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The Role of Faith-Based Organizations in United States Programming in Africa

For over the last 30 plus years I have spent my life working in Africa. I have spent more of my biological life in Africa than the United States.

In 1993 I was appointed by the late Cardinal Maurice Otunga to develop the Eastern Deanery AIDS Relief Program. The term deanery is a church term for a section of the archdiocese so in political terms you might consider the deanery to be like a district of the House. The Eastern Deanery AIDS Relief Program developed because many of the parishes on the eastern side of the city had slums as part of their parishes and were encountering people dying from HIV/AIDS related illnesses with no care being offered to them. The priests saw the suffering of their people living in the slums and said that we should try to respond in what ever way we could to these people. At that time most people were not talking about HIV/AIDS. Initial funding came from a German Catholic development organization called Misereor and my own community Maryknoll Fathers and Brothers. Both of these church groups have continued to fund us with their limited resources.

As HIV/AIDS became more of issue prior to the President's Emergency Plan for AIDS Relief , United States government funds were coming mostly through the United States Agency for International Development (USAID). However though it was not official USG policy, the Catholic Church was not welcomed at the funding table for HIV/AIDS. In point of fact, I felt stigmatization by being a Catholic priest and running a Catholic run AIDS care program.

In the year 2002, I felt the complete opposite attitude coming from the US agency Center for Disease Control (CDC) through their Kenya office. CDC Kenya wanted to work with us as they were developing Voluntary Counseling and Testing (VCT) in Kenya and tuberculosis services. CDC did not have the funding stream at that time and initially could only offer technical services. When they began to receive more funding they tried to assist as they could. With the implementation of PEPFAR, I was able to obtain a five year cooperative agreement with CDC in the area of HIV/AIDS care, counseling, HIV/TB and next year orphans and vulnerable children. CDC has respected the traditions

of the Catholic Church and has never tried to impose conditions on our work that would be in conflict with the Church.

Now from the situation of not being welcomed at the table by some people within the USG system, Eastern Deanery AIDS Relief Program is currently the number two individual supplier of anti-retroviral treatment (ART) in Kenya under PEPFAR. We are the number one individual supplier of ART in Nairobi province. Our tuberculosis service was awarded the number one TB site in Nairobi Province in the year 2006. Our TB services are only one of two sites nationally allowed by the National Leprosy and Tuberculosis Program (NLTP) to offer Isonaizid prophylaxis as part of comprehensive AIDS care. We were also allowed by NLTP to do a pilot study on Diagnostic Testing and Counseling for in relation to tuberculosis care. This study had now become the national protocol for TB care.

Through the assistance of PEPFAR and CDC, the USG has been able to reach poor people living in the slums which are what the U.S taxpayers believe their tax dollars should be. At present, we have over 6,500 patients receiving comprehensive AIDS care. Out of these 6,500 patients, over 700 of them are children receiving AIDS care. We are presently testing an average of 3,000 clients every month in our VCT centers and through clinical Diagnostic Testing and Counseling. At our ante-natal clinic, all our pregnant mothers accept to be tested because we believe that any mother wants the best for their baby and if testing is communicated properly the mother will accept. The sadness is that 22% of our mothers are being tested HIV Positive but at least now we can offer these mothers and children various treatments to keep them alive.

What USG money had done through Eastern Deanery is keep poor families alive. Poor children as any children need the love and support of parents. Through the use of anti-retroviral treatment parents are being kept alive. Thus a hidden outcome from PEPFAR is that we are supporting the strengthening of the family unit which is crucial for any society. As the family unit breaks down, children become vulnerable and also societies become more vulnerable because of manipulation of vulnerable children for unhealthy activities.

HIV/AIDS needs to be viewed in all its components including prevention. The Catholic Church has been in the forefront on abstinence and prevention programs even though not recognized by many.

The basis of Church policy on abstinence is in the formation of people and in particular young people. Young people around the world face the same struggles as young people in the USA trying to understand themselves as young men and women with issues around sexual identity and sexual feelings. The Church is trying to help young people know themselves better and develop appropriate life skills so that they can positively say no to inappropriate activities. It is easy to tell someone to say no to sex but it is another to help that person to develop internal skills so they can say no to sex before marriage. Young people feel at times that they are being pressured into sex even though they want to say no. By helping children develop life skills, the ability is there to say no.

Many of our young women are being infected by older men because of issues around poverty and psychological seduction. The Church is trying to challenge the adult male population on the role of a real man. Does a real man have sex with a young woman who could be the age of his daughter? This challenge is also a challenge to the cultural dynamic of the superior/inferior relationship in the male/female relationship.

As the Church has been marginalized pre PEPFAR, the same marginalization can be seen in relation to the Global Fund. Global fund figures show that approximately only 6% of all Global funds go to Faith Based Organizations. Why should only 6% of the funds go to FBO when in many of these countries the FBO are major suppliers of health care? The Global Fund will claim that it is a national problem and not theirs. However if the Global Fund has guidelines on many parts of their program why deny the problem with the FBO? As it is the FBO are categorized in the same category as any local NGO which might not have any credibility. I have written a paper for the Kenya Episcopal Conference on this issue so that the Bishops can question the Kenya government on local allocation of Global Fund funds.

We must acknowledge that PEPFAR has tried to address the issue of FBO as well as attempt to track outcomes for all that receive PEPFAR funding. PEPFAR also works hard that supplies are there so there will not be a break in services. The same cannot be said for the Global Fund. I personally believe that it makes no sense if you have an effective program that is reaching people that you fund a program that will be at the cost of PEPFAR. You know the positive outcomes of PEPFAR, and if anything, funding should be increased instead of decreased. This is what a good business person would do.

As PEPFAR comes to an end, my concern is what will happen after PEPFAR? Who is going to meet the costs of all these poor patients?

Another concern that I see post PEPFAR is that the glass ceiling being put in place so that FBO are not allowed at the table. The Global Fund percentage shows that the glass ceiling is already in place and the risk is that personnel within the USG might also follow in the same direction.