith-based processes)
INDIVIDUAL (& FAMILY)	• Relationship building • Opportunities to learn and practice service/ministry skills • Social support • Growth through spiritual disciplines (e.g., study, prayer)	• Strong interpersonal relationships • Sense of mastery and control • Church attendance and participation • Influence on church operations and policy • Spiritual maturity
FAITH-BASED ORGANIZATIONS	• Helping members discover spiritual gifts, natural talents, passions, and purpose • Develops members' leadership skills • Provides members social support • Program (i.e., ministry) development • Develop organizational capacity	• Actively involved members • Shared organizational leadership • Increased organizational capacity • Ability to acquire and effectively manage resources, influence public policy and deliver formal services
NEIGHBORHOOD (& BEYOND)	• Collaboration with other faith-based organizations • Community organizing around social issues • Developing linkages across sectors	• Collaboration across sectors • Transformed communities • Political power • Coalitions of organizations

(Source: Wallace, "Holistic Faith-Based Development")

CHAPTER 3 – ANALYTICAL FRAMEWORK

3.1 SOCIAL CAPITAL

Social capital can defined as an "instantiated informal norm that promotes cooperation between two or more individuals…[that] are related to traditional virtues like honesty, the keeping of commitments, reliable performance of duties, reciprocity, and the like."[27] Robert Putnam defines social capital as "features of social organizations, such as networks, norms, and trust, that facilitate coordination and cooperation for mutual benefits."[28] Furthermore, social capital can also be classified into two categories: structural and cognitive. Structural social capital "concerns the density and extent to which individuals or members participate in various formal and informal associations and other activity…it builds cooperation and facilitates mutual benefits through collective actions," while cognitive social capital includes "values, attitudes, beliefs, norms, and reciprocity which can be seen as a resource held between individuals interacting within the social networks."[29] Social capital—both structural and cognitive—allow individuals to work together for a common purpose or towards a shared goal. Especially in a religious or faith-based network where trust is built, the

[27] Fukuyama, Francis. (1999). "Social Capital and Civil Society." *The Institute of Public Policy*. p. 1
[28] Putnam, Robert. (1995). "Bowling alone: American's declining social capital." *Journal of Democracy,* p. 67
[29] Frumence, Gasto; *et al.* (2010). "Social capital and decline of HIV transmission—A case study in three villages in the Kagera region of Tanzania." *Journal of Social Aspects of HIV/AIDS*, p. 10

deep beliefs and norms of that religious group can help to solidify the purposes and meanings for the individuals as well as the community as a whole. To further understand how faith is connected to social capital, one needs to understand the different types, or sub-categories, found within structural social capital: bonding, bridging, and linking. Bonding is based on "enduring, multi-faceted relationships between similar people with strong mutual commitments," which can be found in within families or groups of friends; bridging refers to "the connections between people who have less in common, but may have overlapping interests," which can be represented in relationships of neighbors or colleagues; finally, linking stems from "the links between people or organizations beyond peer boundaries, cutting across status and similarity and enabling people to exert influence and reach resources outside their normal circles."[30]

3.1.1 FAITH AS SOCIAL CAPITAL

In addition to moral and ethical standards, understanding local context, and greater flexibility, one of the greatest strengths of FBOs, or simply religion in the context of communities, is the ability to build and generate social capital. Since FBOs provide an avenue in which people can be engaged in a religious network, there is an opportunity for greater experience and trust to be built up. There is also much discussion around the idea of social capital based on faith; essentially what faith-based capital entails is that it is "grounded in beliefs, customs, habits, and obligations that are not seriously threatened by individual

[30] Furbey, Robert; *et al*. (2006). "Faith as social capital" Joseph Rowntree Foundation, p. 7

defection."[31] Faith is able to build social capital through community service, cooperation, pursuit of social justice, and acceptance of others.[32] In the mainstream world religions, there are core principals relating to an understanding of a God as well as moral ground for helping those who are oppressed, or in need, and value of human life. These very moral values or core beliefs—however they may be practiced in each faith—can bring networks of people together allowing for trust and cooperation, to achieve greater influence in bringing forth change. A particular strength that can be found in faith-based or religious institution in relation to social capital is the belief or the existence of "hope and possibility of tolerance, and indeed a respect and obligation to 'the other', suggesting potential for a contribution to 'bridging' and 'linking' social capital."[33] While there is the possibility that faith traditions can contribute to division due to different beliefs and practices among the different faiths, there is still a larger possibility for bridging and linking social capital either within one faith or between faiths because of core beliefs in loving and respecting 'the other.' Outside of sharing core beliefs and values, the question remains of how or in which social capital can be built within the context of faith. Furbey refers to five key aspects, or frameworks, in which faith communities can help to form social capital: faith communities 'organize' people's associations with each other; they can be supportive contexts for new and diverse association; they help to inspire trust and confidence, commanding influence and power and affording

[31] Candland, Christopher. "Faith as Social Capital: Religion and community development in Southern Asia" p. 130
[32] Furbey, Robert, *et al.* "Faith as social capital", p. 8
[33] ibid., p. 10

opportunities for association across power differentials; they bring people together in associations that are developmental and strategic through their organizational structures; and lastly they can act as non-organizational networks.[34] Faith communities are able to shape people's association with others by bringing people together in relationships through an organized structure, such as a church. Churches, or other structures or organizations in which faith communities are able to meet and come together, provide an opportunity for people to come together and connect on both a large or small scale. This type of social capital provided by a faith community is oftentimes wide-reaching, yet thin, especially in cases where there is a large participation because it is harder to develop deep and intimate connections within a context of large participation and can be seen as more impersonal.[35]

How then is social capital within faith communities related to fighting against HIV/AIDS? The ability for faith communities, or FBOs, to build and strengthen social capital networks aids in their efforts to bring about behavior change in communities. The influence of these organizations can help to set certain social behavior standards or norms in which people may be more inclined to modify their behaviors and follow certain norms. The nature of HIV/AIDS is one where it is not spread easily in terms of being airborne or simple person-to-person contact, but is passed on through bodily fluids, and is therefore usually associated with risky behavior such as drug use or non-monogamous sexual relationships. Through organized religion, fellowship activities or events, and shared values a deeper sense of trust

[34] ibid., p. 26
[35] ibid., p. 27

and social capital can be built within communities to help greater influence change. More specifically, in cases where there is high HIV/AIDS prevalence, the strong social networks that are built by faith organizations can help to result in "social and cultural pressure to discourage high risk sexual behavior."[36] While NGOs and other organizations or groups can also build social capital in communities to help build trust and strong networks, FBOs generate a specific type of social capital, one that is based and grounded in faith which can lead to "a deeper level of commitment to the activity at hand and greater trust between actors, producing a positive impact on program quality and beneficiary satisfaction."[37] Faith is a strong motivating factor for workers or volunteers in the various communities that have been strongly affected by HIV/AIDS. Not only does faith help them to have a deeper level of commitment towards the work they do within the community, but also brings a strong sense of commitment and duty to the members of the community themselves. As previously noted, this commitment helps to portray a feeling of greater security and ultimately, trust, within the community towards faith-based groups. As greater trust is built, there is a greater chance for the initiatives taken by FBOs to have greater impact and bring about real change.

In addition to considering and recognizing how FBOs are able to wield influence in the development arena through building social capital and their strengths in fostering community and flexibility, we can also consider their roles in policy analysis in the realm of healthcare.

[36] Frumence, Gasto, "Social capital and decline of HIV transmission", p. 11
[37] Lipsky, "Evaluating the Strength of Faith", p. 27

3.2 STIGMATIZATION

An area of tension usually witnessed in communities with high HIV/AIDS prevalence is in the stigmatization against people living with HIV/AIDS (PLWHA) may oftentimes face. There is usually a certain stigma and discrimination attached to PWLHA that may make it difficult for them to be connected to the community, and actually make them feel ostracized. Stigma is considered to be "the condition of being considered unworthy or devalued in the estimation of others due to having an alleged fault or character trait."[38] However, the influence on FBO in this area can be seen both spectrums of either helping tackle the AIDS related stigma, or contributing to it. The idea of stigma in the fight against HIV/AIDS carries a lot of weight because it can actively affect prevention efforts in that it "often interferes with and undermines efforts directed at HIV and AIDS prevention, care and treatment, by isolating and creating fear and self-stigmatizing behavior, often among those who are in most need of the services."[39] The HIV/AIDS related stigma originally resulted due to fear and the lack of information, or misinformation, about the virus. Also, the extent of stigmatization and awareness of it highly varied throughout Africa in that some people believed that AIDS stigma was very strong and prevalent, while others seemed to be oblivious to it. One of the reasons for this because the stigma tended to focus on those

[38] Mwaura, Philomena Njeri. (2008). "Stigmatization and Discrimination of HIV/AIDS Women in Kenya: A Violation of Human Rights and its Theological Implications." *Exchange*, p. 41

[39] Keikelame, Mpoe Johannah; *et al.* (2010). "Perceptions of HIV/AIDS leaders about faith-based organizations' influence on HIV/AIDS stigma in South Africa." *African Journal of AIDS Research*, p. 63

considered being vulnerable, namely "poor people, the young, women, and especially sex workers—while mature people with economic independence rarely suffered it."[40]

FBO work in regards to confronting HIV/AIDS stigma can be seen in a similar vein to their general involvement in development work in that there is a sense of moral and ethical obligation or motivation. Just as they have an intrinsic motivation to help those in need—therefore helping those with HIV/AIDS even in the midst of unfavorable conditions—they also have a responsibility to fight stigma that exists because of a faith-based mandate to love and serve others.[41] FBOs are also able to carry a lot of influence of perception and attitude towards those infected with HIV/AIDS, especially within areas where there is a high level of religious involvement and where the church or other faith-based actors are highly involved in development efforts. Due to the fact that FBOs are able to establish high levels of trust as well as building up social capital, they carry more weight and influence in comparison to legislative or state actors when it comes to modifying both perception and behavior. Although they may not necessarily have the power to enact or change laws, they are better able to influence the heart and minds of the people they interact with, therefore potentially aiding in minimizing stigma.[42]

One of the biggest contributors to AIDS related stigma stems from the lack of information about the actual virus, especially in terms of how it can be contracted and spread.

[40] Iliffe, *The African AIDS Epidemic: A History*, p. 88
[41] Keikelame, "Perceptions of HIV/AIDS leaders about faith-based organizations' influence on HIV/AIDS stigma in South Africa." p. 66
[42] ibid., p. 66

The initial response by many faith communities and organizations was to associate the disease with sin or some sort of moral shortcoming thus leading a person to contract the virus. Furthermore, due to the way HIV/AIDS is spread and transmitted it requires the leaders of churches and other FBOs to discuss sex and sexuality, which was found difficult for many faith communities to do so openly. For the religious community to be engaged with the prevention efforts required that they "address human sexual activity and illicit drug use. Addressing these activities also requires acceptance of them and an ability to communicate effectively about these activities and how they relate to religious teachings and beliefs."[43] A reason for this is that oftentimes the conservative nature of many of the faith organizations and communities does not prepare the community leaders to have the needed skills or knowledge to discuss aspects of HIV/AIDS that revolve around sexual transmission of the virus. Also, the transmission of HIV was usually associated with immorality, promiscuity, and other "sinful" practices, so it required leaders and members to be able to approach the topic in a way that would not contradict or compromise their religious beliefs while trying to prevent those who were infected from feeling ostracized from the community.

In the initial stages of response towards the spreading of the epidemic, FBOs could be seen as hindering positive responses and helped to contribute towards the stigmatization of PLWHA, but as knowledge and understanding of HIV grows, FBOs are now playing a larger

[43] Clarke, Matthew; Simone Charnley, Juliette Lumbers. (2011). "Churches, mosques, and condoms: understanding successful HIV and AIDS interventions by faith-based organizations." *Development in Practice*, p. 6

role in both prevention and anti-stigmatization efforts.[44] Leaders of FBOs can help reduce the amount of stigma that PLWHA face by wielding their influence that they carry both within their faith community—for example, within their church—and also in the wider community in which they are based. In addition to misinformation that exists about the nature of HIV and how it is spread, the behavior of different leaders towards those affected by the virus also contributes to HIV/AIDS stigma.[45] Therefore, in order to successfully combat the stigmatization of PLWHA, FBO leaders must also monitor their own behavior and perception so that they can set the standard in terms of how to relate and reach out to those affected.

3.3 BEHAVIOR CHANGE

Looking at the very nature of HIV, one can see that an HIV infection is "invariably the result of human behavior" therefore leading to the belief that the change in behavior is a vital part of restricting the spread of the virus.[46] Oftentimes, when the decline in HIV/AIDS infection is observed, it can frequently be traced back to a change in perception and behavior. More specifically, the declining trends of HIV infection witnessed in Uganda were credited to the change in behavior among the young, urban men and women.[47]

Though it is widely recognized among all actors that behavior change is a key

[44] ibid., p. 7
[45] Muturi, Nancy. (2007). "The Interpersonal Communication Approach to HIV/AIDS Prevention Strategies and Challenges for Faith-Based Organizations." *Journal of Creative Communications*, p. 323
[46] Global HIV Prevention Working Group, (2008). "Behavior Change and HIV Prevention: (Re)Considerations for the 21st Century." p. 8
[47] Bollinger, "The Economic Impact of AIDS in Uganda." p. 11

component in helping to prevent the spread of HIV and AIDS, FBOs can play a unique role in this area that other state, or private sector actors, may not be able to emulate. The advantage of FBOs in this area is their connection and basis on religion, which can be used as a basis or motivation for a person, or groups of peoples, to modify their current behavior. Despite their ability to motivate behavior change, it has been argued that FBOs are biased in their approach because "while [they] are said to cover the spectrum of behavior-change strategies, many FBOs are perceived to focus exclusively on abstinence and faithfulness."[48] This is mainly due to their religious and moral standings towards their view on sexuality and what may or may not be considered as appropriate behavior. This exclusivity can pose obstacles in instilling behavior change if FBOs are unable to communicate other ways to influence a change in behavior without providing proper support or education on other methods outside just abstinence and faithfulness.

CHAPTER 4. UGANDA CASE STUDY

4.0 INTRODUCTION

Uganda presents an interesting and unique case when discussing HIV & AIDS in Africa. It is often looked to as a success story in terms of fighting the virus and effectively reducing the prevalence of the epidemic within the country. By 2000, Uganda was considered as "one of the few countries in Africa that had made progress in reversing the HIV/AIDS

[48] Global Health Council, "Faith in Action", p. 10

epidemic," thus representing a contrasting image compared to other countries in the region.[49] The quick response of the government as well as various organizations (NGOs, FBOs) is cited as a large contributor to fight off the transmission of the virus, and the case of Uganda has become "an international template for effective HIV/AIDS intervention particularly in developing countries."[50] It is for this very reason that Uganda was chosen for this case study as it presented a unique case unlike many of its neighboring countries in terms of a successful campaign against HIV/AIDS.

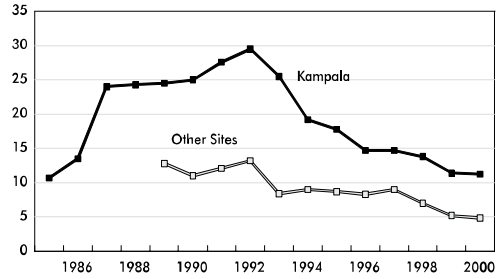
AIDS was first recognized in Uganda in 1982 in Lake Victoria, a fishing village, and became a full-blown epidemic by the later part of the decade.[51] After taking place as the new president of Uganda in 1986, President Yoweri Museveni responded to the growing epidemic by making HIV/AIDS prevention a top priority on the government agenda, and later that year implemented an AIDS Control Program (ACP) and followed by the formation of the Uganda Aids Commission (UAC) in 1992.[52] The ACP started a mass HIV/AIDS education program campaign that was designed to go nationwide through the use of an "aggressive public media campaign that included print materials, radio, billboards, and

[49] World Bank Implementation Completion and Results Report, Uganda HIV/AIDS Control Project. (2007), p. 1
[50] Kiweewa, John M. (2008). "Uganda's HIV/AIDS Success Story: Reviewing the Evidence." *Journal of Development and Social Transformation* p. 53
[51] Tumushabe, Joseph. (2006). "The Politics of HIV/AIDS in Uganda." *United Nations Research Institute for Social Development*, Social Policy and Development Programme Paper Number 28, p. 2
[52] Kiweewa, "Uganda's HIV/AIDS Success Story: Reviewing the Evidence" p. 53

community mobilization for a grass-roots offensive against HIV."[53] Furthermore, the UAC was mandated to oversee three main objectives: "(i) coordinate the development of policies and implementation of HIV/AIDS guidelines; (ii) forge the integration and harmonization of efforts to combat HIV/AIDS; and (iii) monitor HIV/AIDS activities in the country."[54] This very response by President Museveni that made the HIV/AIDS epidemic a national priority was unlike the efforts of many other countries in the region that were having a similar experience regarding the spread of the virus. There was still a lot of stigma and a lack of information about HIV during the time where the President started to respond with various government efforts. The initiatives taken on my the Ugandan state required various fields and sectors to work together to try and find ways to best effectively respond to both the outbreak of the epidemic while also trying to find ways to best prevent transmission. While there are many reasons cited at why a quick response was deemed critical by the government, it remains that the initial efforts taken helped to tackle the epidemic before the situation became considerably worse.

[53] Hogle, Janice A. (2002). "What Happened in Uganda? Declining HIV Prevalence, Behavior Change, and the National Response." U.S. Agency for International Development. The Synergy Project, p. 4
[54] Tumushabe, "The Politics of HIV/AIDS in Uganda", p. 7

MEDIAN HIV PREVALENCE AMONG PREGNANT WOMEN IN UGANDA
(Interpolated for one year gaps in site data)



Source: HIV/AIDS Surveillance Report, STD/AIDS Control Programme, Ministry of Health, Uganda, June 2001.

The graph above helps to get a picture of HIV prevalence in Uganda over the years, and shows a pattern of decline between the years of 1986—when the government started to respond to the epidemic—to 2000. Although the graph does not provide exact numbers in terms of total people infected by HIV, it displays the number of pregnant women with HIV, which is considered to be an indicator of the prevalence of the virus. While the Ugandan government put forth efforts to bring awareness about the epidemic alongside educating people about HIV and its transmission, the item of utmost importance was the idea of effectively encouraging behavior change. Despite the initial success witnessed in Uganda in HIV/AIDS prevalence, a more recent trend has been noticed within the country as prevalence rates have begun to rise once more. Though there was believed to be much success in fighting and preventing HIV/AIDS, the recent increase in infection rate is attributed to three main reasons: a) complacency about AIDS, thus resulting in high-risk behavior; b) negative changes in the social and economic environment such as increased population growth, rapid

urbanization, and unemployment; and c) decline of political support in HIV/AIDS prevention and response efforts.[55]

However, despite the tremendous progress and success that was credited to the country in terms of mitigating the presence of AIDS and seeing initial decline, there remained much socioeconomic devastation and Uganda was still considered to be one of the worst affected countries. For that reason, there are numerous non-state actors that have also contributed to the HIV/AIDS response such as international organizations, NGOs, and FBOs. While many of these non-state actors working within Uganda specifically target the issue of AIDS in varying in size, resources, and outreach capabilities, there are a few notable actors such as the World Bank, the President's Emergency Plan for AIDS Relief (PEPFAR) initiated by the United States government, the Global Fund, and World Vision International which is a major FBO working in the field of development, along many other organizations.

In addition to Uganda's early success in fighting the HIV/AIDS epidemic, the religious climate of the country is also of importance. According to a report released by USAID, the majority of Ugandans belong to a faith and attend religious services, and "reasonably comport themselves to the basic code of behavior advocated by church/mosque leadership." [56] Therefore, one can argue that religious and FBOs play a large role in community development, and are keys in effectively reaching and influencing community

[55] Inter Religious Council of Uganda. (2013). "Evaluation Report: USAID/Uganda Faith-Based HIV and AIDS Program." p. 1

[56] ibid., p.6

members. It is for this reason that both state and non-state organizations within Uganda can be seen partnering with different faith organizations and entities concerning the issue of HIV/AIDS. While it is important to effectively treat the virus and provide healthcare, there is also an aspect of emotional and personal support to be extended, and oftentimes this can be found within the context of religion. Furthermore, the Ugandan government has even set up medical bureaus operated by different faith bodies: Ugandan Protestant Medical Bureau, Ugandan Catholic Medical Bureau, and the Ugandan Muslim Medical Bureau. These three organizations are important actors in the healthcare sector of the country, and provide quality treatment as they operate some of the highest quality hospitals within the country.

4.1 PROJECT OVERVIEW

Three different organizations were studied in order to compare and analyze the ability of FBOs, specifically Christian organizations, to build social capital and use their networks of trust and reciprocity, by looking into their different projects focused upon the issue of HIV/AIDS, whether it be in the area of treatment or prevention. To see the efforts of different organizations and how they may vary in both their response as well as their ability to reach the communities, the following organizations will be analyzed: the World Bank, an international organization; PEPFAR, representing a bilateral donor organization; and World Vision International, a Christian FBO working in the area of development. Though this paper attempts to compare and analyze the projects by the different organizations, there are several challenges present due to the difficulty in tracking funding. First, many organizations do not

make funding information available for public use; therefore it is difficult to retrieve data to track the use of funding. Second, funding apportioned towards HIV/AIDS can be used for many different sectors such as healthcare, education, care and assistance, and even towards projects such as supporting the agricultural sector due to lack of workers. For these reasons, much of the data used for the comparison and analysis of the organizations is qualitative focusing on knowledge, perception, and behavior change rather than focusing on quantitative data pertaining to HIV/AIDS prevalence.

4.1.1 WORLD BANK

The World Bank funded a project in Uganda, the "HIV/AIDS Control Project" in which it distributed funds towards the Ministry of Health and the Uganda AIDS Commission. The aim, or main objective of the project was to "support the Government of Uganda's National Strategic Framework for HIV/AIDS which aims to (a) reduce the spread of HIV infection; (b) mitigate the health and socioeconomic impact of HIV/AIDS at individual, household and community levels; (c) strengthen the national capacity to respond to the epidemic."[57] Furthermore, the key indicators for the project were there following[58]:

1. By end of 2006, increase the proportion of sexually active persons who report using a condom the last sexual act with a non-regular increases from 3.5% to 20% for female (15-49) and 42% to 60% (15-54).

[57] World Bank Implementation Completion and Results Report, p. ii
[58] ibid; p. 2. The key indicators that are listed are the revised versions that were implemented during the mid-term review.

2. By the end of 2006, reduce the proportion of 15-24 who report sex with on-regular partner in past 12 months from 30.2% to less than 20%.
3. By end of 2006, reduce the proportion of reported STIs in men aged 15-54 years in last 12 months from 18.8% to 10%.
4. By end of 2006, reduce HIV prevalence below 6% among women of childbearing age attending antenatal care (ANC).
5. By end of 2006, increase the proportions of orphans attending school 5 days in the preceding week from 71.6% to 80%.
6. By end of 2006, increase the proportion of PLWHAs identified by CSOs that are receiving some form of psychological support to 90%.

In order to reach these indicators, the project was separated into three different components where the first consisted of Nationally Coordinated Initiatives, in which 50% of the funding was allocated. The second and third components both were allocated 20% of the funding and were comprised of District Initiatives and Community-led HIV/AIDS Initiatives (CHAIs) respectably. The remaining funds were unallocated and were to be later allocated to the second or third components based upon their progress review and needs of the project.

Table 3: Progress of revised project indicators and targets

Indicator	Baseline (MTR)	Target	2006 (end-of-project)
Prevention			
% of men aged 15-54 reporting STIs	19.7% urethritis 10.0% urethral discharge	10% urethritis 5% urethral discharge	14.9% urethritis 16.2 % urethral discharge
% of 15-24 years old reporting sex with non-regular partner in the past 12 months	30.2%	Below 20%	*16.8%*
% of sexually active persons reporting condom use in the last sexual act with a non-regular partner	46.2% for men 3.3% for women	60% for men 20% for women	24.0% for men 3.8% for women
Mitigation			
% of PLWHAs identified by CSOs that are receiving some form of psychosocial support	75.9%	90%	86.3%
The number of PLWHAs identified through the project that are receiving care (from the project)	5,504	7,706 (40% increase)	*33,309*
% of orphans who attended school 5 days in the preceding week	69.7%	80 %	71.1%
The number of orphaned children identified through the project that are receiving educational support (from the project)	12,979	19,469 (50% increase)	*301,129* (>100% increase)

Source: LQAS and PCT

The table above displays the various project indicators set by the World Bank, and the performance in each area. In general, one can argue that HIV/AIDS Control Project was successful in bringing positive outcomes and change, especially in the area of high-risk sexual behavior and identification of those who are in need of extra care and support. Despite these successes in meeting some of the project indicators, the World Bank has found that though there has been a respectable amount of community response and mobilization, much effort is focused upon orphans and vulnerable children (OVCs) or PLWHA. The emphasis on providing support and care for these groups results in a subsequent inadequate response to targeting other high-risk groups or other prevention efforts such as condom promotion. In this regard, the efforts by the World Bank display sufficient ability in regards to HIV/AIDS mitigation, yet there remains room for improvement, especially within the community level, to strengthen its prevention efforts.

4.1.2 PEPFAR

PEPFAR was established in 2003 under the presidency of George W. Bush and represents the initiative of the U.S. government to help those suffering from HIV and AIDS around the world. Currently there are 65 countries that receive PEPFAR support through its bilateral and regional programs. The overall goals of the program are cited as follows[59]:

1. Transition from an emergency response to promotion of sustainable country programs.
2. Strengthen partner government capacity to lead the response to this epidemic and other health demands.
3. Expand prevention, care, and treatment in both concentrated and generalized epidemics.
4. Integrate and coordinate HIV/AIDS programs with broader global health and development programs to maximize impact on health systems.
5. Invest in innovation and operations research to evaluate impact, improve service delivery and maximize outcomes.

It is important to note that though PEPFAR is a major actor in terms of funding and support for HIV/AIDS treatment, care, and prevention efforts, it works with a number of various organizations within the recipient country. For that reason, it is important to look not only at PEPFAR's efforts and funding towards countries, but also at which organizations they partner with and distribute their funding to. The selection process and criteria for recipient

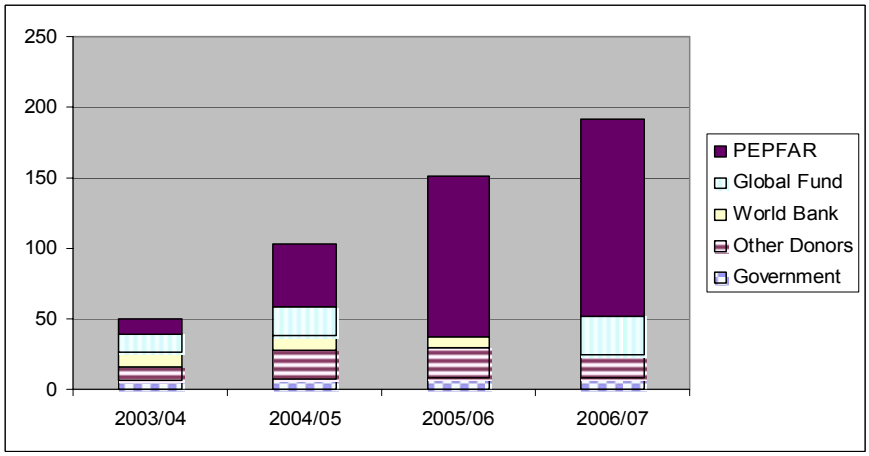
[59] The goals listed can be found on PEPFAR's website.

organizations (ROs) for PEPFAR funds has become highly competitive over the years. The bidding process to acquire PEPFAR funds requires potential ROs to provide a plan for the funding, planned output, monitoring and evaluation plan, and organizational capacity amongst other decisive factors.[60]

PEPFAR is considered as one of the main and most important donors and actors in Uganda for providing resources for HIV/AIDS response and prevention. By 2006, PEPFAR money accounted for 73% of the HIV/AIDS resources in the country, making it the largest provider of HIV/AIDS funding in Uganda.[61] The figure below demonstrates both the funding for HIV/AIDS in the country and a look into the level of funding different donors are supplying. From the figure below, one can see that the amount of funding provided by PEPFAR greatly increased within a few years, and that funding from the program is considerably larger than other donors.

Figure 2: Uganda National HIV/AIDS Funding

[60] Oomman, Nandini; Michael Bernstein, Steven Rosenzweig. (2007). "Following the Funding for HIV/AIDS A Comparative Analysis of the Funding Practices of PEPFAR, the Global Fund, and World Bank MAP in Mozambique, Uganda, and Zambia." Center for Global Development, p. 23
[61] ibid., p. 9

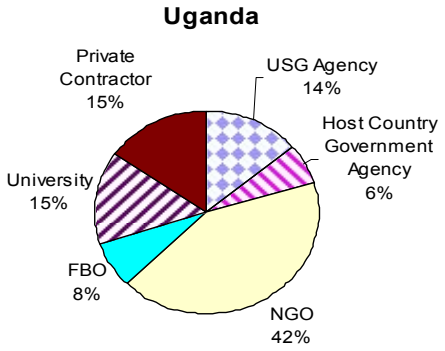


Source: Lake, "Sector Based Assessment of AIDS Spending in Uganda 2006."
Note: Based on the Ugandan fiscal year.

Though PEPFAR provides a great amount of support to Uganda, much of the money is primarily focused upon treatment and care, with funding for prevention is modest. While the program is helping to provide treatment, care, and support to those who are already infected by the virus, it was found that less than one in every four dollars by PEPFAR went towards the effort in preventing new infections.[62] As noted earlier, PEPFAR works with other organizations—both regional and non-regional—to disperse their funds. Data collected by the Center of Global Development (CGD) in 2006 found that NGOs were the largest recipients of funding, accounting for 42% in Uganda.

Figure 3: 2006 PEPFAR Obligations by Recipient Organization Type[63]

[62] ibid., p. 19
[63] ibid., p. 24. Based upon PEPFAR categorizations, which consider FBOs separately than NGOs.



Another important aspect of PEPFAR policy in relation to the programs is the importance of building local capacity. PEPFAR recognizes that building local capacity will help to ensure project and program sustainability over the long run, and therefore much of the program targets are aimed towards training new healthcare workers alongside other staff and volunteers.[64] Much of the capacity building efforts involve training as well as strengthening policy with the hopes that local capacity to run and sustain the programs will increase.

Though PEPFAR aims to build local capacity to ensure sustainability of projects, the program itself is "driven by the need to meet legislatively-mandated targets on prevention, treatment, and care. The emphasis on targets leads PEPFAR to prioritize speed and efficiency over factors like sustainability."[65] Due to the fact that PEPFAR is required by Congress to meet certain targets during a set time period, there is pressure upon the organization to give funds towards organizations that can quickly implement programs, which tend to be organizations based within the United States, therefore decreasing local ownership. This

[64] ibid., p. 27
[65] ibid., p. 28

presents a contradiction to PEPFAR's efforts to build local capacity, and also prevents the ability to truly invest in projects that may be more sustainable, yet may take longer to see results. However, despite these shortcomings in building local capacity, PEPFAR does provide much needed support on the national level in terms of national agendas and targets set by the Ugandan government.

4.1.3 WORLD VISION INTERNATIONAL

World Vision defines itself as a "Christian relief, development, and advocacy organization dedicated to working with children, families and communities to overcome poverty and injustice…World Vision is dedicated to working with the world's most vulnerable children and communities."[66] One of the primary ways that World Vision engages in HIV/AIDS response efforts is through its HIV and AIDS Hope Initiative, which was launched in 2000. This initiative developed the following three project models in which the organization believed would best address the needs of children and other people affected by HIV/AIDS in high-prevalence contexts (HPCs) as stated within their research report:

- *Community Care Coalitions (CCC):* Mobilizing and strengthening community-based care and support for orphans, children living with HIV, other vulnerable children, and their households.
- *Channels of Hope (CoH):* Mobilizing and equipping churches and other faith

[66] Chege, Jane. (2008). "Research Results from Child-Focused, Faith- and Community-Based Responses to HIV." World Vision International, p. 2

communities to respond to the needs of people affected by HIV and AIDS in positive and powerful ways.

- *Values-Based Life Skills Training / HIV Prevention Model*: Providing information and strategies that enable children and youth aged 5 to 24 years to develop knowledge, attitudes, and skills necessary to make healthy life choices and avoid acquiring HIV.

World Vision designed and conducted these three HIV/AIDS program models in their Katwe Area Development Program (ADP) in Uganda from 2002 to 2004. To further study the effectiveness as well as impacts of the project models, World Vision created an operations research (OR) study in which the program models were implemented in other regions. The main purpose was to "gather and provide information on the implementation of three program models in order to improve HIV prevention, and advocacy and care programming in communities highly affected by HIV and AIDS."[67]

The study on the effectiveness and impact of the World Vision program models was conducted through a qualitative approach in which there were documentary reviews, key informant interviews, focus group discussions, case studies, as well as verbal debriefing sessions. The basis of why World Vision believed that both the project implementations as well as study were important and relevant was due to the fact that the majority of the participants in which they met and worked still consider HIV and AIDS to be a major problem. As discussed previously, HIV/AIDS has far reaching impacts on not just the

[67] World Vision Uganda. (2009). "Assessing the Effectiveness and Impact of World Vision Core HIV and AIDS Project Models: Qualitative Study Findings From Uganda." p. 1

individual or immediate family members, but within the community as well. HIV/AIDS claimed the lives of many productive members n the locations of the World Vision ADP, and the loss of these community members had devastating effects on the entire community because it "led to a reduction in food production, depletion of family resources due to rising expenditures on HIV and AIDS treatment, and increased poverty."[68] However, this was not the extent of the negative results as other socioeconomic impacts were: disintegration of the family unit, early marriages, dropping out of school, increased child labor, and hopelessness. For these reasons, World Vision believed that more than just providing immediate healthcare to those who were diagnosed with the virus, it was also important to provide community care and support systems for each person effected by HIV/AIDS whether directly or indirectly.

One of the most devastating impacts of the HIV and AIDS epidemic is the negative outcomes that are witnessed in families, mainly concerning orphans and vulnerable children. According to a report conducted by UNICEF in 2008, 12.1 million children in sub-Saharan Africa are orphaned by AIDS.[69] If the trend of increasing OVC persists, it will continue to hinder growth and development by straining families, communities, and basic governmental services such as healthcare. For that reason, World Vision's CCC model is important as it seeks to build up the community response and capability to respond to the needs of OVC and chronically ill household members. Oftentimes, when a family member—especially a

[68] ibid., p. 3
[69] UNICEF, UNAIDS, World Health Organization. (2008). "Children and AIDS: Second Stocktaking Report."

guardian—is sick and unable to take care of themselves and the family, the children within that household are forced to quit school and instead start taking care of and providing for the family. World Vision implemented the CCC model by recruiting and training home volunteers (HV) in home-based care for OVC and for chronically ill household members. Furthermore, World Vision worked to support the HV in their home-care and partnered with various community-based organizations, NGOs, and the government to undertake greater efforts for care and support of OVC. Overall, the members of the CCC project were trained to "disseminate HIV and AIDS information, provide care for OVC and chronically ill household members, mobilize resources and raise funds."[70] The selection of the HV were based upon interest, character, and love for OVC and chronically ill, responsibility and trustworthiness, in addition to a commitment of willingness to serve the community. World Vision puts high priority in ensuring that those who participated within the project would be fully committed to both the OVC and the community.

Though there were many challenges and setbacks in CCC project efforts, World Vision found that through the project and interventions that the chronically ill household members who were suffering with HIV and AIDS faced less stigma and discrimination.[71] The reasoning for this is that as CCC members and HV received greater information and understanding of the situation and needs of the chronically ill, the community in which they served also benefited in terms of having a greater access to information about HIV/AIDS, and

[70] World Vision Uganda, "Core HIV and AIDS Project Models"; p. 10
[71] ibid., p. 12

therefore greater understanding.

While the CCC aimed to strengthen community-based support care, the COH model focuses more specifically on faith communities as a means of providing support to the community. In addition, the COH model aims to not only build the capacity of FBOs to help monitor and provide HIV/AIDS-based support, but also seeks to "transform attitudes of religious leaders to respond more effectively to impacts of HIV and AIDS within their congregations and communities."[72] Due to the fact that FBOs and religious leaders can contribute to the stigma and discrimination of those who suffer from HIV/AIDS, it is important that these leaders and organizations are specifically targeted to increase their awareness and knowledge about the virus. The main impact as a result of the COH model was the change in understanding about the existence of the virus—mainly why and how it was transmitted. The perception of why someone had HIV/AIDS was radically altered from believing it to be a punishment from God for sinful behavior or resulting from witchcraft, to understanding the different behaviors that allowed for transmission of the virus to take place. In addition to creating a platform where both religious leaders and members could gain a better understanding of HIV/AIDS, CoH also helped to provide more awareness of the situation and needs of OVC and the chronically ill. As religious leaders are more aware of the situation, they can then turn to their congregations to encourage them to embrace the OVC and chronically ill and offer support and care.

[72] ibid., p. 18

The HIV prevention model aimed to equip children from ages five to fifteen with knowledge and various life skills that would help guide their perception of both themselves and those living with HIV/AIDS. As this model also focused on strengthening community engagement, World Vision worked with volunteers to help train students in various HIV prevention skills. Some of the basic skills and knowledge that the volunteers work to teach the students are not sharing razor blades, being faithful in sexual relationships, and participating in volunteer testing for HIV and AIDS before marriage. The main platform for implementation for the prevention model took place at schools where there was greater access and opportunity to reach out to the students. While the aim of the prevention model was to give students a greater awareness and skills to increase prevention from HIV and AIDS, it also worked to break the silence of sex-related issues. Topics related to sex or sexuality were considered to be taboo, but the discussion was able to steadily improve with the implementation of the project model because it helped to provide an open platform for these issues to be discussed. World Vision's study on the impact of the HIV prevention model found that the program efforts was not just limited to reaching their target audience of children, but that the entire community benefitted because there was a community-wide increase of education in value-based skills and awareness.[73]

4.2 PROJECT ANALYSES AND COMPARISON

The World Bank, PEPFAR, and World Vision initiated various types of programs and

[73] World Vision Uganda, "Core HIV and AIDS Project Models"; p. 7

projects to meet the different needs to respond to the HIV/AIDS epidemic with the aim of reaching certain goals and standards. Some of the projects that the three different undertook were similar in nature, while others may have been completely different due to the availability of resources for each organization and their own individual targets.

4.2.1 COMPARING SOCIAL CAPITAL

The World Bank, PEPFAR, and World Vision collectively recognize the importance of social networks within communities to build trust and create greater levels of ownership. Each organization understood the value of community-led initiatives for projects and programs targeted towards HIV/AIDS treatment and prevention, and this was displayed through their project goals. Both the World Bank and PEPFAR put forth efforts in their various projects to build local capacity and provide funding for community-led initiatives. As noted earlier, World Bank allocated money and worked alongside communities to promote community-led programs, yet the community initiatives received a small fraction of funding in comparison to the nation-wide initiatives.

PEPFAR has noted intentions to build local-capacity of community to initiate and take ownership of various projects, yet the very nature and design of PEPFAR makes it difficult to successfully invest into these endeavors. One of the largest obstacles in the ability of PEPFAR to devote greater amount of resources—whether in terms of funding, time, or manpower—is because of the legislatively demanded targets that the organization is faced with. This makes it difficult for the organization to invest in projects that may be sustainable

in the long-run, but may not provide quick results to meet certain targets in the short-run. Although the importance of local capacity is recognized, the demands placed upon PEPFAR create a challenging environment for networks of trust to be established within the communities, and therefore difficult to build and accumulate greater levels of social capital.

The various project models initiated by World Vision place much emphasis upon community-led programs and working alongside local churches and organization to reach their project goals and targets. Both the CCC and CoH project models are specifically designed to strengthen community ownership and response to the various HIV/AIDS related issues whether it is training the community to better take care of those in need such as OVCs or whether it is providing support groups. One main difference found in the World Vision projects compared to those of the World Bank and PEPFAR is the establishment of local support or discussion groups through partnering with local churches. As World Vision partners with local churches, it helps to provide both a physical and social venue in which social capital can be built. Churches provide the physical venue in which people are able to gather for the support and discussion groups, and through this social interaction in the community, it can be argued that there is increasing social capital as people are able to strengthen their social networks, build trust, and feel more connected to those in their community. Another aspect of the World Vision project that contributes to the building of social capital is emphasis of on education and information to understand HIV/AIDS to help change perspectives and stigma that may come along with the disease. As people become

better educated about the disease, especially religious leaders within the communities, it allows room for greater trust to be established.

4.2.2 COMPARING EFFORTS AGAINST STIGMATIZATION

In the area of combating HIV/AIDS related stigma, the World Bank showed no clear focus or emphasis to specifically target this area. As observed from the indicators for their project, the main objectives were in the area of prevention through reduction in sexual activity those reporting high-risk sexual behavior, such as having multiple partners, as well as mitigation efforts through higher care for OVCs and school enrollment. Though stigmatization may not have been directly targeted in the Bank's efforts, one cannot say with certainty that there was no effect upon HIV/AIDS related stigma. Within the sphere of its community interventions—which made up 20 percent of the Bank's initiatives—is community AIDS education. As noted previously, much HIV/AIDS related stigma is a result of misinformation or lack of knowledge pertaining to the virus. It can be inferred, therefore, that the community AIDS education making up 20 percent of the community-based initiatives, can contribute to decreasing stigma as members of the community have greater access to information.[74]

PEPFAR gives special care and attention to the issue of HIV/AIDS stigma, which can be witnessed through its various projects and partnerships with other organizations with

[74] World Bank Implementation Completion and Results Report, p. 19. Information on the different community interventions provided on a table where Community AIDS education is listed to make up 20%.

Uganda to specifically address this issue. One way they address the issue of stigma is through providing care and support programs for those affected by HIV/AIDS in the hopes that it could help to reduce stigma associated with PLWHA. Furthermore, other projects that PEPFAR is involved in also work on de-stigmatizing the use of condoms. While it is not directly targeting the stigma or discrimination that PLWHA may face, their efforts to fight against stigma associated with condom use can help in the area of behavior change and prevention. In particular, most of condom destigmatization efforts are in relation to those who are more likely to engage in high-risk sexual behavior such as commercial sex workers, long-distance truck drivers, fisherman, and uniformed service men.[75] Whether or not PEPFAR's efforts to combat stigma has been successful or not is hard to observe because it is hard to accurately measure the levels and rate of which people may experience stigma or discrimination. Despite the difficulty in measuring the effectiveness and results, it is clear to see that PEPFAR does place emphasis and importance in this area.

The main way World Vision seems to tackle the issue of HIV/AIDS related stigma and discrimination is through their Channels of Hope project model in which they work specifically with local churches and religious leaders. As previously mentioned, religion—or in this case, the local church and pastors—can serve as both an instigator and combatant of stigma dependent upon the beliefs and information one has regarding the virus. When religious leaders and their congregations associate HIV/AIDS with sinful behavior and deem

[75] PEPFAR Uganda Operational Plan Report (2013), p. 323

such people with the virus as receiving punishment, stigma and discrimination may be prevalent. However, if churches and the congregations decide to extend care and support to PLWHA, it can help to combat against existing stigma. World Vision's CoH project, therefore, can be seen as a vessel to bring about a decrease in stigma and discrimination. As the organization partners with local churches, provides greater information on HIV/AIDS, it helps to encourage the local church leaders and congregations to have a renewed perspective about the virus and those who are affected by it. Through testimonies taken from local discussion groups, World Vision claims that discrimination and stigma has declined as members of the community is educated on how HIV can and cannot be contracted, and thus church members who have HIV/AIDS are not as ostracized as before.[76]

4.2.3 COMAPRING EFFORTS TOWARDS BEHAVIOR CHANGE

One aspect of World Bank's projects and efforts in Uganda was to target groups engaged in high-risk behavior through providing education as well as encouraging behavior change. According to the project evaluation released by the World Bank, they were fairly successful in this area as there was a reported reduction in the number of 15-24 year olds who reported engaging in sexual relations with a non-regular partner (decreased to 16.8% from 30.2%), alongside an increase in women who reported the use of condoms (from 3.3% to 3.8%).[77] These numbers show that on some level, the World Bank was able to help influence

[76] World Vision Uganda, "Core HIV and AIDS Project Models"; p. 20
[77] World Bank Project Report; p. 16. Though the number of women reporting use of condoms

a change in behavior and therefore may contribute to lower HIV/AIDS prevalence levels within the communities. Furthermore, the World Bank considered those who are engaged in high-risk HIV-related behaviors to be one of the main beneficiaries of their projects within Uganda and this is reflected through the reported results.

PEPFAR works closely alongside the Ugandan government and their efforts towards HIV/AIDS prevention, which can be represented in their efforts in influencing behavior change. The organization works alongside different government entities, such as the Ministry of Education, to design curriculum and programs targeted towards youth in order to help reduce risky behaviors that could lead to contracting the virus. PEPFAR not only recognized the importance of behavior change in order to see an actual decline in HIV/AIDS prevalence, but also understood the importance of the gender roles and challenges that each gender may face, and thus created behavior change strategies specific to males and females. More specifically, PEPFAR created a Gender Challenge Fund, which focused on gender-related programming inclusive of acknowledging gender norms and behaviors in order to better address the different issues at hand.[78] However, despite the fact that PEPFAR recognizes that behavior change is an important step in prevention, the main emphasis and focus of the funds is placed upon treatment and care to help mitigate the negative impacts of HIV/AIDS.

The HIV Prevention Model promoted by World Vision is specifically aimed at

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increased, the number of men reporting condom use actually decreased quite dramatically from 46.2% to 24.0%.

[78] PEPFAR Uganda Operational Plan Report, p. 149

educating and training students in various prevention skills to help change behavior. As previously mentioned, students are encouraged to limit sexual partners or practice abstinence as well as refraining from sharing razor blades with others. The organization recognizes that behavior change is a vital aspect towards reducing HIV prevalence, but also believes that there needs to be greater community involvement in this area as well. To see sustainable and effective results from the behavior change efforts, World Vision also works to provide community-wide education to bring more awareness and information. In a similar vein as the stigmatization of HIV/AIDS, behavior change is also dependent and influenced by the information and awareness that exists within the community. World Vision believes that as the community becomes more educated on the virus and how it is transmitted, it will help to spur change in behavior as people become more aware about the risky behavior they might be personally involved in. According to the report released by World Vision Uganda, students and OVC attending schools reported both a greater awareness of risky behavior and a significant change in behavior, such as the use of condoms.[79]

CHAPTER 5 – CONCLUCSION

5.1 SUMMARY OF FINDINGS

The case studies and respective project reports and evaluations from the three organizations help to get a glimpse of the various efforts in Uganda to fight against the

[79] World Vision Uganda, "Core HIV and AIDS Project Models"; p. 7

HIV/AIDS epidemic. Each organization displays, to varying degrees, different types of actors and the projects that they implement according to their objectives and viewpoints of what are the most important aspects in HIV/AIDS mitigation and prevention. Despite their different emphases and approaches, the World Bank, PEPFAR, and World Vision all recognize the importance of community-led initiatives for sustainability and lasting impact towards the epidemic. Although involvement of the community is an important factor according to each of the organizations, they are not equal in their approach or partnerships with the community. For example, much of PEPFAR efforts are focused upon aiding and strengthening the government initiatives, and therefore, may at times forego investing in or equipping local communities.

While all three organizations are important actors in Uganda to fight the HIV/AIDS epidemic, World Vision seemed to be the most capable of the three to build social capital and local ownership in addressing HIV/AIDS related issues. The reason for this can be seen through its commitment to building and strengthening the local churches through education and training. Much of the misperceptions and stigma related to HIV/AIDS can be addressed and corrected through educating members of the community, and as they become more aware and better informed, stigma and discrimination can be reduced, leading to stronger social ties among community members. In addition, World Vision also trained local leaders in the church and community to provide counseling and care towards OVC and PLWHA, which provided both a physical venue and social avenue where people could come together to share

their experiences and challenges.

All three organizations reported both efforts and results in terms of addressing behavior change, which is considered to be a good indicator of HIV/AIDS prevalence, throughout their projects. Each organization can be said to be somewhat successful in this area due to their attempts to target high-risk groups, but the World Bank and World Vision showed the most promise in this area. However, it can be argued that World Vision may be able to best sustain efforts toward behavior change due to their ability to build social capital and empower the local communities. If a community is empowered to educate its own members as well as create new norms or standards of behavior, there is a greater chance that the change in behavior will be sustained. Though it is important to specifically target those who are considered to be "high-risk," it is also important that the general population of each community has access to information as well as various social services, such as support groups or care facilities, for counsel or moral support.

5.2 RECOMMENDATIONS

It can be argued that World Vision has a comparative advantage over both the World Bank and PEPFAR in building social capital and local empowerment. However, the advantage that PEPFAR and World Bank have compared to World Vision is the availability of resources. Both organizations have a greater access to funding than World Vision, and in that sense they are able to finance more projects or programs that require a high levels of funding. Also, due to the nature of the two secular organizations and their access to funds, it can be

argued that they have greater access to technical or human resources. Furthermore, World Vision is more limited in human resources due to their faith nature in which they aim to hire those with a Christian faith to work within the organization. What can be observed, therefore, are different advantages that three organizations have in various fields. For this reason, it can be argued that there should be a partnership between organizations of faith and secular organizations to be able to fully and successfully address the HIV/AIDS epidemic within Uganda.

A complementary partnership between FBOs and secular organizations would be the best and most sustainable approach to fight against HIV/AIDS. From the example of World Vision, FBOs seem to be the most capable at empowering communities and building networks of trust within the communities, while secular organizations such as PEPFAR and World Bank have greater access to resources as well as their partnership with the national government. Although World Vision works alongside the government to a certain extent, much of the focus is placed upon local communities, while PEPFAR, on the other hand, is focused on already existing government efforts. Therefore, a partnership could benefit not only the donor organizations, but also the Ugandan government as well as local communities. As secular organizations are able to partner with FBOs, there is the opportunity to build a stronger link in government efforts and seeing them implemented and materialized within the local level. This partnership between secular and faith organizations is not entirely new to the development world as there is increasing incidence of large development organizations

working alongside FBOs to better meet the needs and see sustainable development.

For example, USAID, which supports and oversees the implementation of PEPFAR, recognizes the importance and power of FBOs in addressing the HIV/AIDS epidemic, and has partnered with the Interreligious Council of Uganda (IRCU). The IRCU is compromised of the five major faiths in Uganda—Catholic, Church of Uganda (Anglican), Seventh Day Adventists, Orthodox, and Islam—and was created in 2001.[80] In an evaluation report released by USAID, it was stated that IRCU is "performing satisfactorily in terms of mobilizing the strengths of the faith based community to address HIV/AIDS prevention and treatment and, in doing so, is making a significant contribution to the overall HIV/AIDS program in Uganda."[81] What this displays is that partnership with a faith organization such as IRCU or World Vision, can tap into the strengths of faith communities to complement the strength of various secular organizations. With the resources from larger development organizations such as the World Bank or PEPFAR and the community reach and commitment of FBOs, there is a greater possibility to have a sustained and effective approach towards HIV/AIDS prevention and treatment.

5.3 LIMITATIONS

The limitations encountered during the research process of this paper were a lack of information on the various projects undertaken by different actors within Uganda and lack of

[80] IRCU, "Evaluation Report: USAID/Uganda Faith-Based HIV and AIDS Program," p.1.
[81] ibid., p. 3

information from other faiths apart from Christianity. While World Vision, World Bank, and PEPFAR provided their own evaluations and operational plans, there is a possibility that an organization bias is existent because of their self-evaluations and reporting. In addition to the difficulty of gathering information on each organization and their projects within Uganda, there is also a deficient amount of quantitative data. This leads to a heavy dependence upon qualitative data, which may not be as reliable or testable as quantitative data. Furthermore, much study and articles have been released on FBOs and their roles in development, yet most reports released pertain towards Christianity, and other faiths such as Islam are not equally represented. It is hard to see if the results and strengths represented in the various reports are an accurate picture of FBOs as a whole or if these strengths are particular to Christianity due to insufficient reports from other faiths. In order for a more thorough study to be conducted, other faiths should also be included to get a more accurate picture of how faith and FBOs are able to impact development as well as HIV/AIDS prevention and care.

5.4 CONCLUSION

The current status of the HIV/AIDS epidemic in Uganda—and more generally, in Africa—requires a multi-tiered as well as a multi-sectored approach to be able to adequately address the various issues and obstacles it presents. As one of the most devastating epidemics, which has already consumed vast amounts of funding for projects, it continues to be a high priority for both national governments as well as the international community. The nature of the HIV virus makes it a large obstacle towards greater economic development for many

developing countries while contributing to many negative impacts to both the economic and non-economic sectors such as healthcare and education.

Traditional approaches in responding to the epidemic has been led mainly by state governments, such as in the case of Uganda, with partnership with large international organizations or NGOs. There is no question about the importance that non-state actors such as the World Bank and PEPFAR play in HIV/AIDS treatment and prevention due to their high levels of funding and access to other resources. Recent studies and observations, however, show that FBOs have been playing an increasingly important and vital role in the realm of development, especially in the area of combating HIV/AIDS. The strengths of FBOs compared to other organizations or actors can be seen through their networks within the community and their ability to build social capital. For nations such as Uganda where a majority of the population is considered to be 'religious' or as belonging to a faith, religious institutions and leaders carry significant influence. This influence of religiously affiliated, or faith-based entities can therefore play a vital role within the community, which can be seen through HIV/AIDS related issues.

The Ugandan case study displayed the ability of a large Christian development organization to connect with local churches and communities to implement various projects and programs focused upon HIV/AIDS treatment and prevention. While other secular organizations are also active within the state, it was observed that the FBO was better able to build social capital through building networks of trust. Furthermore, because of the deeper

and stronger ties that many FBOs have compared to NGOs, international organizations, or state organizations, they are better able to influence behavior change and combat against stigma that exist within the communities. However, a limitation that many FBOs face—internationally or locally based—is lack of funding compared to the larger secular organizations such as the World Bank or PEPFAR. I argue, therefore, that a greater level of partnership should be implemented for the most effective and sustainable response in combating HIV/AIDS. With the funding and other resources available to larger non-faith organizations alongside the capacity for social capital as well as community networks of FBOs, is the ability to better equip local communities to take ownership for sustainable HIV/AIDS prevention.

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[KOREAN ABSTRACT]

HIV/AIDS 전염병은 개발도상국내 에서 가장 크고 최악의 전염병의 하나 가 될것으로 간구됩니다. 연구조사와 예방프로그램 또 의학의 관점에서 전염병의 확산을 방지하는데 많은 진전이 있었지만 완전한 치료는 아직 없습니다. 또한 무서운 영향을 준 바이러스는 아프리카와 같은 많은 여역들의 앞으러의 발전을 흔들리게 하는 주요 장애물 중에 가장 큰 하나입니다. 다양한 조직에서는 많은 프로젝트와 프로그램을 통해 HIV/AIDS의 예방 노력에 참여하고 있습니다. 다른 단체에서는 종교단체 (FBO)가 지역 사회 내에서의 영향력과 사회적 자본을 구축 할수 있는 능력에 중요한 단체로 간주됩니다. FBO는 차별을 줄이고 행동변화에 영향을 줄수있습니다. 우간다의

사례연구는 더 나은 HIV/AIDS의 치료 및 예방을위한 FBO의 중요성과 역할을 이해하기 위해 실시되었다. 사례연구는 FBO와 세속적인 조직 사이의 더 큰 협력의 필요성을 표시하기위해 기독교, World Bank과 PEPFAR의 단체를 비교합니다.

Keywords: HIV/AIDS 전염병; 중교단체; 우간다
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