Advancing sexual and reproductive health and rights through faith-based approaches: A mapping study
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The study was part of a project undertaken by the following partners: DSW - Deutsche Stiftung Weltbevölkerung; Cordaid; ACRL-RfP – African Council for Religious Leaders-Religions for Peace; Al-Azhar University’s International Islamic Centre for Population Studies and Research; CCIH – Christian Connections for International Health; and MFCS – Muslim Family Counselling Services.

Published by the Faith to Action Network Secretariat with support from the Ministry of Foreign Affairs of the Netherlands

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ACKNOWLEDGMENTS AND DISCLAIMERS

This study was authored by Dominika Jajkowicz, Monitoring & Research Officer, the Faith to Action Network Secretariat, DSW (Deutsche Stiftung Weltbevoelkerung). The author would like to thank all participating faith-based organisations for their time and contributions.

Acknowledgement also goes to the Faith to Action Steering Council members who helped link up with the majority of participating faith-based organisations. Special thanks should be given to Prof. Ahmed Ragab, Al-Azhar University, Vice-Chair Person of the Faith to Action Network who provided methodological inputs to the study.

Last but not least, thanks to Peter Munene and Angela Mutegi, the Faith to Action Network Secretariat, DSW, for their review of the report, and especially Matthias Brucker, DSW, for guiding the research from its inception, and for his ongoing support and enthusiasm for the study.

The opinions expressed in the report are those of the author and, where indicated, of the participating faith-based organisations and might not necessarily reflect the views of the Faith to Action Network.
FOREWORD

We are a global inter-faith Network of faith-based organisations committed to improve family health and wellbeing. We promote a comprehensive approach to advocacy and programming for sexual and reproductive health and rights. To this end we facilitate dialogue and knowledge sharing within and between faiths, build the technical and financial capacity of faith-based organisations and religious institutions and facilitate interventions around sexual and reproductive health and rights. Our intention is to combine innovative, evidence-backed and community-based programming with national, regional and international advocacy efforts to influence change at all levels. We also aim to be on the forefront of generating and disseminating evidence on faith-based approaches to sexual and reproductive health and rights. We are committed to meeting international standards of quality and accountability, and ensuring the relevance of our interventions to everyday life of our communities. Our four priority areas of: networking and coordination, advocacy and communications, capacity development and technical support, and research, monitoring and evaluation reflect the above mentioned commitments.

Faith-based organisations are a crucial building block to the achievement of sexual and reproductive health and rights worldwide. There is however, incredible diversity among religious leaders and faith communities regarding their attitudes around the issues of sexual and reproductive health and rights. Therefore their participation in dialogue is often hindered by lack of a unified voice. Hence, we came together as an interfaith network to address the need for a strong faith-based voice in promoting family health and wellbeing. We recognise that faith-based organisations need a joint space to discuss common values and areas of consensus on sexual and reproductive health and rights. We also acknowledge the need for building the skills of faith leaders and religious institutions to discuss and actively address the issues of sexual and reproductive health and rights.

As Council members of the Faith to Action Network, we want to leverage the efforts of faith-based organisations in addressing sexual and reproductive health and rights and showcase their contributions. Therefore we ask: How are we, as faith-based community, addressing sexual and reproductive health and rights? Where lay our strengths? Where do we face barriers? How can we best leverage our faith-based approaches to advance sexual and reproductive health and rights? This is why we have commissioned the Faith to Action Network Secretariat to research the sexual and reproductive health and rights interventions of our Network members and the wider faith-based community.

The findings of the study shed light on great opportunities but also barriers that present themselves to faith-based organisations working on sexual and reproductive health and rights. These findings prompt to leverage our existing strengths and mitigate the challenges to deliver for family health and wellbeing:

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1 Our operational definition of family health and wellbeing includes: birth spacing, fertility awareness, safe motherhood, preventing mother-to-child transmission, maternal and child health, age appropriate sexuality education, gender equity and prevention of female genital cutting, early marriage and all forms of gender-based violence.
• Our diversity of sexual and reproductive health and rights responses underpinned by a joint vision of physical and spiritual wellbeing uniquely positions us to realise a holistic vision of health and sexual and reproductive health and rights. **We will continue promoting this approach and highlighting the importance of nurturing positive attitudes and values towards one’s own sexual and reproductive health and rights.**

• Our sexual and reproductive health and rights advocacy strengths lie in numbers and the ability to influence both the grassroots and the policy level. **We will strive to continuously building the capacity of faith-based organisations in evidence-based advocacy and policy influencing. This is to ensure our messages and asks are better heard at the national and international level. Our interfaith voice will be active in promoting family health and wellbeing. At the same time we will support our members in forming alliances for specific sexual and reproductive health and rights advocacy asks.**

• Our sexual and reproductive health and rights service delivery offers context-embedded responses founded on compassion and motivation to serve. Underpinned by the respect for diversity of approaches, **we commit ourselves to building the capacity of faith-based organisations in providing adequate technical knowledge and facts on sexual and reproductive health and rights. At the same time we will encourage more partnerships with different faiths and with faith-neutral organisations for complementarity of service delivery.**

• We are uniquely positioned to raise resources within our constituencies thanks to existing assets and well-defined resource mobilisation audiences (our religious institution, followers and well-wishers). **We therefore call upon ourselves to empower faith-based organisations to unlock their resource potential for realising family health and wellbeing.**

• We acknowledge that our diverse faith communities can themselves pose challenges to sexual and reproductive health and rights due to hindering factors such as conspiracy theories and stigmatisation. **We are committing ourselves to provision of internal advocacy and sensitisation of our communities to ease delivery of family health and wellbeing.**

• Our contributions to sexual and reproductive health and rights are not sufficiently acknowledged. The reasons for the limited publicity partially lay in the foundations of our work; compassion and service to humanity. However, we also acknowledge our capacity gaps in research, documentation and communications. **We therefore commit ourselves to encouraging knowledge exchange and sharing on faith approaches to sexual and reproductive health and rights. We also urge ourselves to enhance the capacity of faith-based organisations in research and documentation.**
Last but not least, we call upon donors and faith-neutral organisations to recognise the uniqueness of our sexual and reproductive health and rights responses and urge for tolerance of diverse viewpoints, languages and approaches to advancing sexual and reproductive health and rights.

Above all, our strengths, needs and barriers present opportunities for collaborations among faith communities and with other civil society organisations, donors, and governments. This study is an effort to engage others on contributions, limitations and needs of faith-based approaches in sexual and reproductive health and rights. The Faith to Action Network is one of the hands stretched to welcome this engagement.
STATEMENT FROM THE CHAIRPERSON

Religion should act as a resource for inspiring the faithful to actions that uphold the dignity of life. This should be through popularising values that promote human dignity; caring, sharing without humiliation, faithful stewardship of relationships, peaceful co-existence and the willingness to sacrifice for the common good.

While in the past different faith groups have struggled to find a common platform to advance these values, increasingly however we are glad to see joint initiatives around issues of common concern such as this effort.

The Faith to Action Network has provided a framework for collaboration between different faith-based organisations globally to promote dialogue around issues related to improving family health and wellbeing.

This research is one of the fruits of this collaboration and points to the great potential within faith-based organisations to contribute pertinent issues in a more accountable manner that does not only seek to satisfy conventional approaches but also upholds the demands of God the Creator, who is the source of our being and meaning.

All matters that relate to human existence have both a scientific and moral dimension. In addressing these matters therefore, there is a need for openness among partners, namely scientists and people of faith to learn to appreciate the contribution of the other. We trust these research findings will go a long way to underscore the indispensable contribution of faith-based organisations to family health and wellbeing.

Reverend Canon Grace Kaiso,
General Secretary, Council of Anglican Provinces of Africa (CAPA)
Chairperson, Faith to Action Network
STATEMENT FROM THE VICE-CHAIRPERSON

Religious leaders are trusted, respected leaders all over the world, especially in rural, underserved areas. Women, men, and youth rely on them for guidance on many personal and family matters. They can share opinions about sexual and reproductive health and rights, and help their followers make important life decisions. Essentially, religious leaders play an active role in the dissemination of accurate information about sexual and reproductive health and rights.

Islam is a comprehensive system that regulates the spiritual aspects as well as civil aspects of individual and communal life. It aims at developing a unique personality of the individual and a distinct culture for the community, based on Islamic ideals and values. The teaching of Islam covers all the fields of human activities, spiritual and material.

Instructions which regulate everyday activities of Muslims are called Shari’ah. Shari’ah is driven from specific sources, mainly: the Holy Quran, the Sunna and the Hadith (which is a collection of traditions, deeds and sayings of the Prophet Mohammed, Peace be Upon Him, developed by jurists over time). Moreover, Shari’ah is also informed by the consensus of Islamic Scholars (Ijmaa), and analogy (Kiass) which is the intelligent reasoning by which a rule of events that the Quran or Sunna did not mention, are matched against similar, or equivalent events, already ruled on.

The Shari’ah is not rigid or fixed except in a few legislations such as worship, rituals and codes of morality. It leaves space to adapt to emerging situations in diverse contexts. It can accommodate different honest opinions as long as they do not conflict with the spirit of its primary sources, and are intended for the benefit of humanity. While Shari’ah is divine, jurisprudence is a human interpretation of Shari’ah and as with all human matters you might find differences among those who interpret Shari’ah. Despite Shari’ah being accommodative, there are some who interpret it rigidly without maintaining the Islam spirit of flexibility.

Against the backdrop of the wide spread of conservatism all over the world, we should keep in mind that religions, although they might be different in ritual aspects and some definitions, share one ultimate goal which is the welfare of humanity. Consequently, let us work on achieving such a goal. Let us work on our commonalities and leave our differences aside.

Prof. Ahmed Ragab, MD, Ph.D
Consultant & Professor of Reproductive and Sexual Health,
International Islamic Centre for Population Studies and Research, Al-Azhar University,
Vice-chairperson, Faith to Action Network
## ACRONYMS

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<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>CSOs</td>
<td>Civil society organisations</td>
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<tr>
<td>IUIDs</td>
<td>Intra uterine insemination devices</td>
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<td>F2A</td>
<td>Faith to Action</td>
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<tr>
<td>FBOs</td>
<td>Faith-based organisations</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human immunodeficiency virus infection/acquired immunodeficiency syndrome</td>
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<td>SRHR</td>
<td>Sexual and reproductive health and rights</td>
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<td>STI</td>
<td>Sexually transmitted infections</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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EXECUTIVE SUMMARY

Introduction and methodological framework

This study was commissioned by the Faith to Action Network Steering Council and is intended to inform the Faith to Action programme, whose objective, amongst others, is to generate knowledge on diverse FBOs’ approaches to SRHR. By doing so, the research aims to contribute to building evidence for uptake by and involvement of FBOs in SRHR advocacy, policy influencing and programming. It further intends to support experience sharing and learning amongst FBOs.

The principal objective of this study was to construct an up-to-date review of FBOs’ interventions in SRHR and highlight patterns and trends of FBOs’ SRHR provision. The study also aimed to (1) identify synergies, added-value, gaps, and points of consideration while engaging with FBOs in SRHR (2) recommend ways to advance SRHR from a faith-based perspective.

The study provides data, analysis and recommendations on the following areas of inquiry:

1. How do FBOs perceive health and SRHR?
2. What is their thematic focus of interventions in SRHR?
3. What type of activities do FBOs undertake in SRHR?
4. How do SRHR services provided by FBOs compare to international guidelines of WHO or UNFPA?
5. How do FBOs perceive their added-value in SRHR?
6. What barriers and obstacles do FBOs perceive in providing SRHR?
7. What are the practical implications and recommendations from the study findings for FBOs’ SRHR interventions?

The study was a formative research based exclusively on primary data. It was a mix of quantitative (online surveys) and qualitative approaches (interviews with stakeholders who were staff of FBOs). The research intended to construct knowledge and evidence through bringing in stakeholders’ perspectives.

A total of 95 FBOs were consulted as part of this analysis:

- 82 FBOs took part in online surveys
- 10 FBOs participated in both online surveys and interviews
- 3 FBOs took part in interviews

Out of 95 participating FBOs, 65% came from Sub-Saharan Africa, 13% from North America, 12% from Europe and 10% from Asia. A large majority of 79% belonged to the Christian faith, 14% to the Muslim faith, while 7% were inter-religious.
Key findings

Health and SRHR in the faith-based context: FBOs promote a holistic approach to health highlighting both physical and spiritual wellbeing. This is reflected in their SRHR work, especially in the context of HIV/AIDS interventions, where counseling and emotional support for HIV positive patients were reported as core to FBOs’ provision.

Thematic foci in SRHR: FBOs’ interventions covered maternal and child health, reproductive health, family planning, adolescent health, gender-based violence, STI, HIV/AIDS, sexual health and sexual and reproductive rights. HIV/AIDS was the most commonly reported thematic area, followed by reproductive health and maternal and child health. Family planning and gender-based violence were underreported. Family planning was often mainstreamed within other thematic areas. Gender-based violence is a loose umbrella term. Some gender-based violence responses, for example trafficking and sexual abuse of women were not labeled accordingly. Instead they were lumped in with other thematic categories. Moreover, language of family planning and women empowerment was sensitive in traditional and rural settings which could have also led to underreporting.

Type of SRHR activities: The greatest numbers of FBOs were involved in SRHR advocacy and policy influencing, followed by capacity development and trainings as well as service delivery.

1. SRHR advocacy and policy influencing: Advocacy and policy influencing were considered important by FBOs. This was underlined by the general recognition that there is potential for the faith community to play a key role in this process. Membership to working groups was the most frequently reported type of advocacy and policy influencing activities undertaken, followed by capacity development in conducting advocacy and organisation of meetings with decision makers and decision influencers. Other forms of common advocacy and policy influencing activities included submission of comments on policy drafts related to SRHR-issues and campaigning. A low number of FBOs indicated to have taken part in an expert study or a fact finding mission as per government or other donors’ invitation. This might imply that FBOs appear as having insufficient expertise or their importance to the SRHR policy and decision making processes is not recognised. In addition, FBOs reported weak capacity to link up with other FBOs and CSOs in their advocacy and policy influencing work as well as highlighted limited access to decision makers and government officials.

2. SRHR service delivery: FBOs reported delivering a wide range of SRHR services covering: antenatal care, delivery care, postnatal care, STI (including HIV/AIDS) counseling, prevention, testing or treatment, contraceptive counseling and provision, post abortion counseling and treatment, reproductive health counseling and referral and provision of youth-friendly reproductive health information and services. HIV/AIDS/STI prevention, testing, treatment and counseling as well as contraceptive counseling were the most frequently reported. The degree of contraceptive provision amongst FBOs ranged from having confirmed numbers of clients using natural family planning, providing pills, condoms, spermicides, injectables, IUIDs and NORPLANT methods to performing sterilization.
Alignment to WHO and UNFPA standards: Provision of SRHR by FBOs does not always comply with WHO or UNFPA guidelines. Some FBOs did not provide comprehensive SRHR information, especially in public education and campaigns. For example, they left out information on the use of condoms. However, in face-to-face settings, such provision was likely to take place. Nevertheless, it was viewed by FBOs as compromising for religious beliefs.

Added-value: The general perception of added-value in FBOs' SRHR work can be broadly classified as follows: (1) existing institutional and community structures and links, (2) large audiences and influence, (3) provision of context-embedded SRHR responses which resonate with communities' values and beliefs, (4) compassion and motivation to serve the needy underlined by work ethics. Strong community and institutional structures and links enable FBOs to mobilise communities and identify beneficiaries of SRHR intervention. FBOs appear less dependent on external funding than secular non-governmental organisations because of clearly defined resource mobilisation audiences within their circles. Links with religious leaders give credibility and a trustworthy image to FBOs and enable them to serve as entry points in health and SRHR-related community outreach. Large number of followers was considered a significant attribute of faith communities, especially in the context of advocacy and policy influencing where the potential of religious leaders to influence decision making at the top was widely recognised. Those organisations that had taken on the interfaith approach have been able to multiply their target audiences and reach greater numbers both in their service provision and advocacy interventions. FBOs are key to contextualisation of SRHR interventions by employing language and approaches that resonate with cultures and beliefs of the communities they serve. FBOs viewed ethics and compassion as their distinct advantage in comparison to other organisations working in SRHR field. Due to their strong values, FBOs-owned or run health facilities were considered to be more favoured by communities. FBOs appear as more compassionate and persistent in serving communities, therefore they offer much stronger sustainability prospects.

Challenges to FBOs’ SRHR provision: Perceived challenges to FBOs’ SRHR provision included: resource barriers, being the most often cited obstacle, social-cultural and religious barriers and various capacity gaps.

1. Resource barriers and resource mobilisation: FBOs recognise donor funding as essential to their existence. However, they see the danger of becoming donor dependent and having limited freedom of implementation, especially in relation to their vision and mission. FBOs acknowledge they are uniquely positioned to raise resources within their constituencies. Yet, many FBOs are not able to make full use of this opportunity because their resource mobilisation efforts are exclusively directed towards traditional donor funding. FBOs reported a strong track record in accessing funding for HIV/AIDS prevention and treatment and STI prevention and treatment. However, success rates for accessing maternal and child health, reproductive health and family planning were much lower with the latter being especially low. FBOs cited several challenges to their SRHR resource mobilisation efforts, mainly: high competition for donor funding, insufficient information on existing grant opportunities, gaps in human resources and little or no funding opportunities for the thematic area they are working on.
2. Socio-cultural and religious barriers: Conspiracy theories and low importance given to SRHR issues in some faith communities were identified by Muslim FBOs as a major obstacle to delivery of SRHR. Most conservative interpretations of religion underlined by sectarian and divisive religious stances equally hindered FBOs’ efforts. FBOs emphasised that faith community and religious leaders themselves can be a source of stigma and hinder knowledge sharing which is crucial to responding to health challenges of contemporary world. Some FBOs that endorse full access to family planning felt that their efforts were being restricted by more conservative voices within their and from other faith communities. Building interfaith consensus on SRHR was viewed by FBOs’ with considerable skepticism due to FBOs’ diverse outlook on the issue. Yet, areas of commonality were highlighted such as the notion of health and wellbeing, where the advantage of having interfaith stance is significant given their power of numbers and larger influence.

3. Capacity gaps: The need for building capacity of religious leaders and their structures to respond to SRHR challenges was highlighted frequently. Weak research, monitoring and evaluation skills and theology-based understanding of accountability were considered key factors which might undermine perceived accountability of FBOs. Management and administration were also cited as weakness of faith community, and an area for potential trainings. It was highlighted that any capacity development and training efforts for FBOs require highly contextualised approaches subject to the capacity of religious leaders.

Recommendations

Conceptual issues:

Employ faith-based approaches to promote a holistic outlook on SRHR incorporating both physical and emotional aspects: This approach should emphasise not only knowledge and skills but also highlight the importance of nurturing positive attitudes and values towards one’s own SRHR. However, appropriate levels of coordination are needed to achieve complementarity between rights-based and faith-based approaches.

Improve FBOs’ acceptance of family planning and gender issues through use of alternative language and mobilising faith voices aligned to WHO and UNFPA standards: Employment of alternative, culture-sensitive or faith-sensitive language can help improve acceptance of family planning and gender issues. Moreover, mobilising and amplifying FBOs’ voices aligned to WHO and UNFPA standards will both balance and challenge opposing viewpoints to reflect on the alternative angles and points of view.

Unpack SRHR terminology to increase roll-out of FBOs’ SRHR responses: Lumping together controversial issues with uncontroversial issues, under the SRHR ‘umbrella term’ has hindered the roll out of FBOs SRHR programmes. Unpacking the concept of SRHR, can help increase the acceptance of specific SRHR components.
Encourage faith-secular dialogue underpinned by the joint vision of family health and wellbeing: This dialogue should stay clear of dogmatism from both sides and involve pragmatic representatives who share a common goal of family health and wellbeing.

Leverage FBOs’ dynamic approaches to promote family health and wellbeing. Define specific SRHR advocacy asks and build alliances with groups of like-minded FBOs: There is room for a common interfaith stance around wider notions related to humanity such as health and wellbeing. FBOs’ advocacy on specific aspects of SRHR is feasible on a case-by-case basis.

Programming issues:

Partner with FBOs to develop culturally and linguistically competent approaches to SRHR: Effective implementation of international frameworks on the ground requires context-embedded responses that resonate with local cultures and beliefs. However, any intervention should be cautious not to reinforce existing gender disparities under the disguise of contextualising international SRHR standards.

Incorporate referral mechanisms for comprehensive provision of SRHR by FBOs: FBOs recognise that abstinence and barrier devices are the most effective HIV/AIDS prevention methods. However, for many FBOs encouraging condom use remains an unlikely strategy due to their religious structures. Wherever possible, condom discussions/distribution should be part of comprehensive HIV/AIDS education provided by FBOs. Otherwise, FBOs should refer to alternative service providers for this type of service, or for any other service which is recommended from the medical standpoint.

Ensure community links are built to enhance functionality of FBOs’ SRHR referral systems: FBOs and religious leaders are very good at raising demand for, and extending the reach of SRHR services. Linking up with other stakeholders and coordination is needed to strengthen ties and ensure the functionality of referral system.

Ensure high efficiency of SRHR interventions by undertaking community assessment during design phases: It is risky to assume that faith communities will always support SRHR initiatives due to conspiracy theories, stigmatisation and other hindering mechanisms. Therefore, in-depth assessment should take place as part of risk analysis while designing SRHR interventions. Whenever necessary, an intensive community sensitisation campaign, involving supportive religious leaders, should be part of the design.

Promote uptake of SRHR evidence amongst religious leaders through participatory monitoring and evaluation approaches: FBOs are interested in employing participatory monitoring and evaluation techniques involving religious leaders. Participatory monitoring and evaluation has a potential to empower faith leaders and promote uptake of the results for better SRHR delivery. Involvement of religious leaders requires a well-defined strategy on how to make monitoring and evaluation appear relevant and sustain their interest and motivation. Focus should be on highlighting the benefits of their involvement beyond acquiring donor-oriented data as well as employing user-friendly tools. However,
religious leaders should not be treated as a replacement for technical staff in some of the more complex monitoring and evaluation exercises.

**Capacity development issues:**

- **Increase the reach of SRHR capacity development efforts by integrating top-down and bottom-up approaches and encouraging exchanges between FBOs:** An ideal model for SRHR awareness raising within religious structures should combine top-down and bottom-up methods. Moreover, FBOs should be given an opportunity to meet and interact to encourage cross-fertilisation of ideas, messages and experiences.

- **Enhance FBOs’ credibility and legitimacy as SRHR advocates by developing their capacity to conduct evidence-based advocacy:** With theology being often the basis for FBOs programming, most of FBOs conduct value-based rather than evidence-based advocacy and policy influencing. While recognising that effective policy influencing combines both evidence and value-based knowledge, greater emphasis should be put on developing FBOs capacity in evidence-based advocacy.

- **Sensitise religious leaders on the consequences of the gap between official religious stance and provision of SRHR by FBOs:** Sensitisation of religious leadership should include provision of medically-sound information on the effectiveness of barrier methods in preventing HIV transmission, presented in the context of relevant theological sources and religious teachings.

- **Enhance sustainability prospects of FBOs’ SRHR work by strengthening FBOs’ capacity in organisational management:** In order to make the most of their sustainability prospects and ensure growth, FBOs should invest in enhancing their managerial capacity or bringing technical staff on board.

- **Diversify funding for FBOs’ SRHR interventions by mobilising resources from FBOs’ social and institutional networks:** FBOs’ strength lies in their ability to mobilise institutional and social networks, and as such their resource mobilisation efforts should not be exclusively focused on donor-related funding but directed at audiences within FBOs’ constituencies. FBOs should develop mapping tools that help identify resources within and outside faith community.

- **Enhance FBOs’ understanding of donor language and encourage peer pressure to promote transparency and accountability:** FBOs should enhance their understanding of the language, perspectives, and priorities of donors and other development partners to be able to make a stronger case for SRHR funding. This would include ensuring proper documentation of resources spent and results achieved. Moreover, encouraging peer pressure within FBO community itself could be an effective tool in promoting better accountability practices.
INTRODUCTION

The involvement of FBOs in SRHR remains largely undocumented despite FBOs being historically involved in the provision of health and education (DFID 2005:4). The vast majority of available literature deals exclusively with their work on HIV/AIDS prevention. As a consequence of limited evidence-base, contributions of FBOs to SRHR have been considerably undermined.

FBOs are sometimes portrayed as opposing advancement of SRHR. By and large, this is due to influential anti-choice voices, whose strength lies not in numbers but in their ability to build alliances with civil society organisations, state actors (Haynes: 2013) and across the religious spectrum (NORAD 2013: 1). However, despite having a well-organised anti-SRHR voice, development community does not view FBOs as a monolithic group, unified against SRHR.

There is an increasing recognition of FBOs’ potential to advance SRHR and bilateral donors, United Nations agencies and non-governmental organisations are engaging with FBOs for greater effectiveness of their SRHR responses. Against the backdrop of fragmented evidence on FBOs and SRHR, there is also a growing interest for a more systematic and evidence-based understanding of the role that faith communities play in achieving the Millennium Development Goals 5 and 6 (WHO 2011).

As the development community is moving from estrangement to engagement with FBOs (Clarke and Jennings 2008), the case of joint working is no longer a subject of debate but an established fact, one which requires well thought out strategies and partnerships. This strong momentum for engagement with FBOs poses an opportunity to advance SRHR, not only through faith-secular but also interfaith and same-faith collaborations.

The process of building meaningful partnerships for SRHR entails creating a mutual understanding and identifying synergies between all the parties, joint commitment to advancing SRHR but also a realistic assessment of boundaries and limitations to such collaborations.

This study was commissioned by the Faith to Action Network Steering Council and is intended to inform the Faith to Action programme, whose objective, amongst others, is to generate knowledge on diverse FBOs approaches to SRHR. By doing so, the research aims to contribute to building evidence for uptake by and involvement of FBOs in SRHR, advocacy, policy influencing and programming. It further intends to support experience sharing and learning amongst FBOs.

The overall objective of the study was to construct an up-to-date review of FBOs’ interventions in SRHR and highlight patterns and trends of FBOs’ SRHR provision. By doing so, the research aimed at identifying synergies, added-value, gaps, and points of consideration while engaging with FBOs in SRHR. It also aspired to recommend ways to advance SRHR from a faith-based perspective. More specifically the study intended to explore the following key questions:
1. How do FBOs perceive health and SRHR?
2. What is their thematic focus of interventions in SRHR?
3. What type of activities do FBOs undertake in SRHR?
4. How do SRHR services provided by FBOs compare to international guidelines of WHO or UNFPA?
5. How do FBOs perceive their added-value in SRHR?
6. What barriers and obstacles do FBOs perceive in providing SRHR?
7. What are the practical implications and recommendations from the study findings for FBOs’ SRHR interventions?

Recognising that defining and categorising FBOs is a vast subject, one which requires a separate debate, a broad definition was adapted, keeping in mind practical considerations. A key factor for selecting participating organisations was their religious affiliation, therefore for the purpose of this study, an FBO was meant to represent any organisation that reports affiliation with a religion, denomination or sub-denominational religious group. Given this broad definition of FBOs, it was possible to include a wide range of organisations, from places of worship to large faith-inspired development organisations.

The first chapter of this study looks into how FBOs view health and SRHR and which thematic areas fall into their SRHR portfolio. By doing so, it helps identify various dimensions which make up health and SRHR in the faith context and explore FBO-specific nuances and sensitivities surrounding the language of SRHR. The findings of this chapter will feed into the operational definition of family health and wellbeing for the Faith to Action Network as well as put forward practical considerations for SRHR programmes.

The second chapter undertakes a detailed review of the type of SRHR activities that FBOs conduct in advocacy and policy influencing as well as service delivery. In addition, it examines to what extent the provision of SRHR by FBOs is comparable to international standards such as those of WHO and UNFPA. Lessons learnt from this chapter will inform discussions on how to ensure the quality and delivery of comprehensive SRHR services by FBOs.

The third chapter looks at how FBOs’ perceive their added-value in SRHR. Key strengths of FBOs’ engagement in SRHR are identified in order to help FBOs showcase their SRHR engagement and guide their SRHR advocacy and policy influencing messages. Moreover, the findings will help identify strategies for FBOs to maximise their strengths and increase their effectiveness in SRHR interventions.

The fourth chapter makes an inquiry into what barriers and challenges FBOs’ perceive in SRHR provision which are internal and external to the faith community. Key obstacles to efficient and effective FBOs’ SRHR interventions are discussed. Lessons learnt from this chapter will help identify mechanisms, internal and external to faith community, for mitigating the barriers.
METHODOLOGY

The study was a formative research based exclusively on primary data. It was a mix of quantitative (online surveys) and qualitative approaches (interviews with stakeholders who are staff of FBOs). The study employed explanatory mixed methods design; with a follow-up qualitative phase after the quantitative study. The rationale behind using mixed method research was to provide a more complete picture of the studied phenomena.

The research intended to construct knowledge and evidence through bringing in stakeholders’ perspectives. A total of 95 FBOs were consulted as part of this analysis.

- 82 FBOs took part in online surveys
- 10 FBOs participated in both online surveys and interviews
- 3 FBOs took part in interviews

Out of 95 participating FBOs, 65% came from Sub-Saharan Africa, 13% from North America, 12% from Europe and 10% from Asia. A large majority of 79% belonged to the Christian faith, 14% to the Muslim faith, while 7% were inter-religious.

Online survey (s)

In October 2013, the first online ‘FBOs’ mapping survey’ was launched in English and French. In order to maximise the response rate, most questions were designed in a close-ended manner and their amount was kept to a necessary minimum. Respondents were primarily identified through the snowball sampling method; Faith to Action Network Steering Council recommended and linked up to most respondents. A total number of 85 FBOs participated in the survey.

In December 2013, a second online survey was launched, ‘the Annual Survey of F2A Network Members’. In addition to the questions from the first ‘FBOs’ mapping survey’, other questions were included in order to acquire a deeper understanding of members’ SRHR work, opinions, needs and challenges. The survey was completed by 10 members of whom 7 were new organisations who had not provided inputs to the earlier ‘FBOs’ mapping survey’.

In the case of repeated questions, data from both surveys were jointly summarised and presented as frequency distributions or percentage values, having taken into account only unique responses without duplicates. Moreover, open ended questions were summarised by means of descriptive text highlighting major trends and patterns and incorporating comments and quotes directly from the respondents.

Out of 92 surveys’ respondents, 65% came from Sub-Saharan Africa, 12% from Europe, 12% from North America and 11% from Asia. 80% of respondents were Christian, 12% Muslim and 8% were inter-religious FBOs.
Face-to-face and telephone interviews

Between October and November 2013, thirteen face-to-face and telephone interviews took place with ten survey respondents as well as three additional FBOs that had not taken part in the ‘FBOs’ mapping survey’. On the whole, the interviews followed up on the survey responses and deepened specific areas of interest by means of qualitative inquiry. Furthermore, the interviews helped better understand the language of respondents and clarify different phenomena through variety of examples given by participating organisations. This qualitative data has been summarised and presented under diverse categories such as family planning, structures, resource mobilisation etc. The interview sample was selected with a consideration for maintaining faith balance and ensuring greater participation of Muslim respondents who were underrepresented in the quantitative phase.
Table 1: Structure of the Interviews’ Sample

<table>
<thead>
<tr>
<th>Geographical Location</th>
<th>Christian</th>
<th>Muslim</th>
<th>Interreligious</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Saharan Africa</td>
<td>4</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>North Africa and Middle East</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>North America</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Data Source: Face-to-Face and Telephone Interviews

Limitations

Employment of convenience sampling, a form non-probability sampling for quantitative phases of the study was both necessary and recommended given time and resource constraints and the fact that a complete list of the population studied (all FBOs) does not exist. The qualitative phase of the research helped validate the findings of the quantitative inquiry, and vice versa, and generate deeper insights into the studied phenomena. Due to the fact that research employed mixed methods approaches, the sample is not statistically representative of the whole population. Moreover, some questions in the quantitative phase were put forward only to members of the Faith to Action Network. This means that number of responses submitted was relatively low.

For the above reasons the analysis is to a greater extent limited to what participating FBOs perceive. The results should not be considered representative of the entire FBOs population but treated as an up-to-date snapshot of faith responses to SRHR. Moreover, the findings are further limited by the geographic and faith factor.

The mapping exercise focused mainly on Sub-Saharan Africa. In addition, the majority of the online survey participants belonged to the Christian faith, with under-representation of the Muslim faith. Other faiths were only represented through voices of interreligious organisations.

Ethical considerations

Participating in the research was entirely voluntary. Prior to taking part in the study, all FBOs were informed about the objective(s) of the study, and the fact that the results of the research would be published. FBOs were also consulted whether their quotations could be included in the report. Moreover, consent was sought in terms of participants’ right to privacy and confidentiality. Only organisations that agreed to have their names published are listed in the APPENDIX 1 of this study, while other participating FBOs remain anonymous.
1. COMPLETE PHYSICAL, MENTAL AND SOCIAL WELLBEING – HOW DO FBOS APPROACH SRHR?

How do FBOS perceive health and SRHR? What is their thematic focus in SRHR?

Depending on the context, SRHR might be framed and understood differently from standard health and human rights discourses. In order to build effective partnerships, it is essential to understand how FBOS perceive and define health and SRHR and what values underpin their SRHR work. It is also crucial to be aware what dimensions make up SRHR in the faith-based context and where boundaries should be drawn.

From its inception, the Faith to Action Network used the terminology of family health and wellbeing implicitly without clearly defining the term. Only recently, the Steering Council identified the need for greater definitional clarity and key components of the term were discussed\(^2\). In order to inform this process, it became imperative to further investigate FBOS’ diverse efforts in the field of SRHR.

This chapter will describe the wider meaning of health in the faith-based context. Moreover, it will look at the thematic scope of FBOS activities carried out as part of their family health and wellbeing/SRHR portfolio to help define what SRHR entails for FBOS. It will present evidence that faith community can be characterised by a holistic outlook on health and consequently SRHR. In addition, various dimensions of faith-oriented SRHR will be discussed such as maternal and child health, reproductive health, family planning, HIV/AIDS prevention and gender-based violence prevention, amongst others.

Health and SRHR in the faith-based context

FBOS’ SRHR work is underpinned by distinct core values of religion and spirituality. Participating FBOS often pointed to a broader understanding of human health bringing together spiritual and emotional dimensions. Survey respondents regularly viewed faith and spiritual development as either one of the core values underpinning their health interventions or a significant advantage of their work in comparison to others actors active in health and SRHR.

\(^2\) During the 2nd Faith to Action Network Steering Council Meeting, held on 15-16 May 2013 in Mombasa, Kenya, it was concluded that the Faith to Action Network needs a definition of its family health and wellbeing concept. Subsequently, the following operational definition was proposed: birth spacing, fertility awareness, safe motherhood, preventing other-to-child transmission, maternal and child health, age appropriate sexuality education, gender equity and prevention of female genital cutting, early marriage and all forms of gender-based violence.
The box below summarises the most regularly quoted phrases and words. The sizes of the words represent the frequency with which those words and phrases appeared in the survey answers.

**Box 1: Text analysis open-ended responses regarding core values underpinning SRHR work and added-value of FBOs in SRHR**

Moreover, further examples of responses emphasising core values and value added of FBOs interventions are presented below:

- A holistic approach to health – Tajikistan Survey Respondent
- Holistic efficient and responsive health care to all
  - Nigeria Survey Respondent
- Spiritual values and committed interfaith harmony
  - Korea Survey Respondent
- Comprehensive integrated approach to family health
  - the United States Survey Respondent
- Spiritual-based (Islamic-based) noble behavior, tolerance
  - Indonesia Survey Respondent
- Our ability to connect with users on the spiritual level- we emphasise our Christian values and that is what makes us unique. We don’t just give health services
  - Uganda Survey Respondent
- Spiritual and Pastoral Support to our Beneficiaries
  - Kenya Survey Respondent
The importance of spiritual and emotional support was especially highlighted in reference to FBOs’ HIV/AIDS work. Not only physical wellbeing but most importantly the provision of care and emotional support were core to FBOs’ approach.

The above findings lend strong support to the argument that a great number of FBOs perceive health as a holistic concept aiming to fulfill not only physical but also religious and spiritual needs. Consequently, FBOs’ view on health stresses not only physical health but also recognises the importance of emotional and spiritual wellbeing. It appears that for the faith-based community, physical health, emotional and spiritual wellbeing are interconnected which is crucial to understanding the assumptions, strategies and work of faith-inspired development organisations.

**Thematic focus**

The online surveys asked participating FBOs about the thematic focus of their interventions within family health and wellbeing. This inquiry helped unpack the term and identify key components to be included in the operational definition. The categorisation of the concepts is meant to be descriptive. There was no intention to present any category as more comprehensive or more widely recognised.

Overall, HV/AIDS prevention was quoted as the most frequent type of interventions within family health and wellbeing with 80 out 90 of respondents indicating they work in this field. This was followed by reproductive health and maternal and child health (64 and 63 respectively). Other quoted responses included STI prevention, adolescent health, family planning and gender-based violence.

In the category ‘others’, sexual health and sexual and reproductive health and rights were cited on several occasions as well as specific examples of FBOs interventions in the area of gender-based violence such as combating of human trafficking and sexual abuse or investigating the impact of pornography.

Interestingly, there is a considerable difference between the figures associated with reproductive health and family planning. Reproductive health and family planning seem to be closely linked, yet fewer organisations quoted the latter as the thematic focus of their interventions.
The case of family planning and gender-based violence

In order to investigate the reasons why FBOs reported lower engagement in family planning in comparison to reproductive health, a qualitative inquiry was conducted to provide further clarity. Responses from the interviews implied that family planning can be at times provided implicitly and mainstreamed within other thematic interventions.

*We do not have a project which is exclusive to family planning. We engage in HIV/AIDS, gender-based violence. So when we discuss gender-based violence, when we discuss HIV/AIDS prevention we discuss family planning. And there are issues of HIV/prevention which can be commonly applicable to family planning.*

- Ethiopia Interviewee

Participating organisations also expressed that family planning can be viewed as synonymous with the use of condoms especially amongst the unmarried couples which some faith-based organisations are reluctant to discuss.

*Their stand on family planning is that they don’t want to talk about condom and they believe that talking about condom is like asking people to use it, especially amongst those who are not married.*

- Uganda Interviewee
Unlike reproductive health, family planning was perceived as a sensitive topic in terms of both content as well as form and often associated with discussing the most intimate aspects of human existence. Respondents frequently pointed out that the term family planning does not always appear neutral and sometimes the type of language which is used to convey family planning messages can influence the level of acceptance.

When it comes to family planning we have a lot of challenges. We have challenges in the message itself, we have challenges in the content, we have challenges in the packaging, we have challenges in the presentation because when you talk about family planning you are talking about sexuality. Muslims have very clearly defined roles and areas where we can practice and talk about sex. However, the misconception that Muslims do not want to talk about sex is totally wrong.

-Kenya Interviewee

When first family planning programmes started, the language of ‘birth limitations’ or family limitations was used which had negative connotations for Muslims. However, when the term ‘birth spacing’ was introduced, family planning became more acceptable.

-Egypt Interviewee

With family planning you might think you are telling me a very good thing but because you put an emphasis in different place that language becomes totally provocative, even violent to some people. We must be very sensitive how we are using language. The presentation matters, the packaging matters, the content matters and even how we deliver it matters.

-Kenya Interviewee

One voice highlighted that in his/her country, it became much easier to reach out to communities and make family planning an acceptable norm when religious leaders made a public declaration that family planning and faith are concordant.

A considerable milestone was achieved in 2012 when a national fatwa declaration was issued by the Ethiopian Ulama Council asserting that Islam and family planning are compatible.

-Ethiopia Interviewee

As highlighted earlier, a couple of survey responses in the category ‘other’ indicated that prevention of gender-based violence, similarly to family planning, can be also provided ‘implicitly’. On a few occasions participating organisations reported engagement in prevention of human trafficking and sexual abuse or investigating the impact of pornography, yet they did not classify it as gender-based violence. The reasons behind such underreporting could be linguistics. Since the term gender-based violence is quite broad, it might bring a lot of different associations making the classifications challenging. It could also point out to sensitivities surrounding the notion gender-based violence, similarly to family planning.
Lessons learnt

- FBOs tend to favour a holistic approach to health which takes into account not only physical but most importantly spiritual and emotional wellbeing of individuals. Addressing spiritual and faith issues was seen by FBOs as inseparably intertwined with provision of SRHR, especially in the context of HIV/AIDS interventions. It should be borne in mind that FBOs’ holistic approach to health, emphasising the importance of emotional wellbeing, is synergistic with WHO’s definition of health as a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.

- Thematic scope of FBOs’ SRHR interventions covered maternal and child health, reproductive health, family planning, adolescent health, gender-based violence prevention, STI/HIV/AIDS prevention, sexual health and sexual and reproductive rights. These areas could form the basis for a descriptive definition of family health and wellbeing.

- HIV/AIDS interventions were the most commonly reported thematic area of FBOs’ activities. It could be attributed to the fact that FBOs have been very involved in the provision of care and support for HIV/AIDS patients.

- Involvement in family planning and gender-based violence was underreported. Mainstreaming of family planning within other thematic interventions such as HIV/AIDS as well as difficulties to classify activities into broad categories i.e. gender-based violence could have led to such underreporting.

- Family planning, unlike reproductive health, was a much less common area of FBOs’ activities and perceived as problematic to engage in. Family planning touches upon one of the most intimate aspects of human nature that is sexuality and promotes values which appear incongruent with religious beliefs of some faith leaders. However, FBOs reported major improvements in this regard thanks to the involvement of like-minded religious leadership and employment of more acceptable language and terminologies such as birth spacing.
What type of activities do FBOs undertake in SRHR?

How do SRHR services provided by FBOs compare to international guidelines of WHO or UNFPA?

Historically, FBOs have been involved in health and education service delivery. However, a new paradigm is emerging, whereby advocacy and policy influencing is becoming more significant for civil society organisations. Consequently, some organisations are shifting from service delivery to advocacy or diversify their portfolio of activities to include advocacy and policy influencing. In the context of SRHR, three areas of civil society organisations’ activities are often cited as core to their SRHR portfolio, namely service delivery, capacity building and policy influencing (Ministry of Foreign Affairs, the Netherlands 2013:30).

This chapter will look into the type of SRHR activities undertaken by participating FBOs. It will demonstrate that advocacy and policy influencing as well as capacity development/trainings and service delivery constitute key SRHR activities of participating FBOs. This section will also explore the extent to which provision of SRHR by FBOs is compatible with international guidelines such as those of WHO or UNFPA. For example, whether HIV/AIDS education provided by FBOs can be considered comprehensive rather than focused exclusively on promoting faithfulness and abstinence. It will lend support to the argument that FBOs’ involvement cannot always be classified as ‘standard SRHR’ as per WHO or UNFPA guidelines. This is due to the fact that some FBOs do not provide comprehensive information regarding HIV/AIDS prevention measures. For example, some leave out information on the use of condoms.

The results of the online survey revealed that advocacy and policy influencing is the most common type of SRHR interventions reported by participating organisations, cited 81 times. This is followed by capacity development/trainings and service delivery (reported 75 and 67 times respectively).
**Chart 4: Type of SRHR activities implemented**

N=89 n=92

Data Source: FBOs’ Mapping and Annual Survey of F2A Network members 2013

**Advocacy and policy influencing**

Interviews revealed a general recognition of the role advocacy and policy influencing play in effective delivery of SRHR and the importance of religious leaders to the success of this process.

> Advocacy is paramount and religious leaders play a key role in engaging service providers, partners and governments.
> –Uganda Interviewee

The chart below shows an overview of advocacy and policy influencing activities undertaken in the year 2012 and 2013. Membership to SRHR working groups was the most frequently reported type of advocacy and policy influencing activities, followed by capacity development in conducting advocacy and organisation of meetings with decision makers and decision influencers. Other forms of common advocacy and policy influencing activities included submission of comments on policy drafts related to SRHR-issues and campaigning. A lower number of organisations indicated to have taken part in an expert study or a fact finding mission through government’s or other donors’ invitation. This might suggest that FBOs are not seen as relevant actors in SRHR policy making. However, further inquiry beyond the scope of this study would be required for a more detailed conclusion regarding the scale of the situation and its reasons.
Chart 5: Type of SRHR advocacy and policy influencing activities undertaken
N=9 n=10

<table>
<thead>
<tr>
<th>Activity</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joined working groups on SRHR issues</td>
<td>8</td>
</tr>
<tr>
<td>Trained others on how to demand accountability in relation to SRHR policies and budgets</td>
<td>7</td>
</tr>
<tr>
<td>Organised meetings with decision makers and decision influencers to discuss SRHR issues</td>
<td>7</td>
</tr>
<tr>
<td>Commented on policy drafts related to SRHR issues</td>
<td>6</td>
</tr>
<tr>
<td>Conducted offline or online campaign(s) on SRHR issues</td>
<td>6</td>
</tr>
<tr>
<td>Undertook policy or budget analysis on SRHR issues</td>
<td>4</td>
</tr>
<tr>
<td>Took part as an expert in a study, fact finding mission on SRHR issues commissioned by government, bilateral or a multilateral donor</td>
<td>2</td>
</tr>
</tbody>
</table>

Data Source: Annual Survey of F2A Network members 2013

Networking and linking up with other FBOs and civil society organisations was seen as a major weak point of FBOs’ advocacy and policy influencing. The advantage of FBOs’ joint efforts in SRHR could result in increased ‘brand’ awareness and greater recognition of their role in the eyes of donor and governments. Moreover, having credible platforms would help create entry points and strengthen FBOs’ capacity to effectively engage with decision and policy makers as well as government officials. Therefore, it would also contribute to addressing other commonly perceived weaknesses such as lack of or limited access to decision and policy makers as well as government officials.

Chart 6: Perceived obstacles to SRHR advocacy and policy influencing
N=6 n=10

<table>
<thead>
<tr>
<th>Obstacle</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor links with other FBOs or CSOs and lacking communications and coordination skills</td>
<td>5</td>
</tr>
<tr>
<td>Lack or limited access to decision and policy makers (e.g. donors, MPs, etc.)</td>
<td>4</td>
</tr>
<tr>
<td>Lack or limited access to government officials</td>
<td>4</td>
</tr>
<tr>
<td>Poor awareness of government and other donor funding mechanisms and key trends in donor commitments and financing</td>
<td>4</td>
</tr>
<tr>
<td>Limited technical competencies and management skills on how to effectively liaise with local and national governments and donor agencies</td>
<td>3</td>
</tr>
<tr>
<td>Limited knowledge of policy making by national and donor agencies and the changing contexts within which they operate</td>
<td>1</td>
</tr>
</tbody>
</table>

Data Source: Annual Survey of F2A Network members 2013
Service delivery

While the awareness on FBOs’ work in HIV/AIDS, SRHR and health in general is growing, it remains largely undocumented to what extent FBOs provide comprehensive SRHR education or services and follow internationally recognised guidelines on SRHR service delivery such as WHO’s guidelines on contraceptive information and services within the framework of right-based approach (WHO 2014).

A couple of responses from the survey indicated that some FBOs promote natural contraceptive methods and abstinence.

*We promote natural family planning for adults, proactive fertility awareness-based sexuality education for teens.*
- the United States Survey Respondent

*Teen STAR is the only sexuality education program which uses experiential learning of fertility signs to help teens understand and value their sexuality and fertility. Behavioural outcomes are monitored through questionnaires to document support for primary and secondary abstinence.*
- the United States Survey Respondent

However, the question remains whether alternative information is also given. Recognising that any form of generalisations can be harmful and inadequate as it might not reflect the reality of actual service provision, further qualitative insights were made into how services are provided by participating FBOs.

One respondent emphasised that in his/her organisation promotion of abstinence is core to their HIV prevention strategy.

*When we work on HIV prevention, we focus on abstinence and being faithful and we don’t go into the next problematic component.*
- Ethiopia Interviewee

The interviews also revealed that in some organisations barrier methods, such as condoms, are not discussed in public communications. However, respondents also indicated that in face-to-face conversations with a client, such discussions might take place. There was an undertone that discussions about barriers methods are seen as conflicting with religious beliefs and provision of comprehensive SRHR education would compromise the official stance of their religion. There was also a voice that failure to provide patients with comprehensive information would bring harmful health outcomes in the communities, especially where the age of sexual debut is very low. Respondents implied that faith communities opposing condoms should be confronted with the reality communities face on the ground.
You know the Catholic Church stand on the use of barriers. The abstinence is the main thing, we know it is very difficult but in our case we preach abstinence before marriage and as for condoms we do not promote it. So it is basically abstinence and we ask people to be faithful to their partners. The areas of condoms, because of the Church, it is not something that comes out clearly maybe in private areas but when we are doing education and campaigns we do not talk about condoms. It is basically abstinence and being faithful.

-Ghana Interviewee

In our centre we have condoms. When we are teaching about discordance, we are doing counseling for the couples. When couples ask about condoms, you are not going to refuse them because maybe they don’t even belong to your religion, and I’m not doing religious work there, I’m doing health issues. I would not go out promoting it, that I have condoms, but if we are doing counseling and the couple asks about condom, we give it away, and some of them never used a condom in their life, so first you need to teach them, then the second thing they say, “we are scared to go and buy them”, so we give it to them. You need to use an approach that is not going to crucify you.

-Uganda Interviewee

We have very many youth. I was doing an HIV prevention project and I was dealing with 8-14 year old and they were sexually active. You are not going to be there all the time and talk to them to be safe or tell them not to have sex. I know they are not supposed to, and most of my work is preventive counseling and guidance, but how about circumstance when people are sexually active. There are many mistakes happening and diseases that come along with it, let alone unwanted pregnancies. I don’t know, I’m not talking on behalf of religious leaders, but as a person who is concerned about what is happening in our community.

-Uganda Interviewee

I think as faith community, we need to sit down and ask ourselves whether we still want to see people dying, do we still want to see women dying because they are religious and are not allowed to use a condom because their faith says so and the pregnancies are putting their lives at risk. We need to look at the alternatives.

-Uganda Interviewee

Some participating FBOs implied to have found a middle ground between the teachings of religious leaders and discussing condoms. However, there seemed to be an implied assumption that comprehensive HIV/AIDS education can be only achieved when the teachings of religious leaders is complemented by the work of medical staff.
We involve both religious leaders and community health workers in our work. Religious leaders will mobilise community and promote abstinence but will not talk about condom while community health workers will do both.  

-Ethiopia Interviewee

On the other hand, there are also FBOs which reported to have been running facilities that provide wide range of services including permanent family planning methods such as sterilisation.

In our health facilities, we have both curative and preventive care. There is antenatal care, postnatal care, growth monitoring of the child, Expanded Programme on Immunization (EPI), family planning with almost all methods, pills distribution, intrauterine device insertion and the long term medicines. Of course, we also give injectables and use government health facilities where we train health workers. At higher level, we have also one hospital in the place called Aira where sterilization is done when people decide not to have more children.  

-Ethiopia Interviewee

At present, we are implementing intensive family planning including distribution of pills and other IUD devices, in all our health facilities and hospitals, and we also have a special programme on family planning in the south with support from Pathfinder International.  

-Ethiopia Interviewee

As you know, people are resisting family planning, you know from the Catholic side, they completely deny except for the natural ones. But the Ethiopian Evangelical Church, Mekane Yesus, accepts not only the natural ones but others too, so we are providing full family planning and also planning to expand our programmes to other regions.  

-Ethiopia Interviewee

Overall, the following service delivery activities were reported to be part of FBOs’ portfolio: antenatal care, delivery care, postnatal care, STI (including HIV/AIDS) prevention, testing, treatment and counseling, contraceptive counseling, post abortion treatment, post abortion counseling, reproductive health counseling, reproductive health referral and youth friendly reproductive health information and services. HIV/AIDS/STI prevention, testing, treatment and counseling as well as contraceptive counseling were the most frequently reported.
Going further, an inquiry was also made into the type of contraceptives provided by Faith to Action Network members. Out of five organisations that reported provision of contraceptives, two were Christian Catholic, two Christian interdenominational and one Muslim of unspecified background. Members reported that in 2013 they provided a diverse range of contraceptives, from having confirmed clients who use natural family planning methods in the case of a Christian Catholic member, providing pills, condoms and spermicides by another Christian Catholic as well as Christian interdenominational organisations, to distributing a wide range of contraceptive commodities such as pills, condoms and spermicides, injectables, IUDs and NORPLANT implants in the case of one Muslim organisation.

### Table 2: Type of contraceptives provided

<table>
<thead>
<tr>
<th>What religious affiliation does your organisation identify with?</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian Catholic</td>
<td>2</td>
</tr>
<tr>
<td>Christian Interdenominational</td>
<td>2</td>
</tr>
<tr>
<td>Muslim Unspecified</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of contraceptives provided in 2013</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pills, condoms, &amp; spermicides</td>
<td>1</td>
</tr>
<tr>
<td>Contraceptive injectables</td>
<td>0</td>
</tr>
<tr>
<td>IUDs &amp; NORPLANT implants</td>
<td>0</td>
</tr>
<tr>
<td>Confirmed clients using natural FP</td>
<td>1</td>
</tr>
</tbody>
</table>

Data Source: Annual Survey of F2A Network Members 2013
Lessons learnt

• Advocacy and policy influencing was the most frequently reported type of SRHR interventions undertaken by participating FBOs. There was a general awareness of the importance of SRHR advocacy and policy influencing and recognition that faith community has a potential to play key role in these processes.

• Membership to SRHR working groups was the most frequently reported type of advocacy and policy influencing activities undertaken, followed by capacity development in conducting advocacy and organisation of meetings with decision makers and decision influencers. Other forms of common advocacy and policy influencing activities included submission of comments on policy drafts related to SRHR-issues and campaigning.

• A low number of organisations indicated to have taken part in an expert study or a fact finding mission as per government or other donors’ invitation. This might imply that FBOs appear as having insufficient expertise or their importance to the SRHR policy and decision making processes is not recognised. This could also mean that SRHR decision making processes are simply neither inclusive nor participatory. That being said, FBOs reported poor capacity to link up with other FBOs and CSOs in their policy and advocacy work which could help increase ‘brand’ awareness and secure recognition of donor and governments. It could also help create entry points to decision makers and government official which was viewed as another weak point of FBOs’ SRHR involvement.

• FBOs’ involvement cannot be always classified as a ‘standard SRHR’ as per WHO or UNFPA guidelines. In some organisations, barrier methods such as condoms were not mentioned during public education and campaigning. However, the same respondents also pointed out that in face-to-face settings, condoms can be discussed and distributed. This suggests a discrepancy between the official religious stance and local practice. Nevertheless, the interviewees felt as if they were compromising between practicing their religion and doing SRHR work. They also felt that religious leaders who are strict in opposing barrier methods would benefit from being confronted with the reality on the ground. Some FBOs implied to have found a middle ground through complementing religious teachings by the work of medical staff.

• The range of FBOs’ service delivery covered a diverse SRHR portfolio including provision of antenatal care, delivery care, postnatal care, sexually transmitted infections (including HIV/AIDS) counseling, prevention, testing or treatment, contraceptive counseling and provision, post abortion counseling and treatment, reproductive health counseling and referral and youth-friendly reproductive health information and services. HIV/AIDS/STI prevention, testing, treatment and counseling as well as contraceptive counseling were the most frequently reported.

• The degree of contraceptive provision amongst participating organisations and network members ranged from having confirmed number of clients using natural family planning, providing pills, condoms, spermicides, injectables, IUIDs and NORPLANT methods to performing sterilisation.
3. STRUCTURES, COVERAGE, INFLUENCE, CONTEXT AND COMPASSION—WHY AND HOW FBOS CAN MAXIMISE SRHR RESPONSES?

How do FBOS perceive their added-value in SRHR?

In an increasingly competitive and results-oriented international development environment, there is a growing pressure on FBOS to define what distinctive advantage they offer. Donors are taking greater interest in added-value of FBOS and the relationship between faith and development (James 2010:5). By and large, conducting effective policy and advocacy by FBOS requires awareness of their own strengths and unique selling points. Moreover, recognition of own qualities and assets can help strategise and better leverage the strengths to advance SRHR.

The findings below summarise distinct advantages of FBOS work in SRHR reported by participating organisations and could constitute a basis for delivering advocacy messages geared towards greater participation of FBOS in policy making and programming on SRHR. Moreover, they can serve FBOS as evidence for identifying strategies on how to best maximise own strengths and increase effectiveness of SRHR responses.

The general self-perception on the added-value of FBOS interventions can be broadly divided into the following categories: (1) existing institutional and community structures and links, (2) large audiences and influence (3) provision of context-embedded SRHR responses which resonate with communities’ values and beliefs (4) compassion and motivation to serve the needy underlined by work ethics.

Institutional and community structures and links

Participating organisations frequently stressed the importance of existing structures, e.g. links with religious authorities, places of worship etc., which FBOS are leveraging in their community outreach. Respondents indicated that FBOS have established a long-term presence in the communities which gives them the knowledge of local contexts and uniquely positions them to identify those in need.

*We already have enormous structures in place and once we get family planning and reproductive health work integrated and mainstreamed, we will be able to make a big difference.*

- Uganda Interviewee
The Church has traditionally been one of the most institutionalized arms because it has development work embedded in every diocese. Therefore when it comes to the mobilisation of community for immunization or testing they get out there.

- Uganda Interviewee

Aid is not always going where it should be. We involve religious leaders in all aspects of programme cycle including beneficiary assessments research and M&E as they are best positioned to identify those in need.

- Ethiopia Interviewee

It was also noted that being part of a wider religious structure, makes it easier to mobilise resources because the initial target audience for resource mobilisation is clearer to define. FBOs often rely on private charitable donations or receive support from their ‘mother institutions’ for instance the Church or Mosque. This explains why they can be considered less donor dependent than the secular non-governmental organisations to a certain extent. However, it was also observed that this trend is slowly reversing and the faith community is losing the ability to raise resources within their own constituencies.

We are now observing the development partner syndrome, and Churches, Mosques and FBOs had a way of raising resources before this syndrome came in. There are some very rich churches that have programmes which can support other programmes for example in Uganda the Catholic Church is very rich and they have many programmes and income generating activities, are they trying to use some of these activities to support others or they are simply waiting upon the partners to come in? How resources can be raised within our own constituencies to contribute to development goals is something to consider.

- Uganda Interviewee

The challenge we have in our community is that it is being presented so much as a recipient community. Whenever a development worker would come into the Muslim community, people would look at them as money and changing this attitude might take a while.

- Uganda Interviewee

Large audiences and influence

Participants underlined that long term presence in the communities, coupled with the fact that an overwhelming majority of community members in the areas of FBOs’ operations identify themselves as being religious gives unique authority to FBOs and helps them build a trustworthy image. This is one of the reasons why FBOs and religious leaders in particular are often treated as entry points for any community outreach due to a large number of people listening and trusting them. It was noted that the strong community trust in faith organisations and religious leaders must be leveraged for effective delivery of health
programmes by FBOS. Therefore FBOs need to maintain links with their relevant religious authorities, sensitising and involving them in the provision of health interventions.

For example here in Uganda, people might not go for immunization. So when we are working with UNICEF and our religious leader such as Mufti of Uganda comes and actually launches it and immunizes a child, it’s most effective because people would follow. In Uganda people are very religious and they go and listen to their leaders without an invitation. So we need to train religious leaders and sensitise them, once they believe in something, the rest will follow.

- Uganda Interviewee

Everybody who is going out into the community is looking at religious leaders as an entry point to work with them because they know that people will listen.

- Uganda Interviewee

It is not economically feasible to have many children. When you are not feeding your children and not sending your kids to school because of economy, this is sin. We say that and the community members accept it, but when religious leaders are telling them they accept even more.

- Ethiopia Interviewee

Large number of followers have been identified as a significant strength of faith-inspired development work, especially in the context of advocacy and policy influencing. This is especially highlighted by those organisations that have taken on the interfaith approach. Moreover, religious leaders are seen as highly influential over politics and policy making.

We are working extensively on immunisation programmes in Gambela region. The experience we had is that people did not want to vaccinate their children thinking it would affect them. There are different rumors and because of them, people don’t want to do that. So to change the attitude of people, we asked the pastors and evangelists of the congregations to teach about immunization and how important it is to vaccinate the child. When we started this programme, there was 15% coverage of vaccination (EPI coverage), now it has reached 72%.

- Ethiopia Interviewee

The best person to reach a family without suspicion is a religious leader because in each of these faiths, there are events where religious leaders visit homes and pray with families. So now we are saying, apart from prayer, is there anything else you can do.

- Uganda Interviewee
Advocacy is about numbers. When you are dealing with politicians and decision makers, these guys want to hear you when you have numbers behind you. Experience shows that in situations when the Church is pro or against an issue, the government tends to really go and panic (sic).

- Uganda Interviewee

The interfaith approach has enabled us to reach out to large numbers of people because of already available audiences and structures as well as respect and trust that communities attach to religious leaders.

- Uganda Interviewee

There are two things which people in Africa connect with, one is religion and the other is ethnicity. If you like it or not, religious leaders are still the power holders. Even the president when he’s seeking blessings, he goes to them.

- Uganda Interviewee

You will find that religious leaders are also very powerful in advocacy, when they come together in interfaith fora or as an alliance, they will be able to seek audience with policy makers in their own countries. And say these are the policy issues which we identified, and this is what the faith community can do, and this is what we cannot do.

- Uganda Interviewee

Context-embedded SRHR responses

There was a persistent view that FBOs contribute significantly to contextualization of SRHR interventions by employing approaches and language which is culturally appropriate and reflects reality and needs that exists on the ground.

We developed a tool for Church people which helps apply scripture to HIV/AIDS issues. However, what we found is that stories that are in the scriptures are very acceptable to people of all faiths and no faiths. In Africa, there are many people who are either Christians or are not offended by Christianity.

-the United Stated Interviewee

We react to the needs of our local community and are not burdened by government targets that may not be relevant to our community.

-the United Kingdom Survey Respondent
One of the problems we found is that in some cultures, people do not trust science and yet people who are doing HIV education use scientific concepts and language to teach. The result is that their audiences just switch off and they say it is interesting but it doesn’t apply to the way we live. We are empowering people to find ways to do HIV education that is motivational and it is presented in a way that their audiences would listen and apply.

-the United Stated Interviewee

Interestingly, not only religion but also elements of culture and tradition were mentioned as FBOs entry points to communities and tools of contextualization.

Although religious leaders have the biggest percentage of followers, it is not only about working with them. We look at all community gatekeepers including cultural leaders. For example in Uganda we have kings and other traditional leaders such as elderly.

-Uganda Interviewee

It was pointed out that FBOs’ approaches tailored to community-relevant values and beliefs are especially important in reaching out to traditional rural communities. At times, very explicit and direct communications might bring resistance and hinder development efforts. In such cases, the discourse of empowerment would be built alternatively, and with careful consideration for traditional norms and beliefs.

When you try to debate gender at the rural level for example in northern Ghana amongst the traditional Muslim communities, community members tell the girl that she won’t get a man to marry if she listens and tries to follow what she’s been told. This is the mechanism that community leaders employ to stop women from talking about gender. The fact that people are reluctant to discuss gender, is difficult to judge or blame because the institution of marriage is a strong value with ever present pressure to get married. The language of empowerment should not imply disrespect for traditional values. It’s a 2-way dialogue requiring good communication and understanding from both men and women based on community-relevant values and beliefs.

-Ghana Interviewee

Despite the advantages of contextualization, respondents emphasised that this should not be done at the expense of compromising standards of implementation. While proposing approaches that resonate with local communities, FBOs should remain cautious to align their implementation to national and international standards of implementation.

FBOs sometimes develop strategies in isolation, yet they must remain relevant to national and international standards.

-Uganda Interviewee
Compassion, motivation and value-driven approach

Almost unanimously, participating organisations stressed their compassion and motivation for serving people and communities.

We are compassionate. We embrace the suffering of our brothers and sisters in our community especially in hard to reach areas and take action to provide holistic, efficient and responsive health care to all.

-Nigeria Survey Respondent

FBOs view themselves as being less instrumental and self-interest driven in promoting human development efforts than other development actors. Moreover, due to FBOs’ strong ethics, their facilities are more favoured by patients than the government owned ones.

Long-term commitment to our member institutions and colleagues demands that we work for the success of others, promoting their capacity to work more effectively and independently and placing a higher value on facilitating their success than on personal or organisational recognition.

-Nigeria Survey Respondent

The Church has a very good name and reputation in the government offices at all levels. And the community appreciates our work because the services in our health institutions are better than in government health institutions. Why? Because of ethics, we treat patients politely and, although it is not a must, when patients come in the morning we do both devotion and health education and even Muslims or whatever religions come. They can accept the lesson and if not they can leave it and will receive treatment just like anybody else. After devotion we give health education on different topics, including family planning.

-Ethiopia Interviewee

FBOs broad understanding of health and wellbeing from a religious angle brings emphasis on emotional and spiritual factors such as motivation and hope building for sick and suffering.

We bring love, joy, compassion and hope to the very sick in their homes. We journey with the sick until they die. We journey with the children who are HIV positive in the area of the disclosure process and beyond until the adults feel they don’t need our services anymore. Spiritual nourishment is a must. Sharing of scriptures at support group meetings, where the sick relate them to their own suffering.

-Kenya Survey Respondent

The motivation that is almost always universally used in HIV education is based on fear, trying to scare people out of things. And we know as a fact that fear is a short term motivator, it doesn’t motivate people over the lifetime and to be effective, HIV education has to be a long term thing, not just short term. The other is that effective motivation comes from inside the culture not from the outside.

-the United Stated Interviewee
Lessons learnt

- FBOs have strong community and institutional structures and links which enable them to mobilise communities and identify beneficiaries of SRHR interventions. FBOs considered themselves less dependent on external funding than secular non-governmental organisations because of clearly defined resource mobilisation audiences within their circles i.e. ‘mother institutions’ (Churches, Mosques) and considerable number of wealthy followers. However, it was noted that this unique strength of FBOs has weakened recently due to a donor dependency syndrome. While competing for donor funding, FBOs should also (re) discover innovative mechanisms for raising funds for their interventions.

- Long presence in the communities and strong links with religious leaders gives credibility and a trustworthy image to FBOs and enables them to serve as entry points in health and SRHR-related community outreach. This distinct capacity of FBOs and religious leaders should continue being leveraged for effective delivery of health messages and raising community demand.

- Large number of followers was considered a significant attribute of faith community, especially in the context of advocacy and policy influencing where the potential of religious leaders to influence decision making at the top is widely recognised. Those organisations who had taken on the interfaith approach have been able to multiply their target audiences and reach greater numbers both in their service provision and advocacy interventions.

- FBOs are key to contextualization of SRHR interventions by employing language and approaches that resonate with cultures and beliefs of the communities they serve. This approach seems to be especially adequate in rural and traditional settings. However, caution needs to be maintained to make sure that contextualisation does not take place at the expense of compromising quality standards.

- FBOs recognise ethics and compassion as well as value-driven approach as their distinct advantages in comparison to other organisations working in SRHR field. Given that FBOs appear as more genuine and persistent in serving communities they offer stronger sustainability prospects.
4. VALUES, CULTURE AND RELIGIOUS BELIEFS AS BOTH ENABLERS AND BARRIERS TO SRHR

In order to develop meaningful and effective strategies to advance SRHR through faith-based approaches, it is necessary to identify and analyse barriers affecting FBOs’ SRHR interventions. The following chapter summarises key perceived barriers to effective SRHR delivery by FBOs, both internal and external to faith community. They were ordered according to frequency of responses, namely resource barriers, socio-cultural and religious barriers as well as technical capacity gaps. The findings of this chapter lend support to the argument that FBOs’ ability to effectively deliver for SRHR depends on two key factors; their organisational capacity and the extent to which the socio-cultural and faith context within which they operate is conducive to SRHR interventions.

Overall, respondents cited resource barriers as the most common obstacles to effective delivery of SRHR interventions (76 FBOs). Frequently quoted were also social and cultural barriers and resistance within own and other faith communities (37, 21 and 19 FBOs respectively) and limited technical capacity (30 FBOs).

Chart 8: Perceived challenges and barriers to SRHR work

Data Source: FBOs’ Mapping Survey
Resource barriers and resource mobilisation

Participating organisations differentiate between activity-based fundraising and mission and vision-rooted resource mobilisation efforts. Even though some organisations recognise traditional donor funding as being essential to their existence, they also see a danger in compromising their mission and vision.

**We direct our resource mobilisation efforts in two ways, through activity-based fundraising, and philosophy-oriented fundraising.**

-Kenya Interviewee

**We are mainly relying on donor funding but currently looking into how we can diversify our resources by having additional sources of income. We feel that having only donor related funding restricts us from doing additional things which we would like to do.**

-Kenya Interviewee

An interesting picture emerges while comparing Faith to Action Network members’ successes in accessing SRHR funding in 2013 with their total attempts made. Member organisations reported a strong track record in accessing funding for HIV/AIDS prevention and treatment and STI Prevention and treatment in 2013 with 100% success rate for accessing STI funds and 83% success rate for accessing HIV/AIDS funding. However, success rates for other thematic areas are much lower, namely 25% for maternal and child health, 25% for reproductive health and 0% for family planning.

These findings raise a number of questions and a further inquiry beyond the scope of this study would enrich the picture. First of all, it would be interesting to investigate to what extent FBOs are eligible to apply for maternal and child health, family planning and reproductive health grant funds on the same basis as all other non-governmental organisations. Secondly, given that not all FBOs provide comprehensive family planning, to what extent could this factor influence donors’ grant making decisions and lower FBOs chances in accessing funds? Thirdly, considering that FBOs report a much stronger involvement in STI/HIV/AIDS activities in comparison to family planning or reproductive health and a good track record in accessing STI/HIV/AIDS funds, could this mean they have established better documentation as well as reputation and confidence of donors in the thematic area of STI/HIV/AIDS?
Participating member organisations considered that high competition for donor funding was the major obstacle to accessing funding for SRHR interventions. Insufficient information on existing grant opportunities was also frequently quoted as a challenge by the majority of participating FBOs. Half of the respondents cited gaps in human resources and little or no funding opportunities for the thematic area they are working on. Similarly to the results on the type of funding accessed in 2013, perceived challenges reconfirm the need for investigating FBOs’ eligibility to compete for funding and assessing their ‘market value’, that is, how competitive they seem in the eyes of the donors in comparison with secular non-governmental organisations.

Chart 9: Perceived barriers to SRHR resource mobilisation

N=6 n=10

| High competition for donor funding | 6 |
| Insufficient information on existing funding opportunities | 4 |
| Lack of donor interaction opportunities or/and weak relationship with the donor | 3 |
| Little or no funding opportunities for the thematic area(s) we are working on | 3 |
| Difficulties in partnership building | 3 |
| Insufficient human resources | 3 |
| Chaotic / unplanned processes with regards to resource mobilization (e.g. proposal writing processes) | 2 |
| Insufficient body of evidence to demonstrate organizational capacity and impact of work | 1 |
| Insufficient proposal writing skills | 1 |
Social, cultural and religious barriers

A range of socio-economic, cultural, and religious factors were identified as either barriers to more effective delivery of SRHR or the reasons why there has been limited progress in this regard. Conspiracy theories, conservatism, multiple religious interpretations combined with lack of a clear stance from religious leadership, stigmatisation, are some of the challenges which were regularly cited by participating organisations.

Conspiracy tone

There was a voice amongst Muslim FBOs that until recently, the notions of development and health were perceived by Muslims as a Western or Christian agenda. Therefore, communities were skeptical to engage and some remain skeptical until now. In addition, the issues of SRHR were not seen as top priority as far as Muslim development cooperation is concerned. Respondents stressed an urgent need to combat these perceptions highlighting their negative impact on the health and wellbeing of communities.

Muslims would look at development as Western, as Christian, why? Because the initial promoters of development were missionaries. When they came in, where there was a Church there was a school, and where a school, there was a health centre. So it took Muslims some time to really appreciate development. Let me give you an example of the civil society, we have a very narrow CSOs space. The most vibrant Muslim CSOs are dwelling on human rights, governance and justice but health doesn’t concern them.

-Uganda Interviewee

In the early fifties, Muslims didn’t educate their kids so much because they associated sexual education with Christian schools. The very people who brought education were missionaries, so Muslims were not interested in sending their kids to mission schools, the only schools available at that time. They felt if you send your kids there, they would be oriented with the Christian values and they would lose focus and direction. So, the second generation of Muslims that went to school were very few.

-Uganda Interviewee

We learn from the organisations we have been working with on health like Jhpiego that there is absolute lack of Muslim involvement in the health sector.

-Kenya Interviewee
In the last two decades conspiracy theories started to emerge that the West is trying to control Muslim fertility which was followed by the sense of hostility toward the concept of family planning. Some Muslims disagree that family planning, female genital mutilation/cutting should be on the development agenda while there are other pressing issues such as water and food security or education. (...) Unless we combat this conspiracy theory, it will be difficult to reverse the current trend.

–Egypt Interviewee

We are trying to say, hey! this is not about the West this is happening in your community, these people have health issues and you as Imam cannot turn a blind eye thinking that solutions will come as we pray.

–Uganda Interviewee

The issue of family planning has some basis in Islam. However, Muslim scholars tend to give low profile sort of approach towards it, so you will find there’s a lot of challenges. If this is the kind of attention that is being given to this particular issue, then actually somebody somewhere might be trying to deny the communities some useful information.

–Kenya Interviewee

Division within the Muslim and the lack of strategic and community-oriented thinking at the top level were also cited as the reason behind insufficient Muslim involvement.

We’ve had warring factions in Islam with two disagreeing parties. The disagreements are mainly about wealth, who controls power and who controls the world. Because they have been locked up in this for the last 10 years or so, they have not had enough time to plan for their communities in terms of education as well as advocating and engaging the state. The leadership did not give any directions in terms of having a strategic focus for the next 10 years on how do we reduce the cases of mothers dying and maternal health related issues.

–Uganda Interviewee

We as Muslims face a lot of challenges, challenge of perceptions, challenges of needs and we have an almost inbuilt capacity to isolate ourselves. We try very much not to interact with others freely. We might talk about issues but when it comes to religion, unfortunately we are very sensitive and it is time for the leaders to become bold, stand up and try to bridge that gap.

–Kenya Interviewee

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3. Muslim leaders in Uganda are divided into two wrangling factions. These are the Uganda Muslim Supreme Council, led by Mufti Sheikh Shaban Ramadhan Mubajje, and their counterparts from Kibuli Mosque, led by Supreme Mufti, Zubairi Kayongo.
Multiple interpretations

Hierarchical gender roles within faith communities tend to be reinforced by the most conservative interpretations of religion. As emphasised by participating organisations, this especially happens when the guidance of parents is missing. Coupled with reluctance towards embracing the changing context, it poses an obstacle to effective delivery of health programmes, reinforces gender disparities and creates additional demand for awareness raising. There was an emphasis that religious leadership should take a bold stance and actively combat such beliefs which lead to reinforcing existing gender inequalities including those views who subscribe to interpretations of scriptures driven by religious conservatism.

There are so many interpretations of Islam as a religion and many times parental responsibility is lacking in terms of orienting us about my sexual education, what I should expect when I go through my menstrual period, how my body changes, how do I conduct myself. I’ve grown up seeing parents not doing that because for them it’s like: if you tell me earlier, it’s like you are telling me to go and discover. So that fear alone is partly there.

-Uganda Interviewee

The place of male in our religion is so defined you cannot nearly have this casual conversations or parental upbringing conversations with our parents and it’s really a big challenge from the household level. But also at the community level, especially issues such as teenage marriage. Because somebody would say that the Prophet married Aisha when she was a certain age and things like that. They would argue out of context because in this day and era of the 21st century, you do not need to marry off someone because it’s very competitive. If you cannot put your ideas on the table, if you can’t find your passions and turn them into reality, then I don’t think you have any place in the 21st century. I mean why you would choose to marry off your daughter who is going to suffer for life.

-Uganda Interviewee

It’s not only about conceiving the child but it’s also about seeing the child grow into a strong human being. So it’s not about marrying off and then getting more kids. There has been an evolution and we need to change, and these are the conversations we are having now.

-Uganda Interviewee

For us, Islam is very clear, you don’t have to marry all the four wives but the argument of course men use our religion says so. Then the question arises, can you satisfy them, can you provide for them?

-Uganda Interviewee
Religious leaders have a lot to work on in terms of religious and cultural aspects, there was a time when they were debating how people have misinterpreted scriptures for example coming from the rib of a man, the common quotations from the Corinthians that a woman must submit to her husband, which were misused as a way of violating the rights of women. However, there has been progress made and if all the policies are implemented (the experience from Uganda is that unless the community, the CSOs, the religious leaders and other partners implement the policies designed by the government, there is no fast progress) we would move forward.

– Uganda Interviewee

Sensitivity of family planning

Participating organisations recognise existing resistance within their own and other faith communities towards some of family planning approaches and methods they use. This resistance is identified as an obstacle to delivery of effective SRHR and a root cause for devastating health outcomes. Reference was made to the stance of religious leaders on the use of barrier methods in HIV/AIDS prevention, many of whom oppose it, even in the case of married discordant couples.

They don’t want to say anything about the condom. I remember when I was discussing with the Mufti Of Uganda, Sheikh Shaban Ramadhan Mubaje about the use of condoms in HIV/AIDS prevention. If there is a couple and they are married-the religious people will look only at the married - and one is positive they are going to infect and it’s like literally murdering the other person. We cannot advocate for condom but we can advise the married people, or if advised by the doctor. Then I asked him, can you say this in public and he said yes, why not? And so, we had a maternal health national consultative assembly with the IRCU and all the FBOs were there and all the religious top leaders were there and I asked him can you share it there and he said yes I will. When it came to condom use, condom and the youth, the FBOs and religious leaders said no and then the Mufti took his turn and said as a Mufti of Uganda I’m not advocating for a condom but there are situations that call for it like couples who are married...and he repeated it about three times...people who are married can use condom if advised by the doctor, especially if there are discordant couples or their life is in danger in any way, they can use it. He was the only one who talked about it.

– Uganda Interviewee

Respondents highlighted that some FBOs that endorse comprehensive access to family planning feel their efforts are being restricted by more conservative voices from other faith communities that oppose full access.
We face challenges from the Catholics; we do other extra interventions in family planning, not only the natural ones which Catholics are following. When we are implementing our interventions, by the way we serve the whole community regardless of faith, what our project officers are telling me is that the Catholic members resist and sometimes Muslims also resist but when we tell the Muslims about birth spacing, they accept it. We also try to discuss with Catholics but they are very strict.

–Ethiopia Interviewee

One respondent also emphasized the mandate of religious leaders in guiding their followers and offering knowledge and information which is relevant to a rapidly changing world with many new health challenges.

All marriages in Churches, and Mosques are conducted by religious leaders, meaning, they are custodians of marriage and their mandate is to ensure the family is healthy. It is their mandate to inform people and give them alternatives to different things responding to what’s happening now, the contemporary world. How does the religious leader connect the past with the present? It is their mandate as religious leaders to help the people move with the times.

–Uganda Interviewee

Contrary to what respondents highlighted as added-value and strength of FBOs interventions, faith leaders and faith groups were also portrayed as a source of stigma in the communities.

One of the things that I became aware of is that around the world, the Church and particularly Evangelical Church, and I am an Evangelical Christian, is the greatest source of stigma and discrimination against people living with HIV/AIDS and that is exactly the opposite where we should be. One of the things that I believe we need to be doing with the faith community, and it’s not just Christians but other faith communities as well, is that we need to be working on stigma.

–the United States Interviewee

(Im)possibility of interfaith consensus on SRHR

In the context of multiple and often competing religious interpretations, a way forward could be to turn to interfaith dialogue or even interfaith consensus as means to foster understanding and help combat poor SRHR outcomes. However, there is need for a feasible approach in this regard, one which takes into account the possibilities and limits of interreligious dialogue or consensus on SRHR issues.

Some informants suggested that in order to succeed with interfaith approach, the agenda must be inclusive. Yet, one participant was concerned that trying to enforce interfaith consensus on SRHR might be seen as pushing someone to compromise their religious beliefs. Therefore the importance of highlighting a common stance across differences...
cannot be overemphasized and bringing the religious leadership to advocate for a wider objective would be the way forward.

If you are asking whether we can get people across the faith spectrum to agree on approaches and ways to do things or reach consensus then I do not know. There are some very deeply held views particularly when it comes to sexuality and my concern is that if I am going to try and enter into consensus with people, too often, consensus involves adopting the least common denominator, it involves compromising for beliefs. I think it is very important for us to emphasise and focus on the things that we have in common rather than things where we differ. But consensus, I fear, would require setting aside what I believe in, and if it did, this is not something that I would support.

- the United States Interviewee

It is important to bring religious leaders to reflect whether some of these aspects are in line with their values and doctrines. So that they are able to see that even if their values do not promote family planning, but they are able to know that the Catholics promote the natural methods and they are able to identify under the natural methods of family planning which ones are effective, they can promote them and encourage use.

-Uganda Interviewee

Bring leadership for a certain cause which benefits the general population on equal terms in a way. It needs to be seen as an all-inclusive thing and not only an issue that belongs to one group or other. The chances of achieving more are very high because we are going to define roles and responsibilities amongst the various players who come on board. By doing so, we will break more barriers and will be likely to influence some of the policy decisions in this country. The history of Kenya has shown that little attention is being given to the health sector. By having that particular approach we will hit the most felt component in the governance and that is the policy. If we are strong enough, we come together and have one voice and one strategy, we have bigger chances for participation in the health policy making, health funding, health infrastructure and these kinds of things.

-Kenya Intervieweee

Capacity gaps

Technical capacity on SRHR and theological awareness

FBOs highlighted the urgency to build the technical capacity of faith leaders to better understand and respond to SRHR challenges. Faith communities can be a victim of their own rhetoric. Therefore, there is a need to challenge perceptions of religious leaders by making reference to SRHR-related extracts from scriptures.
We engage with religious leaders who have the knowledge of holy texts but they lack scientific, medical knowledge. As a trusted institution who held FIGO presidency until recently, and is regularly featured on TV, we provide Islamic religious leaders with knowledge on family planning and turn them into family planning champions.

—Egypt Interviewee

The religious leaders need to be empowered with knowledge and skills on reproductive health issues, family planning, HIV and other key health aspects that relate to day to day life of the communities. In doing that they are able to mainstream in their sermons, during the meetings like the mothers Union, the Fathers Union, the Youth group.

—Uganda Interviewee

We need to change the context and perspective at which they look at some of these SRHR issues and also use the scriptures to be able to bring out the messages. Because it’s not completely new messages, these things are written down in scriptures, in the Quran but it’s about being able to bring them into the current context.

—Uganda Interviewee

If you want to succeed within the religious people you must base your argument on the scriptures. A lot of time we have not supported and empowered our religious leaders so that they can take the scriptures and use the message to package within the scriptures so that delivery can be easy and can be easily accessed. This is the gap that we need to fill.

—Kenya Interviewee

It was stressed that the work of religious should not limit itself to raising awareness or creating demand. Religious leaders need to make use of existing mechanisms and structures for effective delivery of services.

In most cases, FBOs are very good at raising demand but one of the challenges faced is the functionality of the referral services, is it really happening that people are accessing the service? FBOs are not able to refer among themselves; there must be a coordinated way of knowing who is where and who is providing what. It often happens that FBOs raise awareness and then it’s up to the community to find the services and they often do not know where to find them.

—Uganda Interviewee

Also they should look at leveraging what is available. We know at some of these structures, there are already health facilities available. The important thing is how they can promote and refer and ensure that people actually seek the services.

—Uganda Interviewee
We work with religious leaders in the dioceses, the Muslim districts and the deaneries etc. They should be able to have a kind of mapping to know in that particular area if someone needs family planning where do you find such services. If you find within your faith fraternity a health facility and when you talk about STI treatment you could do an automatic referral to that health facility but you should also know who else is in that community. It’s not just a referral but a functional referral.

–Uganda Interviewee

However, a concern was expressed that focusing exclusively on a top-down approach in sensitising religious leaders might not guarantee the same messages would be taken up at all levels.

The top down approach has been a big challenge in Muslim community, because as I said civil society is very narrow and people find it much easier to work from the top, from the national level. And at the national level, their strategies of getting the message down to the lower level don’t work out.

–Uganda Interviewee

The models that are often applied tend to identify Imams and leaders at the county and district level but there are few models that are locally based which would help getting the message to the other final person in a local Mosque.

–Uganda Interviewee

We work at the national and district level. Then we have what you call counties, we call them Twaaales, then we have family units where everybody gathers and if you want to make impact, most of the work is done there. There are also Mosques at national level. They must speak the same language. We need to train the people so that they speak the same language.

–Uganda Interviewee

Research, knowledge management and monitoring and evaluation

Research, knowledge management, monitoring and evaluation and reporting have been frequently quoted as one of the weakest points of FBOs and religious leaders. Moreover, given that theology is often the basis of FBOs programming, this leads to a different understanding of accountability by FBOs or religious leaders and constitutes a strong challenge for evidence-based programming in view of participating organisations.

Religious leaders have different understanding of accountability. They are only accountable to God.

–Kenya Interviewee
We as religious leaders have one and only one mandate. To represent the Creator and work for His creation. His Creation: all human beings, all animals, all trees, we must provide services to them. We must take care of our environment, we must take care of ourselves, and we must take care of our resources.

-Kenya Interviewee

It was highlighted that the advantage of involving religious leaders and building capacity of FBOs to undertake monitoring and evaluation tasks can result in empowerment and ownership of the results. In addition, it helps FBOs and religious leaders improve their interventions by building a strong evidence base for programming and advocacy.

I feel that at institutional level, we might need a lot of capacity enhancement for example in research. Research is very critical. There is no information out there and we need to document. Documentation is the source for you to negotiate, advocate and is also an aspect on which we can build and develop our interventions.

-Uganda Interviewee

Religious leaders need more training on scientific part, need M&E skills to help them understand what impact they make because development interventions are not only about activities but most importantly about results.

-Ethiopia Interviewee

One respondent pointed out that in order to ensure their interest and participation, tools for religious leaders should be made user-friendly. It was noted that simplified reporting should not compromise technical aspects. Therefore involvement of technical staff would help ensure quality. In reference to capacity development, the need for contextualisation was highlighted, taking into account capacity of faith leaders and FBOs themselves.

Another way of ensuring that the religious leaders get really involved in documentation and other programme aspects of reproductive health and family planning is to simplify the messages and also the tools. For example, if religious leaders give out the message and council the youth, how can they document that information so they would be able to prove I met 10 youth this week and these are the messages I gave them on family planning or reproductive health? There should be someone who is able to organise that and put it into the tools and the formats as expected by the national standards and partners.

-Uganda Interviewee
We conducted an organisational capacity assessment of our members who were supported in Uganda and for most of them, the capacity was estimated to be below 50%. We also realized that the type of high-level training they were offered does not improve capacity, especially at service delivery level. There is a need for a highly contextualized training based on understanding of the language and structures. The standard types of training might not always be beneficial to FBOs depending on the capacity of faith leaders.

-Uganda interviewee

In addition to the above, financial management and administration were also identified as weak points of FBOs and religious leaders, and negatively affecting their health interventions.

Basic management is really a challenge. If they go to school of theology, they are only told to pass on the message that strengthens one’s faith and keeps people connected to Allah but the basics of management are lacking. We have been helping them to define the Mosque beyond the place of worship and looking at the Mosque for example as a body to partner with a district health centre and encourage Muslims to come and test for HIV and encourage them to stay after the Friday prayers for like 10 minutes for health awareness or offer blood donation space.

-Uganda Interviewee
Lessons learnt

- Funding barriers were identified as key obstacles to FBOs’ SRHR work. FBOs differentiate between activity-based fundraising and philosophy oriented resource mobilisation and recognise donor funding as essential to their existence. However, they fear donor dependence because it poses limitations to fulfillment of their wider strategic framework.

- FBOs reported a much better track record in accessing funding for HIV/AIDS and STI prevention and treatment in comparison to maternal health and child health and family planning with the latter having the lowest success rate of 0%. Reasons as to why FBOs encounter difficulties accessing funding could vary from not being equally eligible to compete for funding, facing donor skepticism due to the fact that some FBOs do not provide comprehensive family planning (education) or having insufficient track record, and documentation of successfully carrying out family planning programmes. Further research in this regard would help enrich the picture and support design of appropriate response strategies.

- Owing to conspiracy theories, the involvement of Muslim FBOs in SRHR has been weakened and underlined by skepticism. This is coupled by the fact that some Muslims do not see health and SRHR as a priority for development work. In addition, a narrow CSOs space for SRHR was perceived as negatively impacting health outcomes in the communities.

- Most conservative interpretations of religion tend to negatively influence gender relationships and reinforce existing gender disparities. Other factors such as lack of parental involvement and conservative voices opposing to embrace the changing context equally hinder SRHR efforts. Given that it cannot be overemphasized how important it is to ensure religious leaders are involved in awareness raising and combating interpretations of scriptures driven by religious conservatism and divisive agendas.

- FBOs emphasised that religious leaders themselves can pose obstacles to effective delivery of SRHR. Especially when medical and religious objectives are not seen as synergistic and seeking of medically recommended approaches, e.g. as part of HIV prevention, is being viewed as violation of God’s law. It was emphasised that the mandate of religious leaders is to guide their followers and offer information relevant in a rapidly changing world instead of hindering knowledge sharing.

- Some faith communities which oppose comprehensive access or education on family planning were viewed as restricting the efforts of FBOs. Faith communities were also perceived as a source of stigma for people living with HIV/AIDS contrary to many positive efforts made by FBOs in providing care and emotional support for HIV/AIDS patients.
The perspective of having interfaith dialogue or consensus on SRHR was viewed with skepticism and at times as compromising religious beliefs. Focus on areas of commonalities was suggested as a way forward. It appears that as one gets more technical and detailed, the likelihood of success reduces. However, there is certainly a room for finding common ground around the wider notions of health and wellbeing. The strong advantage of such an approach is a large number of followers with a greater potential to have their voice heard in public deliberations.

Religious leaders require better understanding of medical aspects related to SRHR but most importantly they need to see the issue of SRHR as relevant. Therefore continuous reference to SRHR-related extracts from scriptures is key to this process.

Too much focus on top-down or bottom up approaches in sensitising religious leaders and their structures might not guarantee that messages will be taken up at all levels. Therefore a feasible mixture between top-down and bottom would be an ideal model for SRHR awareness raising within religious structures.

It is paramount that the involvement of religious leaders does not exclusively limit itself to awareness raising. Linkages should be made to service providers to ensure functional referral.

Religious leaders were considered weak in documentation and reporting which negatively impacts perceived accountability of FBOs. This is also underlined by the fact that religious leaders tend to have a different understanding of accountability given that theology is often their basis for programming.

Involving religious leaders in research and monitoring and evaluation can contribute to their empowerment and increased ownership of SRHR interventions. However, efforts need to be made to encourage religious leaders’ participation. Focus should be on highlighting the benefits of their involvement beyond acquiring donor-oriented data as well as employing user-friendly tools. Further, religious leaders should not be treated as a replacement for technical staff in some of the more complex monitoring and evaluation exercises.

Management and administration were also cited as weakness of faith community and areas for potential training. However, trainings and capacity development programmes require highly contextualized approaches. Conventional trainings with technical curricula might not result in skills enhancement depending on the capacity of religious leaders.
CONCLUSIONS AND RECOMMENDATIONS

What are the practical implications and recommendations from the study findings for FBOs’ SRHR interventions?

The study intended to construct an up-to-date review of FBOs’ SRHR work. While recognising and demonstrating the diversity of faith-based responses to SRHR, it highlighted patterns and trends of SRHR provision. Looking into how FBOs’ frame SRHR and what type of SRHR activities they undertake, it aimed at identifying key building blocks and points of consideration for faith-secular, interfaith and same-faith collaborations on SRHR. In addition, the study investigated comparative advantages and strengths of FBOs’ SRHR delivery to inform strategies and approaches for better FBOs’ involvement in SRHR. Last but not least, the research identified perceived challenges and obstacles to FBOs’ SRHR delivery, both within and beyond faith community. By doing so, it aimed at building evidence base for designing strategies to cope with risks and challenges of FBOs’ SRHR interventions.

Based on its findings, the study recommends the following:

**Conceptual issues:**

1. **Employ faith-based approaches to promote a holistic outlook on SRHR, incorporating both physical and emotional aspects**

   The findings confirmed that FBOs favour a holistic approach to health and SRHR, focusing on physical as well as spiritual and emotional wellbeing. This is strongly reflected in FBOs’ SRHR, work where counseling and provision of emotional support played a key role. Partnering with FBOs can help promote a comprehensive approach to human sexuality. This approach should emphasise not only knowledge and skills but also highlight the importance of nurturing positive attitudes and values towards one’s own SRHR. Incorporating both the physical and the emotional aspects of SRHR helps contribute to the achievement of WHO’s holistic vision of health. However, appropriate levels of coordination are needed to achieve complementarity between rights-based and faith-based approaches.

2. **Improve FBOs’ acceptance of family planning and gender issues through use of alternative language and mobilising faith voices aligned to WHO and UNFPA standards**

   The study found that thematic scope of FBOs interventions in SRHR covered maternal and child health, reproductive health, family planning, adolescent health, prevention of gender-based violence, STI/HIV/AIDS prevention, sexual health and sexual and reproductive rights.
However, family planning, in particular, and gender and rights issues, at times, do not generate consensus across the faith-based spectrum, especially as far as public discussions are concerned. In some cases, divergent language could lead to an assumption that values of faith communities are not compatible with family planning and women empowerment. In such instances employment of culture-sensitive language could help improve acceptance. In other cases, a way forward would be to mobilise and amplify FBOs’ voices aligned to WHO and UNFPA standards to both balance and challenge opposing viewpoints to reflect on the alternative angles and points of view.

3. Unpack SRHR terminology to increase roll-out of FBOs’ SRHR responses

The study showed that rather than easing SRHR interventions international SRHR terminology has created obstacles in responding to people’s suffering for FBOs and people of faith. Lumping together controversial issues with uncontroversial issues, under the SRHR ‘umbrella term’ has hindered the roll out of FBOs SRHR programmes. Unpacking the concept of SRHR, can help increase the acceptance of specific SRHR components.

4. Encourage faith-secular dialogue underpinned by the joint vision of family health and wellbeing to promote pragmatic SRHR responses

The study revealed that FBOs often oscillate between doctrine requirements and pragmatic responses to the demands of every-day life. Often, people of faith facing human suffering take pragmatic decisions which might differ from the official stance of their religion. The notion of SRHR can be controversial at the conceptual level and at times the most effective approach is to take a pragmatic position, addressing human suffering rather than discussing conceptual content. Dialogue, exchanges and collaborations should take place between secular organisations and FBOs. This dialogue should stay clear of dogmatism from both sides and involve pragmatic representatives who share a common goal of family health and wellbeing.

5. Leverage FBOs’ dynamic approaches to promote family health and wellbeing. Define specific SRHR advocacy asks and build alliances with groups of like-minded FBOs.

The findings confirmed that achieving an interfaith/dialogue consensus on SRHR is viewed by FBOs with skepticism and seen as compromising for beliefs. Critiques may conclude that any attempt to establish an interfaith consensus on SRHR will fail due to the faith community’s diverse outlook on SRHR. The study shows that there is room for a common stance around wider notions related to humanity such as health and wellbeing. However, FBOs’ advocacy on specific aspects of SRHR is only feasible on a case-by-case basis.
Programming issues:

6. Partner with FBOs to develop culturally and linguistically competent yet balanced approaches to SRHR

The study found that FBOs play a crucial role in translating SRHR interventions into local contexts. SRHR remains a sensitive topic and in many cultural and religious settings, conventional WHO and UNFPA language is not necessarily how people frame their understanding of SRHR.

Effective implementation of international frameworks on the ground requires context-embedded responses that resonate with local cultures and beliefs. However, any intervention should be cautious not to reinforce existing gender disparities under the disguise of contextualizing international SRHR standards.

7. Incorporate referral mechanisms for comprehensive provision of SRHR by FBOs

The evidence suggested that FBOs do not always provide comprehensive SRHR education as per WHO or UNFPA guidelines. For instance barrier methods such as condoms are not always discussed, especially in public communications and education on HIV/AIDS prevention. FBOs recognise that abstinence and barrier devices are the most effective HIV/AIDS prevention methods. However, for many FBOs encouraging condom use remains an unlikely strategy due to their religious structures. Nevertheless, there is room for employing faith-based approaches in comprehensive SRHR. Wherever possible, condom discussions/distribution should be part of comprehensive HIV/AIDS education provided by FBOs. Otherwise, FBOs should make referral to alternative service providers for this type of service, or for any other service which is recommended from the medical standpoint.

8. Ensure community links are built to enhance functionality of FBOs’ SRHR referral systems

The findings showed that FBOs provide structures that enable them to reach out to large audiences with health messages and education therefore raising demand for, and extending the reach of SRHR services. However, it appears that FBOs’ referrals are often made in an uncoordinated manner and with little follow-up. Linking up with other stakeholders and coordination is needed to strengthen ties and ensure the functionality of referral system.

9. Ensure high efficiency of SRHR interventions by undertaking community assessment during design phases. If proven necessary, incorporate sensitisation campaigns involving religious leaders

The study revealed that conspiracy theories and most conservative interpretations of religious doctrines can hinder SRHR efforts and result in low efficiency of interventions. It is risky to assume that communities will always support SRHR initiatives. Therefore in-depth assessment should take place as part of risk analysis while designing SRHR interventions.
Whenever, necessary an intensive community sensitisation campaign, involving supportive religious leaders, should be part of the design. This would help prevent community misconceptions, stigmatisation and combat religious teachings which are antagonistic towards SRHR.

10. Promote uptake of SRHR evidence amongst religious leaders through participatory monitoring and evaluation approaches with a clearly defined engagement strategy

The study found that FBOs are very interested in employing participatory monitoring and evaluation techniques involving religious leaders. Participatory monitoring and evaluation has a potential to empower faith leaders and promote uptake of the results for better SRHR delivery. However, involvement of religious leaders requires a well-defined strategy on how to make monitoring and evaluation appear relevant and sustain their interest and motivation.

Focus should be on highlighting the benefits of their involvement beyond acquiring donor-oriented data as well as employing user-friendly tools. However, religious leaders should not be treated as a replacement for technical staff in some of the more complex monitoring and evaluation exercises.

Capacity development issues:

11. Increase the reach of SRHR capacity development efforts by integrating top-down and bottom-up approaches and encouraging exchanges between FBOs

The study found that SRHR interventions exclusively employing top-down approaches in building capacity and sensitising religious leaders and their structures do not guarantee that the SRHR messages will reach the grassroots. Whenever possible, an ideal model for SRHR awareness raising within religious structures should combine top-down and bottom-up methods. Moreover, FBOs should be given an opportunity to meet and interact to encourage cross-fertilisation of ideas, messages and experiences.

12. Enhance FBOs’ credibility and legitimacy as SRHR advocates by developing their capacity to conduct evidence-based advocacy

The study revealed high involvement in SRHR advocacy and policy influencing amongst FBOs which is underlined by the general recognition that FBOs have a capacity to play a key role in their national policy making on SRHR. However, with theology, being often the basis for FBOs programming, most of FBOs’ conduct value-based rather than evidence-based advocacy and policy influencing. Given, an increasing emphasis on evidence-based policy making from governments and international donor organisations (Overseas Development Institute 2005), FBOs might be viewed as less relevant at the international level if they cannot prove their policy advice through rigorous evidence. While recognising that effective policy influencing combines both evidence and value-based knowledge, greater emphasis should be put on developing FBOs capacity in evidence-based advocacy.
13. Sensitise religious leaders on the consequences of the gap between official religious stance and provision of SRHR by FBOs

The findings confirmed the discrepancy between official religious stances and local FBOs’ practices, especially in relation to condom use. Often comprehensive SRHR provided by FBOs on the ground is being hindered by conservative voices of religious leadership at the policy level. Sensitisation of religious leadership should include provision of medically-sound information on the effectiveness of barrier methods in preventing HIV transmission, presented in the context of relevant theological sources and religious teachings.

14. Enhance sustainability prospects of FBOs’ SRHR work by strengthening FBOS’ capacity in organisational management

The findings revealed that FBO appear to be more sustainable than secular organisations thanks to permanent community links and local influence which is underlined by the compassion and motivation to serve the needy. In addition FBOs’ service is imbedded in the community value system.

However, these factors are not always accompanied by adequate managerial and administrative competences. In order to make the most of their sustainability prospects and ensure growth, FBOs should invest in enhancing their managerial capacity or bring technical staff on board.

15. Diversify funding for FBOs’ SRHR interventions by mobilising resources from FBOs’ social and institutional networks

The evidence suggested that resource barriers remain by far the largest obstacle to FBOs’ work. At the same time FBOs’ track record in accessing donor funding, for some of the SRHR thematic areas, especially family planning, is poor. The reasons as to why FBOs experience difficulties in raising donor funds might vary from having weak proposal writing skills, to failing to provide adequate technical knowledge and facts on SRHR. However, FBOs’ strength lies in their ability to mobilise institutional and social networks, and as such their resource mobilisation efforts should not be exclusively focused on donor-related funding but directed at audiences within FBOs’ constituencies. FBOs should develop mapping tools that help identify resources within and outside faith community.

16. Enhance FBOs’ understanding of donor language and encourage peer pressure to promote transparency and accountability

The findings revealed that FBOs have often different sense of accountability, one related to the Divine and/or the virtue of compassion, which might weaken their perceived transparency and accountability in the eyes of donors and partners. This is underlined by weak research and documentation capacity. FBOs should enhance their understanding of the language, perspectives, and priorities of donors and other development partners to be able to make a stronger case for SRHR funding. This would include ensuring proper documentation of resources spent and results achieved. Moreover, encouraging peer pressure within FBO community itself could be an effective tool in promoting better accountability practices.
APPENDIX 1: LIST OF PARTICIPATING ORGANISATIONS:

• ACET Ireland
• African Council of Religious Leaders — Religions for Peace, (ACRL—RfP)
• Ahmadiyya Muslim Mission
• AIDS Care Education and Training Society (ACET) Nigeria
• Alliance for Strengthening Education in Ghana (ASEG)
• Assemblies of God Relief & Development Services, Ghana (AGREDS-GHANA)
• Assemblées Chrétiennes du Chad
• Association Evangélique d'Appui au Développement (AEAD)
• Asian Conference of Religions for Peace
• Baertracks
• Bathesda
• Born Again Faith in Uganda
• Buds of Christ
• Cameroon Baptist Convention Health Department
• Caritas, Cyangugu Diocese
• Centre for Development of People/Methodist Church
• Christian Conference of Asia (CCA) - HIV & AIDS Program
• Christian Council of Ghana
• Christian Health Association of Nigeria (CHAN)
• Communauté Baptiste au Centre de l’Afrique
• Communauté des Eglises de Pentecôte au Burundi (CEPBU)
• Coordination diocésaine de la santé de bafoussam au Cameroun (branche de L’OCASC : organisation catholique pour la santé au Cameroun)
• Cordaid Burundi
• CSCW
• Dignity in Development

4. Several organisations requested to remain anonymous without having their name published
• Dodoma Christian medical Centre Trust
• Ecumenical Pharmaceutical Network (EPN)
• EHA
• Empowerment Centre For Women and Children
• Eglise Méthodiste Libre en RDC/Coordination médicale
• EP Church Development Services
• Esteem Resource Network
• Evangelical Churches Fellowship of Ethiopia
• Ethiopian Interfaith Forum for Development Dialogue and Action
• Ethiopian Evangelical Church Mekane Yesus
• Ethiopian Muslims Development Agency (EMDA)
• Family Aids Caring Trust (FACT)
• Franciscan Missionary Sisters for Africa. Love and Hope Centre
• German Institute for Medical Mission
• Grace & Light
• Groupe Chrétien Contre Le Sida au Togo
• Hand to Orphan and Needy Children Project HONEP
• Health Services of the Presbyterian Church in Cameroon
• HIV Hope International
• Inamallah Muslim Trust
• Inter-Religious Council of Kenya
• Inter-Religious Council of Uganda
• International Islamic Center For Population Studies and Research, Al Azhar University
• Institute Médical Chrétien du Kasai (IMCK)
• Islamic Relief South Africa
• Islamic Youth Development Society
• Inamallah Muslim Trust
- Jeevan Sahara Kendra
- Kenya Muslim Youth Alliance
- Kibogora District Hospital
- LifeNet International
- Methodist Women Fellowship
- Mission for Essential Drugs and Supplies (MEDS)
- Mission for Essential Medical Supplies (MEMS)
- Muhammadiyah
- Muslim Family Counselling Services
- National Catholic Health Services (NCHS)
- Sanru
- Shelter
- Teen Star Programme
- Uganda Muslim Supreme Council (UMSC)
- Uganda Muslim Youth Development Forum
- Uganda Protestant Medical Bureau
- World Vision International Zimbabwe
APPENDIX 2: REFERENCES


Advancing sexual and reproductive health and rights through faith-based approaches: A mapping study