FINAL REPORT

PAN AFRICAN CHRISTIAN AIDS NETWORK SITUATION ANALYSIS REPORT ON CHRISTIAN INSTITUTIONS RESPONDING TO HIV/AIDS IN LIBERIA

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The report was prepared by the RECEIVE in collaboration with PACANet Task Force in Liberia.

The survey was coordinated by a team composed of two research advisors, one research coordinator, nine research assistants, two data processors/analysts and one verifier in collaboration with targeted Christian/church institutions.

We are very much grateful for the level of cooperation and support from both PACANet and its local Task Force and the targeted Christian/church institutions. It is our hope and prayer that the findings will inform intervention strategies.

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TABLE OF CONTENTS

ACRONYMS

AIDS – Acquired Immune Deficiency Syndrome
CHAL – Christian Health Association of Liberia
CPA – Comprehensive Peace Agreement
GOL – Government of Liberia
HIV – Human Immunodeficiency Virus
IEC – Information Education and Communication
IGA – Income Generation Activity
ECOMIL – Economic Community of West African States Mission in Liberia
ECOWAS – Economic Community of West African States
ELWA – Eternal Love Winning Africa
FGD – Focus Group Discussion
MDGT – Millennium Development Goals and Target
MOH – Ministry of Health and Social Welfare
MOU – Memorandum of Understanding
NAC – National AIDS Commission
NACP – National AIDS Control Program
NHP – National Health Policy
NTGL – National Transitional Government of Liberia
PACANet – Pan African Christian AIDS Network
PEA – Ministry of Planning and Economic Affairs
PMTCT – Prevention of Mother to Child Transmission
PTFIL – PACANET Task Force in Liberia
RECEIVE – Resource Center for Community Empowerment and Integrated Development
SAS – Situation analysis survey
STI – Sexually transmitted infection
PLWHAs - People Living with HIV & AIDS
PTFIL – PACANET Task Force in Liberia
UN – United Nations
UNAIDS – United Nations Programme on HIV/AIDS
UNDP – United Nations Development Programme
UNICEF – United Nations International Children Educational Fund
UNMIL – United Nations Mission in Liberia
UP – Unity Party
WFP – World Food Program
WHO – World Health Organization

EXECUTIVE SUMMARY

This report contains five chapters. Chapter One is *Introduction*; Chapter Two, *Review of Related Literature*. Chapter Three, *Methodology*; Chapter Four, *Findings and Discussions*; and Chapter Five; *Strategies Adopted by Christian Institutions to Overcome Challenges*.

Owing to bad governance, Liberia was engulfed by civil strife. The entire population was affected, with many being displaced internally and externally. To end the civil conflict, a negotiated settlement of all key players and stakeholders was reached and the CPA signed 2003, in Accra, Ghana. Consequently, a transitional government was set up and it oversaw national democratic elections held in October and November 2005. The newly elected UP government was inaugurated January 2006.

Health is a cardinal sector for post-war reconstruction in Liberia. Christian faith-based organizations or institutions are working in collaboration with the government at creating an effective and efficient health delivery system.

In order to contribute towards the post-war reconstruction efforts in Liberia, PACANet through its local consortium, PTFIL contracted RECEIVE to conduct an SAS on Christian faith-based institutions involved with the fight against the spread of HIV/AIDS. The main objectives of the study are:

- To identify existing HIV/AIDS interventions by the church and Christian based organizations, classify interventions by theme, level and type;
- To identify and document best practices along thematic areas according to agreed standards;
- To identify and document existing resources available and accessible to the church and establish funding opportunities available to the church and their limitations;
- To identify behavior change communication and education materials currently used and the gaps that exist so as to adequately respond to the epidemic;
- To ascertain the human resource capacity currently involved in these responses
- To establish the institutional and programme capacity of the church-based institutions on their responses;
- To find out if there are any forms of stigma and discrimination which exist in the Church, and what the church has done to address them;
- To investigate the gender concerns that are being addressed by the church in handling the HIV/AIDS effects as a result of the HIV/AIDS epidemic;
- To establish the challenges/problems/gaps the church is experiencing in implementing the HIV/AIDs interventions; and
- To recommend mechanisms of how the church can scale up its HIV/AIDS response

The study was conducted in 12 of the 15 counties and revealed that both Grand Gedeh and Sinoe counties have no church related HIV/AIDS program. Rivercess County was inassessable due to bad road and bridges. Therefore, the ten questionnaires for these counties were returned blank. Consequently, the findings in this report include information gathered from sixty-five (65) questionnaires and twenty-two (22) FGDs. These questionnaires targeted sixty-five (65) Christian faith-based institutions. Additionally, a verification/validation exercise was held. The findings were also discussed during the PACANet conference held in December 2006 and inputs were made into the document.

The SAS covers six (6) thematic areas - Identification of interventions; Identification of resources; Assessment of institutional capacity; HIV/AIDS stigma and discrimination; Policy and strategies; and Gender and culture. In the first section, preventive activities are the highest, care and support second and advocacy and networking third. Among the preventive activities named are provision of information for general awareness about HIV/AIDS, abstinence and the use of condoms. The care and support activities include voluntary counseling and provision of life skills. Under advocacy and networking the named activities are information sharing and generating funds.

In section two, human, material/financial and institutional resources are focused. A higher number of institutions confirmed having some level of resources, mainly human, material and institutional capacities. Also, an average percentage indicated low financial resources capacity.

In the third section, assessment of institutional capacity is examined. Here most respondents confirmed willingness and the existence of semi structures – boards, committees, accounts and treasurers and limited logistics while the fourth section focuses on HIV/AIDS stigma and discrimination.

Here, the answer did not come out as expected because the question was posed to program implementers in these faith-based Christian organizations who themselves are Christians. And as Christians they believe that love, care and support are Christian obligations. However, at the PACANet conference, it was revealed that HIV/AIDS stigma and discrimination prevail because of lack of knowledge about all aspects of the disease, lack of trust in church leaders (by PLWHAs) and the widespread view within the larger church community that HIV/AIDS infected people are promiscuous. Additionally, when the question was posed to PLWHAs at the LIGHT Association, two claims were made - acceptance, love, care and support; and rejection, discrimination and stigmatization by church members and authorities.[*]

Section five evaluates the existence of policy and strategies. The Christian faith based institutions confirmed the existence of policies and strategies which are known by some members. Copies of these policies and strategies were exhibited by some institutions while others did not. Section six deals with gender and culture and an affirmative average confirmed care and support for PLWHAs belonging to all sexes, social and cultural groups.

Interestingly, the study also revealed that Liberia's HIV/AIDS national policies are still draft acts and yet to be passed into law by the national legislature. This, the research results consider being a hindrance.

The study also discovered that the main factors contributing to the spread of HIV/AIDS in Liberia include environmental, social/cultural and individual. It can also be deduced from the findings that faith based Christian institutions/ organizations fighting HIV/AIDS in Liberia, need effective, vibrant, reliable and functional networks, continuous institutional capacity building training, available and affordable materials and equipment and increased financial support. Here PACANet can be of great help, a relevant and indispensable partner in this global challenge and fight to prevent HIV/AIDS, care and support for PLWHAs and advocate for all.

[*] Personal interviews with LIGHT Association (PLWHAs) in Monrovia, November 21,2006.

1.0 CHAPTER ONE: INTRODUCTION

1.1 Background and Objectives

The PACANet is a Christian based coordinated response to the HIV/AIDS epidemic in Africa. To obtain information about the Christian response to the HIV/AIDS situation in Africa, the organization undertakes SAS of various African countries. The HIV/AIDS situation in Liberia is still not widely known. Therefore, in order to know the HIV/AIDS situation in Liberia generally and particularly the Christian response, PACANet decided to undertake an SAS. The objectives of the SAS are:

- To identify existing HIV/AIDS interventions by the church and Christian faith- based organizations, classify interventions by theme, level and type;
- To identify and document best practices along thematic areas according to agreed standards;
- To identify and document existing resources available and accessible to the church and establish funding opportunities available to the church and their limitations
- To identify behavior change communication and education materials currently used and the gaps that exist so as to adequately respond to the epidemic;
- To ascertain the human resource capacity currently involved in these responses
- To establish the institutional and programme capacity of the churches based on their responses in area of HIV/AIDS;
- To find out if there are any forms of stigma and discrimination which exist in the Church, and what the church has done to address them;
- To investigate the gender concerns that are being addressed by the church in handling the HIV/AIDS effects as a result of the HIV/AIDS epidemic;
- To establish the challenges/problems/gaps the church is experiencing in implementing the HIV/AIDs interventions; and
- Recommend mechanisms of how the church can scale up its HIV/AIDS response.

Based on this background, PACANet contracted RECEIVE to conduct HIV/AIDS SAS of Christian faith-based institutions/agencies in Liberia. The key goal of this survey is to develop a strategic framework and to formulate a coordinated Christian response to the HIV/AIDS pandemic. PACANet has envisioned that the SAS would inform Christian organizations, churches and networks to enhance their HIV/AIDS responses by sharing information, ideas, skills, and experiences to stimulate strategic partnership. Therefore, the findings of this survey are to:

- Provide information that will identify progress and inform decision-making;

- Strengthen the capacity of PACANet and in-country faith-based HIV/AIDS Christian responses;

- Identify programmatic, geographic and resource gaps that necessitate scale up of the churches' response to the HIV/AIDS pandemic; and

- Monitor the progress of the churches' response and identify successful HIV/AIDS church interventions that could be documented as best practice and to be replicated in other thematic areas.

Consistent with the terms of reference of the study, PTFIL, commissioned RECEIVE to conduct the SAS on Christian faith-based response to HIV/AIDS in Liberia. This SAS considered programmes, kinds of interventions, resource capacity and limitations, existing financial gaps; challenges and problems. The SAS was guided by the terms of reference provided by PACANet and the MOU signed on September 1, 2006 between PACANet by and through its PTFIL; and RECEIVE by and through its executive director.

1.2 Rationale of the Study

HIV/AIDS is a well documented and deliberated disease phenomenon throughout the world, with the largest affected population in sub-Saharan Africa (UNAIDS, 2005). Current accurate statistics regarding the HIV/AIDS prevalence rate and level of epidemic in Liberia is limited; primarily because of the breakdown of the health sector during the country's protracted civil war, the stigma attached to the pandemic and the lack of a coordinated response to fight the disease across cultural, ethnic, political and religious divides.

Despite these problems, the Christian community in Liberia has become a useful partner in the fight against this menacing disease as there are several churches and church related institutions like hospitals involved in the treatment of HIV/AIDS and related illnesses. In fact the first patient diagnosed with full blown AIDS was discovered at the Lutheran run Curran Hospital in Zorzor, Lofa County.

But what is lacking is a coordinated Christian response in the fight against HIV/AIDS; therefore, it is important to find out and know the churches' strength, weakness, needs, and capacity in this endeavor. Hence, the rationale of the study is for PACANet to determine a framework for a coordinated Christian response and to galvanize support in the fight against HIV/AIDS (UNAIDS) in Liberia.

1.3 Outcome of the Study

The outcome of the PACANet HIV/AIDS SAS is to provide PACANet with the appropriate information of what is unfolding in Liberia, specifically relating to church and church related institutions involved in combating HIV/AIDS. Such relevant information would help PACANet to, among other essential actions:

- Come out with a common direction of programme efforts given the uncertainty surrounding HIV/AIDS epidemic;
- Enhance the sharing and utilizing of information at various levels for effective intervention;
- Find out about any form of stigma and or discrimination existing in the church and what the church is doing to address same; and

- Develop a coordinated framework and standardized indicators to measure the goals of PACANET in its coordination role as a network.

1.4 Limitations of the Study

- Bad road conditions made it impossible to reach Rivercess County.

- Sinoe and Grand Gedeh were not included in the SAS because they did not have churches, church-related para-church organizations involved in AIDS activities.

- The bulkiness and duplication of question contents in different sections; thereby, making it difficult to quantify responses.

- There was rigidity as a result of judgment sample of the population; that is types of respondents (such as program directors) were named/listed to be interviewed which did not allow other forms of samplings.

- PLWHAs were not among the named/listed types of respondents.

- Communities benefiting from the Christian faith-based institutions' HIV/AIDS were not part of sampled population to ascertain if these institutions were indeed involved in HIV/AIDS activities or were making impact in these communities.

2.0 CHAPTER TWO: TWO LITERATURE REVIEW

2.1 Brief History

Liberia was founded as a home for repatriated slaves from the New World in the 19th Century. Its political, judiciary and legislative branches are patterned after those of the United States of America. A minority Settler group known as the Americo-Liberians dominated the country's political life from July 26, 1847 to April 12, 1980. As a result of bad governance, the country experienced years of civil war that devastated all sectors of the country between 1989 and 2003. The regional grouping ECOWAS brokered a ceasefire in Accra in 2003 and the NTGL was set up to run the country. The ECOWAS ceasefire monitoring group ECOMIL arrived in the country after the signing of the ceasefire agreement to keep the peace. ECOMIL was transformed into UNMIL in October 2003. General and presidential elections were held 2005 and UP led by Mrs. Ellen Johnson-Sirleaf was declared winners.

2.2 Demography, Education and General Economic Condition:

The PEA in Monrovia says the country has a population of 3 million (2004); youths constituting the majority, with 53 % being under the age of 15 years[1]. The citizens of Liberia are divided into four major linguistic groups. These are the Kwa/Kruan, Mende, Mel/West Atlantic and Settler/Americo. Education is very low. Literacy rate is believed to be about 20%. Primary and secondary school enrolment is little over half of school going age children; 57 % males to 43 % females. This disparity is greater in the rural areas[2].

Liberia's economy totally collapsed during the civil war years. The mining, forestry and iron ore sectors were the mainstay of the economy. But all these are down and attempts are being made to revive these sectors. Only small alluvial mining takes place. This economic decline has led to increased poverty throughout the country as unemployment has reached 85%. The country is among the poorest in the world. More than two (2) persons out of every three (3) or 76.2% of the country's population live below the poverty threshold of US$1.00[3].

2.3 Health

Like the rest of the sectors in the country, the health sector was completely destroyed during the civil war. The destruction included both public and private health facilities. Added to this was brain drain of trained medical personnel. It is believed that less than 30% of the population has access to health care; thus, contributing to the drop in life expectancy from 55 years in the 1980s to 35 years currently. The first AIDS patient was discovered in Liberia in 1986 and thereafter, the GOL set up the NACP in 1987 and gave budgetary support within MOH to fight the deadly disease[4]. The NACP is a governmental arm that functions as a Secretariat to the NAC. Its terms of reference have been streamlined to leave implementation of HIV/AIDS programmes and interventions to non-state actors. These non-state actors include both civil and religious (principally Christian and Muslim) groups. Many cases of HIV/AIDS have been diagnosed in Liberia since the coming into being of both the NAC and NACP. These cases suggest that the HIV/AIDS crisis has reached a pandemic in Liberia (National Multi-Sectoral Strategic Plan of

[1] *UNICEF (2005) Liberia Situation Analysis Survey Feb. 2006, p.3*
[2] *Liberia Democratic Health Survey (2000); and Liberia HIV/AIDS Situation Analysis, Feb. 2006, p.8*
[3] *National Poverty Line, Republic of Liberia (2000): Liberia HIV/AIDS Situation Analysis, Feb. 2006, p.8*
[4] *Liberia HIV/AIDS Situation Analysis, Feb. 2006; p.25*

Action for Prevention and Control of HIV/AIDS/ STI in Liberia, 2001/2002/2003) Citing UNAIDS/WHO, Tellowoyan gives the following statistics for the period 1986 to 1997 for confirmed HIV/AIDS cases in Liberia: [5]

1. 1986, two persons;
2. 1989, three persons;
3. 1991, fourteen persons;
4. 1993, four persons;
5. 1994, twelve persons;
6. 1996, eighteen persons; and
7. 1997, forty-eight persons.

By 2001, some 39,000 persons were reportedly affected with HIV/AIDS in Liberia[6]. In 2004 the NTGL Joint Needs Assessment put the national HIV prevalence rate at 10 – 12 %, although no population is mentioned. That same year, UNAIDS Liberia Epidemiology Update reported an adult (15 – 49 years) HIV prevalence of 5.9 %, with a range of 2.7 % to 12.4 %[7]. However, these HIV prevalence reports have limitations that have been documented[8]. Despite the data limitations, the key points about HIV prevalence in Liberia can be summarized as follows:

- Reported prevalence rates are based on problematic surveillance data.
- Efforts are underway to improve the routine surveillance and to conduct a national sero-prevalance study which has not been done yet.

The blood donor prevalence reported by NACP is around 5 % and there is a documented trend of an increase in limited amount among blood donors[9].

Heterosexual activity is thought to be the main mode of HIV/AIDS transmission in Liberia. An estimation presented by the NACP in the National Multi-Sectoral Strategic Plan of Action 2000 – 2002, stated that 82% of HIV transmission occurs through heterosexual contact (2005). The GOL recognizes HIV/AIDS as a national development and security problem and formulated the NHP to serve as a national framework to deliver health care services in the country up to 2024. In this policy, HIV/AIDS is clearly articulated. The GOL, in promulgating its MDGTs has also articulated the problem of HIV/AIDS and set goals, targets, and baseline indicators to measure progress in achieving HIV/AIDS goals and targets[10].

Little data exists about the percentage of mother-to-child or blood transfusion transmission, but these two modes are generally accepted as the second and third on the list of main transmissions. Various studies report a number of interrelated factors that explain the causes of HIV prevalence and the suspected higher prevalence[11]. These factors are presented in the table below.

[5] *Tellewoyan, Joseph K. The Years The Locusts Have Eaten Liberia 1816 – 2004 [http://pages. prodigy. .net/jkess3/History.html]*
[6] *(Tellewoyan, citing Time Magazine/UNAIDS)*
[7] *UNAIDS (2005) Liberia HIV/AIDS Situation Analysis, Feb. 2006, p.9*
[8] *WFP (2004); NACP (2004) ; Liberia HIV/AID Situation Analysis, Feb. 2006, p.9*
[9] *Salama (2004); Liberia HIV/AID Situation Analysis, Feb. 2006, p.6*
[10] *UNDP Country Report (2000)*
[11] *UNICEF (2005a; WFP, 2004; Salama, 2004; Otti and Barth. 2001) Liberia HIV/AID Situation Analysis, Feb. 2006, p.10*

Table 1: Factors Contributing to HIV in Liberia

Environmental	***Cultural/Societal***	***Individual***
1. War A. Family disorganization B. Health system break down C. Sexual and gender- based violence D. Peacekeepers and armed factions 2. Poverty/Economic Development A. Poor health/high STIs B. Urban migration C. Low literacy D. Low employment	1. Female genital mutilation 2. Gender inequalities Sexual decision making A. Transactional sex 3.Polygamy 4. Early Marriage 5. Early age sexual debut	1. High risk behaviors A. Early sexual debut B. Low condom use C. Multiple sexual partners D. Alcohol and drug use 2. Low awareness, low accurate knowledge A. Disbelief, misconception B. Low urgency

(***Source: The 2004 WFP Needs Review of the HIV/AIDS Response***)

As a show of the GOL's desire and commitment to addressing the problem of HIV/AIDS, a national HIV/AIDS conference was organized in 2003 to formulate policy, technical guidelines and legislations. The proposed policy statement on HIV/AIDS in part states:

> *The prevention and control of HIV/AIDS and STI in Liberia pose the greatest challenge to the health, peace, and economic stability of the nation. To secure the future, a greater portion of the nation's resources will have to be mobilized and employed to prevent and control the spread of the disease.*
>
> *In light of this awareness, the GOL hereby adopts the following public resource management policy:*
>
> 1. *Until the risks posed by the HIV/AIDS pandemic is reduced to a controllable level, resource appropriation for health services, particularly for HIV/AIDS prevention and treatment, shall constitute the highest percentage of state revenue allocation; and*
>
> 2. *All public institutions shall be expected to establish and implement, in consultation with the Minister of Health and Social Welfare, special programs that contribute to increased general understanding of the critical issues involved with the effort to prevent and control the spread of the HIV/AIDS pandemic*[12].

Further, Section 18.3 (*e* to *g*) of the proposed Liberia HIV/AIDS Legislation of November 30, 2002 states the following:

> e. *The minister [of health] shall promulgate and publish, for public guidance, such other policies, guidelines, rules and regulations as a necessary, but not provided for in this Chapter, to govern and the conduct of all persons, institutions to prevent and control the spread of HIV/AIDS in Liberia;*

[12] *Republic of Liberia (2003) Republic of Liberia HIV/AIDS Policy, March 2003, p.5*

f. *In the event any portion of the responsibilities and functions defined by this Act is performed advertently or inadvertently by any other institution, agency or a unit thereof, or by an individual, the minister [of health] shall take all necessary administrative and if necessary, legal steps to compel adherence to the provision of this Chapter;*

g. *The minister [of health] shall encourage, from time to time, collaboration and consultation between and amongst institutions, individuals (experts and non-experts) in the development and promotion of programs aimed at preventing and controlling HIV/AIDS*

Information obtained during the SAS maintained that the proposed HIV/AIDS Legislation has not been passed into law. This makes the implementation of any policy difficult as there are no legal backings for enforcement.

3. 0 CHAPTER THREE: METHODOLOGY

The research framework used to guide the HIV/AIDS SAS, was provided by PACANet. Following the signing of the MOU, a two day training workshop was conducted for ten (10) research assistants identified and recruited by RECEIVE. The workshop allowed them to develop a clear familiarity and understanding of the survey instruments (questionnaires and FGDs). During the workshop, a mock interview was conducted involving research assistants, followed by a one day pretesting survey among churches in the Monrovia area. The pre-testing was to check the length of time the interview would take and determine if respondents clearly understand the questions as structured. The pre-testing showed that the questionnaire was bulky, with content areas being replicated. Because of time factor there was no time to revise the questionnaire.

Both qualitative and quantitative information was required to collect data on the interventions, programmes, and needs of churches or faith-based organizations involved in HIV/AIDS work in Liberia. To successfully carry on this task, a judgment sample frame work was used based upon the list identified and presented by PTFIL of faith-bases institutions.

Two methods were employed by RECEIVE for the data collections. These methods included structured interviews and FGDs; and desk or literature review. For the qualitative component of the survey, it involved holding several sessions of FGDs. This meant organizing and conducting group sessions involving selected church congregations. The participants of the FGDs were heterogeneous ranging from 5 to 10 persons and encouraged gender participation. The research team utilized the FGD guide provided by PACANet. The respondents for the structured interviews (quantitative) were drawn from the membership of churches, church-based organizations, para-church groups, church related programmes and institutions such as clinics and hospitals involved in HIV/AIDS work.

The sample selection was carried out from the list of churches, para-church organizations, church related programmes, and direct church programmes involved in HIV/AIDS interventions supplied by PTFIL. In total, there were seventy-five (75) structured questionnaires sent in the field to be administered; covering the fifteen (15) political sub-divisions of Liberia and targeting Christian institutions involved with HIV/AIDS activities.

Out of the seventy-five (75) questionnaires, sixty-five (65) were answered and received while the other ten questionnaires (10) intended for Grand Gedeh, Sinoe and Rivercess came blank due to bad road and damaged bridges linking Rivercess to other parts of the county and there were no Christian institutions identified in Sinoe and Grand Gedeh involved with HIV/AIDS activities. Twenty-two (22) FGDs were also conducted across the country targeting a cross section of the Christian community.

The SPSS/EP-INFO suggested by PACANet could not be accessed and as a result, RECEIVE asked PACANet to use “Quick Poll” as an alternative. The survey data was collected and edited while the survey was being conducted. Editing the data in the field allowed for close coordination with the survey supervisors. The data entry and analyses were conducted using ‘Quick Poll’ Survey Analysis Software, as the suggested alternative; and then converted to MS Excel spreadsheet. Simple frequencies were run before carrying on bi-vicariate and multivariate analysis. The results are presented in the form of tables (using ratios and percentage) and graphs.

The statistical analyses consist of Chi-square test, analyses of variance, and correlation analysis. Furthermore, significant differences, whenever mentioned in this report, refer to 95 percent confidence level. All data were entered by two data entry operators under the direct supervision of the survey consultant. Entry of incorrect data was prevented using the 'Quick Poll" internal verification program.

4. 0 CHAPTER FOUR: FINDINGS AND DISCUSSIONS

4.1 HIV/AIDS Intervention by the Church/Christian Institutions

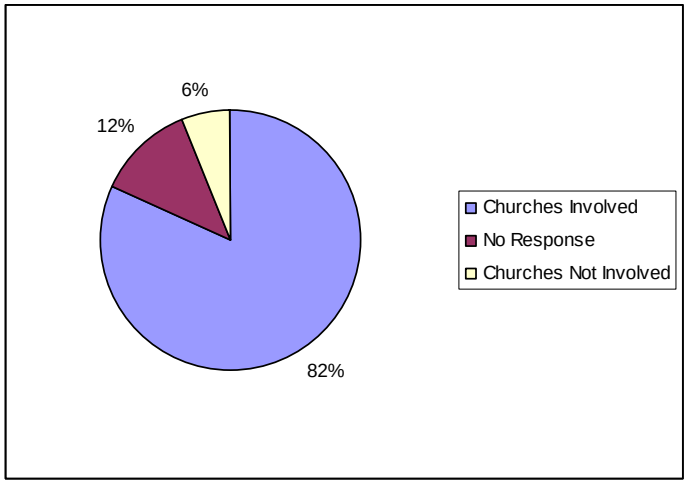
Table 4.1.1: Number of Interviews and FGDs and Participants by Sex

County	# of S/ Interview conducted	# of FGD Conducted	# of Participants		
			Male	Female	Total
Bassa	10	3	12	9	21
Montserrado	21	8	16	14	30
Nimba	6	2	7	11	18
Cape Mount	1	1	5	3	8
Bomi	3	1	4	4	8
Gbarpolu	2	1	6	4	10
Margibi	3	1	5	5	10
Rivercess	0	0	0	0	0
Bong	7	1	4	5	9
Lofa	3	1	6	2	8
Maryland	3	1	5	2	7
River Gee	2	1	6	3	9
Grand Kru	4	1	7	1	8
Grand Gedeh	0	0	0	0	0
Sinoe	No activities of such		0	0	0
Total	65	22	83	62	146

The findings and discussions in this report covered twelve (12) of the fifteen political sub-divisions of Liberia, targeting religious institutions involved with HIV/AIDS intervention activities. Moreover, the data collection teams could not reach Rivercess due to bad road and damaged bridges linking this county to other parts of the country.

However, report gathered also states that there is no such activity being implemented by any Christian institution in Grand Gedeh and Sinoe Counties. Two (2) methods of evaluations were used for this study. On the overall, the structured interviews targeted sixty-five (65) respondents representing thirty-one (31) churches and Christian institutions/agencies while the FGDs were conducted to validate information gathered from the structured interviews. A total of 22 FGDs were conducted targeting 146 persons, 83-male and 62-female respondents/ participants. The participants were selected randomly and both sexes took part in the discussions at the same time.

Chart 4.1.1. Institutions Involvement



*The Study revealed that eighty-two percent (82%) of the sixty-five (65) respondents interviewed are involved with HIV/AIDS activities; twelve percent (12%) could not confirm their level of involvement and six percent (6%) said **no** to any involvement of their institution into HIV/AIDS activities.* **See Table 4.1.1** *for counties covered and number of interviews conducted per county.*

The churches and Christian institutions involved in HIV/AIDS activities have limited human and program capacities. However the faith based institutions that have more human resources and capacity are the Catholic, Lutheran and the Methodist related institutions/organizations.

To have wider participation and help those institutions that are not involved in HIV/AIDS activities, participants at the PACANet conference rightly suggested the following as practical ways:

- *Organizing and conducting HIV/AIDS/STI capacity building training of Trainer workshops;*
- *Networking and providing coaching and free consultancy for needed Institutions;*
- *Designing and conducting project cycle management for institutions in need; and*
- *Identifying churches or Christian faith-based institutions doing what and where; and stating what they need and creating the link.*

4.2 Types and Level of Interventions

Table 4.2.1: Confidence Level of Involvement

Areas of Involvement	Score in %
Prevention	67%
Care and support	57%
Advocacy and networking	54%
Average Score	59%

Table-4.2.1 *presents an average summary of the expressed views of the sixty-five (65) respondents interviewed for the survey using a set of designed data collection forms administered by an independent team of competent data collectors. As mentioned in this table, the level of involvement by Christian institutions shows that more emphasis is placed on prevention activities which count for 67% than care and support for PLWHAs as well as advocacy and networking. These prevention activities named are carrying out awareness through various methods including but not limited to preaching, and house-to-house campaigns; distribution of condoms and advocacy for abstinence from sexual activities before marriage, and faithfulness in marriage. This information was also, validated using twenty-two (22) FGDs targeting a cross section of 146 church members. Results from the FGD emphasise creating awareness, promoting abstinence and condom distributions and voluntary counseling which present 21% confidence level of involvement compared to 59% confidence level from the structural interviewed which gives an overall confidence level of 39%.*

During the PACANet conference hosted in December 2006, participants discussing the draft PACANet SAS Report suggested some prevention activities that should be undertaken by Christian faith-based organizations involved in HIV/AIDS. The prevention activities suggested by the participants were hosting of periodic HIV/AIDS workshops; creating awareness in Sunday schools, church services, etc; and establishing ministry to deal with HIV/AIDS issues in the church with focus on education, counseling and caregiving.

Table 4.2.2: Expressed Views of Respondent in FGD

Church/Christian agency HIV/AIDS Activities	Score in %
General awareness & sensitization	42%
Promoting Abstinence	29%
Voluntary Counseling	24%
Condom distribution	23%
Life skills	17%
PMTCT	15%
Stigma	12%
Testing	9%
Average Score	21.00%

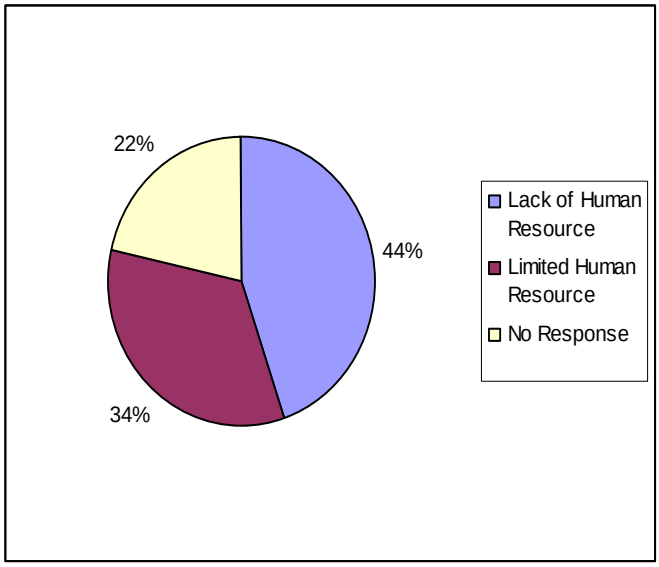
The FGD identified creating general awareness and sensitization, promoting abstinence, voluntary counseling, condom distributions, life skills, PMTCT, Stigma and testing as the level of involvement by these Christian institutions.

Discussing the draft report during the PACANet conference, participants said that since youth constitutes the largest population in Liberia, abstinence should be directed at them. The practical ways suggested by the participants to undertake abstinence to the youths were the following:

- *Ensuring family life education;*
- *Introducing HIV/AIDS awareness in morning devotions;*
- *Talking about dating, courtship, etc;*
- *Involving leaders that would serve as mentors and coaches/role models;*
- *Organizing youth camps and retreat purposely for the sake of awareness*
- *Forming peer support groups to be able to give them more education on abstinence; and*
- *Awarding youths that have good moral conduct in church congregations for such things as good dress code.*

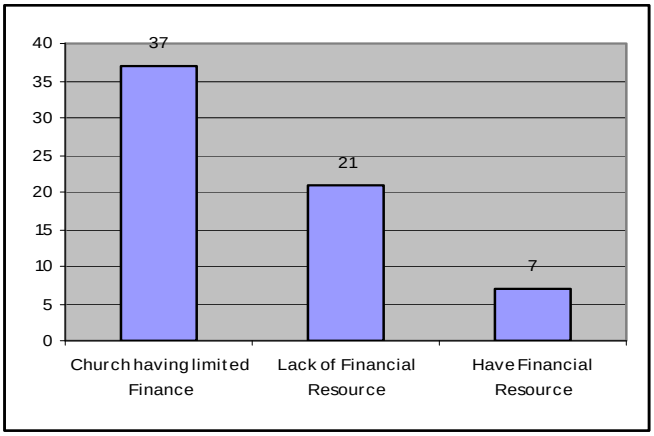
4.3 Human Resources and Programme Capacity

Chart 4. 3. 1: Christian Faith-Based Institutions Having Human Resource Capacity



Although the main task of running a program focuses mainly on material/ financial and physical resources, this does not mean that the performance of one of the organization's main resources, (human resource) can be exempt from the process. In this light, the study assessed the human resource and program capacity of institutions involved with HIV/AIDS. Results gathered show that thirty-four percent (34%) of the respondents confirmed their entities having limited human resource capacity for their intervention activities. The human resource capacity is in bits and pieces. The limited human resource capacity includes small number of skilled and unskilled volunteers and personnel. On the other hand, forty-four percent (44%) lamented not having the required human resource capacity to implement their activities, and twenty-two percent (22%) mentioned no response

Chart 4. 3.2: Christian Faith-Based Institutions Having Financial Resources



In **Chart 4.3.2** *thirty-seven (37) respondents confirmed having limited financial resources for program implementation and seven (7)) others admitted having the needed funds to implement their intervention activities in their respective communities. On the contrary, twenty-one (21) lack the needed financial resources to carry out their program activities. This indicates that most Christian faith-based institutions involved in HIV/AIDS activities do not have the desired financial resources to implement their projects/programs.*

Chart 4.3.3: Christian Faith-Based Institutions Having Material Resources

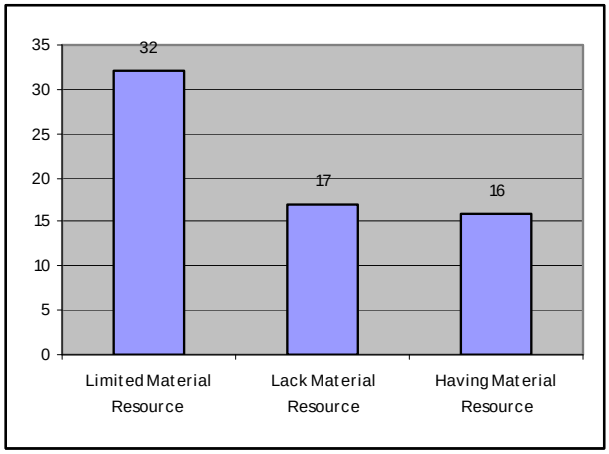


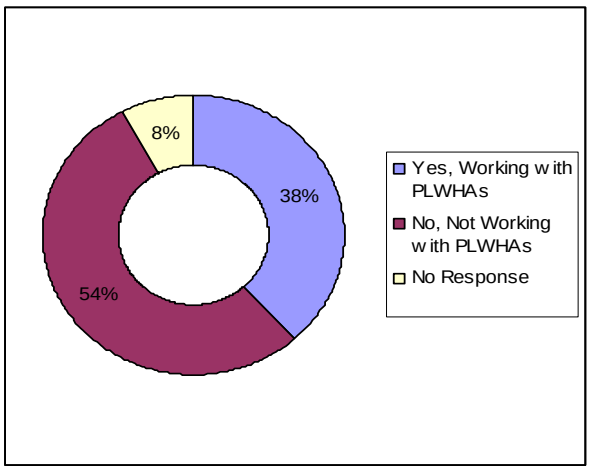
Chart 4.3.3 *indicates that thirty-two (32) or of the Sixty-five (65) respondents involved with HIV/AIDS intervention activities confirmed having limited material resources while sixteen (16) have material resources for program implementation and seventeen (17) lack the needed material resources required to carry out its intervention activities. These limited resources include testing kits and training materials.*

Table 4.3.1: Material Sources

Source of HIV Materials	# of Respondents	%
International Partners/ Community	11	17%
NACP	9	14%
YMCA	7	10%
UMC Hospital (Ganta, Nimba County)	7	10%
PHEBE Hospital	5	7%
Ministry of Health & Social Welfare	4	6%
Liberia Council of Churches	4	6%
UNMIL HIV/AIDS Unit	3	5%
Global Strategy	3	5%
TEARFUNDS	3	5%
LCL/ HIV/AIDS Program	3	5%
Family planning Association of Liberia	3	5%
WCC-EHAIA	3	5%
Total Rating of Respondents		100%

The following organizations in **Table 4.3.1** *have been identified by Christian institutions as sources for material support in their fight against HIV/AIDS in the country and look forward for more support to consider other aspects of their interventions to include medical care for PLWHAs, infrastructural construction and the supplies of food, clothing amongst others.*

Chart 4.3.4: Staff Working Directly with PLWHA



This figure shows the number of respondents who confirmed their institutions or churches having staff directly working with PLWHAs in their respective community of work: thirty-eight percent (38%) of Christian institutions have staff directly working with PLWHAs. Fifty-four percent (54%) others have no staff directly working with PLWHAs and eight percent (8%) others could not confirm yes *or* no *to their institutions' involvement.*

Table: 4.3.2: Kind of Staff Working on the Program

Kind of Staff	# of Church/institution	Percentage
Local Staff	29	45%
International Local Staff	13	20%
No Response	12	18%
Volunteer	11	17%
Total	**65**	**100%**

This table shows the number of respondents whose churches and institutions have the following categories of Staff. Other institutions also expressed their desire to get fully involved in working with PLWHAs directly but lack basis skills and material support. See figure above.

Table 4.3.3: Kind of Training Received by Staff and Volunteers

N0	Kind of Training Received	Staff	Duration	Volunteers	Duration
1	Basic HIV information and awareness	17	1-week	12	3-weeks
2	Prevention	13	2-weeks	13	Not mentioned
3	Home-based care	13	3-weeks	11	1-week
4	Counseling and testing	12	1-month	9	1-week
5	Psycho-social support	11	1-month, 1-wee	-	Not mentioned
6	Financial management	11	6-weeks	8	1-month
7	Developing IECD/ BCC material	10	1-month	10	2-weeks
8	Organizational capacity	9	3-weeks	8	Not mentioned
9	PMTCT	10	1-month	7	1-week
10	Prevention of Mother to child transmition	8	1-week	9	5-weeks
11	Development (Management)	7	1-month	6	Not mentioned
12	Vaccine trials	7	6-weeks	8	1-week
13	Networking and advocacy	7	Not mentioned	-	-
14	Anti retroviral Treatment (ART)	6	1-month	-	-
Total		151		101	

*As reflected in **Table 4.3.3** above, some staff received basic training in the implementation of their HIV/AIDS activities. The longest training received was for six (6) weeks while the shortest was one (1) week. Training received included basic HIV information and awareness, prevention, home-based care among others.*

Thus, the table indicates the need for more intensive and specialized trainings to build the capacity of Christian faith-based institutions involved in HIV/AIDS activities.

Table 4.3.4: Area of Training That Are Needed by Staff and Volunteers

N0	Areas of Training Needed	Staff	Duration	Volunteers	Duration
1	Basic HIV information and awareness	13	2-week	15	1-week
2	Prevention	5	1-month	7	2-weeks
3	Home-based care	7	Not mentione	2	3-weeks
4	Psycho-social support	6	6-weeks	12	1-month
5	Counseling and testing	7	2-weeks	9	1-month, 2-weeks
6	Developing IECD/BCC material	4	1-week	7	Not Mentioned
	Financial management	4	Not Mentioned	7	Not Mentioned
	Organizational Capacity	9	3-weeks	3	Not Mentioned
	Development (Management)	10	1-month	6	Not Mentioned
	Prevention of Mother to child transmition	8	Not Mentioned	10	Not Mentioned
	PMTCT	10	1-week	3	Not Mentioned
	Vaccine trials	8	Not Mentioned	6	Not Mentioned
	Networking and advocacy	5	2-weeks	-	No response
	Anti retroviral Treatment (ART)	-	1-weeks	-	No response
Total		96		87	

4.4 Funding Source

FINANCIAL SOURCE:

Table 4.4.1: Means of Support

Funding Sources	Responses
Proposal written to International Donor/ partners	39
Sister churches/ Local & International	10
Government	8
Congregational Contribution	5
Private sector contributions	3
Total Respondents	**65**

*It appears that Church and Christian institutions get their funding from Proposal Writing, sister church/ local and international and the government. Getting funding to implement a project is not limited to one institution but it is an overall approach which seeks the commitment of every organization wanting to achieve its goal of making impact. As such, all of the churches or agencies interviewed expressed their willingness to go beyond their goal and objectives in the fight against this epidemic but are equally having problems in getting the needed resources/funds required to do this. As reflected in **Table 4.4.1** proposal writing; and aid from sisterly institutions/churches, government, congregational support and private sector contributions are identified as the main sources of support for their program implementation.*

Table 4.4.2: Most Successful Means of Support

Successful Means of F/ Support	Responses
Proposal written	34
Sister churches/ Local & International	13
Liaise with international NGOs	9
Lobbying for cash & material	5
Private sector contributions	4
Total Respondents	**65**

The results gathered from the interviews show that proposal writing is considered the most successful methods used to gather funding for program implementation, followed by aids from sisterly churches, liaising with international NGOs, lobbying for cash, Materials and private sector contributions. However, funding is still a major problem that demands serious attention As mentioned in ***Table 4.4.2,*** *despite efforts by these institutions in getting funding for their HIV/AIDS programs, they equally have problems in getting funding due to too many requirements by donors, miss-match between donor priorities and the delay in receiving funds from donors as mentioned in* ***Table 4.4.3****.*

Table 4.4.3: Problems in Getting Funding

Funding Problems	Responses	Rating
Too many requirements by donors	32	49%
Miss-match between donor priorities	18	28%
Delay in receiving funds from donors	15	23%
Total	65	100%

Nonetheless, these institutions strongly believe that when given the necessary support, they would extend their activities to the wider community to care for PLWHAs more than what is being done now. ***Table 4.4.3*** *gives the three top problems encountered by agencies or Christian organization involved with HIV/AIDS awareness.*

Table 4.4.4: Methods or Strategies Adapted to Generate Funds

Strategies adapted to Generate funds	Responses	Percentages
Writing/submission of Proposal	30	46%
Through Networking	10	15%
Funds raising activities through the church	10	15%
Contacting private source (Company, Agencies)	8	12%
Using individual contact	4	6%
Using denominational contact	3	5%
Total	65	99%

As a result of the problems mentioned in ***Table 4.4.3*** *the churches have adapted other strategies as a means of getting funds to implement their programs. The strategies named were not limited to writing/submitting proposals, to donors or partners for funding, increased networks and mobilization of community and church support for more funding.* ***See Table 4.4.4.***

4.5 Resource Material Used By Faith-Based Institutions:

Table 4.5.1: HIV/AIDS Resource Material Use

Resource Materials	Respondents	Rating
Poster	29	45%
Brochures	26	40%
Condom	7	11%
Video Set (DVD, VCD, TV etc)	3	4%
Total	65	100%

As indicated in ***Table 4.5.1,*** *the information gathered shows that these institutions used poster; brochures; and DVD, VCD and condom distributions as intervention materials for program implementation.*

Table 4.5.2: Other Material Needed by Christian Faith-Based Agencies

Needed HIV/AIDS Materials	Respondents	Rating
Advocacy Material (Poster)	18	28%
Booklet on awareness	18	28%
Testing Kits	12	18%
Overhead Projector	6	9%
More Video Set (TV, DVD, VCD)	6	9%
Prevention Material (Brochure)	5	8%
Total	65	100%

*In addition to **Tables 4.5.1,** information gathered as reflected in **Table 4.5.2** shows that these institutions still need more material support; mainly for advocacy awareness and prevention, testing kits, TV sets and types on HIV/AIDS Awareness and prevention and overhead projectors for presentations at workshops and training sections. The institutions believe that provision of more materials will help make their interventions more meaniful and more impact will be made.*

4.6 Behavior Change Communication and Education Materials Currently Used and Gaps

Table 4.6.1: Material Rating (Relevant to Target Group)

HIV/AIDS Material Rating	Percentages
Culturally sensitive	85%
Easy to use	74%
Language Use	70%
Covers the necessary information	63%
Relevant to target group	55%
Total Average Score (Good)	69%

*There have been some steady behavior changes because of the communication and information materials about HIV/AIDS supplied the recipient communities by the intervening institutions. But the outstanding gaps include insufficiency of materials and limited supplies of visual aids for local communities. The results of the study suggest that the materials used by these Christian Institutions in the fight against HIV/ AIDS are good. **Table-4.6.1** presents an average summary of the expressed views of the sixty-five (65) respondents interviewed. The results identified that language use in the posters, news letters, brochures, etc are easy to understand and they reflect cultural sensitivities, the necessary information and meet the relevant target groups.*

Moreover, the significance that cultural differences might have for human relationships becomes clear when one attempts to describe culture. Therefore, the issue of cultural sensitivity was probed, and information gathered also presents an average score of 69% as being good and covered the necessary information. On the contrary, 21% others considered these materials to be fair while another 10% referred to the materials used by the institutions to be poor because of limited simplistic visual presentation and less cultural sensitivity.

4.7: Institutional Capacity

All of the Christian faith-based institutions visited for the SAS as well as the validation and expanded information confirmed having some structures in place. The structures include constitution/policies, boards or committees, serving as the governing body that monitor and evaluate their performance through regular or annual meetings. A record keeping system that is audited on a regular or annual basis exists for some, while others have valid accounts in local banks, program office, monitoring system, etc. **Table 4.7.1:** indicates that forty (40) or 62% of the respondents interviewed confirmed having written policies used to guide their program activities, these policies were displayed to the researchers during their visits to these institutions, while eighteen (18) or 28% said *yes* to having a written policies but were not seen and seven (7) or 10% said they have no idea about their program policies. **See Table 4.7.1, Table 4.7.2, Table 4.7.3, Table 4.7.4, Chart 4.7.1, Chart 4.7.2, Table 4.7.5, Chart 4.7.3,**

Table 4.7.1: Constitution/ policy issues:

Response to Having Constitution/Policy	# of Churches	Rating
Yes, have a policy/ constitution not seen	40	62%
Yes, have a policy/ constitution seen	18	28%
No idea	7	10%
Total Respondents	**65**	**100%**

Table 4.7.2: Having a Board or Committee:

Response to having a Board Committee	# of Churches	Rating
Yes, have A Board that Meet regularly	51	78%
No response	8	12%
Yes, have A Board that Meet Annually	6	9%
Yes, have A Board but do not meet	0	0%
Total Respondents	**65**	**99%**

Table 4.7.3: Having Records:

Response to Having Records	# of Churches	Rating
Yes, record was displayed	38	58%
Yes, but record was not seen	21	32%
No idea of Program records	3	5%
No response	3	5%
Total Respondents	**65**	**100%**

Table 4.7.4: Institution Having Bank Accounts:

Response to Having Bank Accounts	# of Churches	Rating
Yes, accounts # and bank book seen	29	44%
No, Account	14	22%
Yes, Account # / Bank book not seen	14	22%
No Response	8	12%
Total	**65**	**100%**

Chart 4.7.1: Account Source:

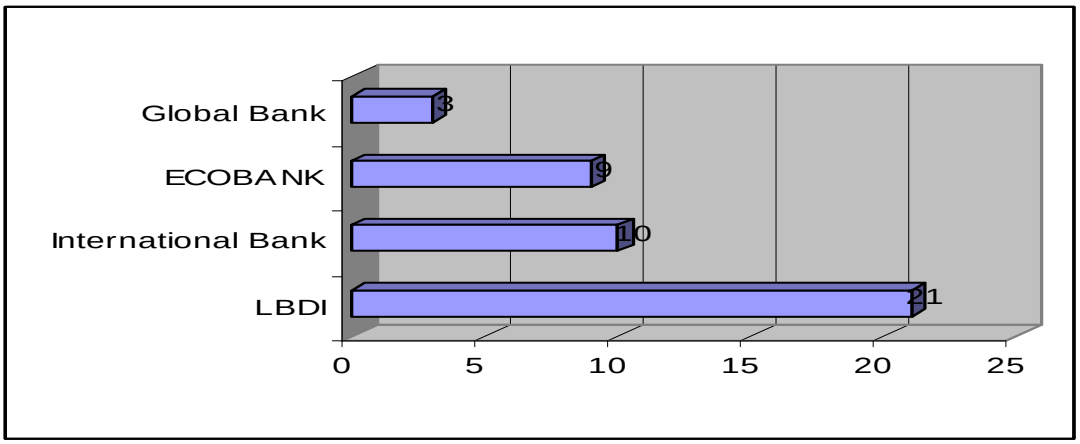


Chart 4.7.2: Institution Allowing For Audit:

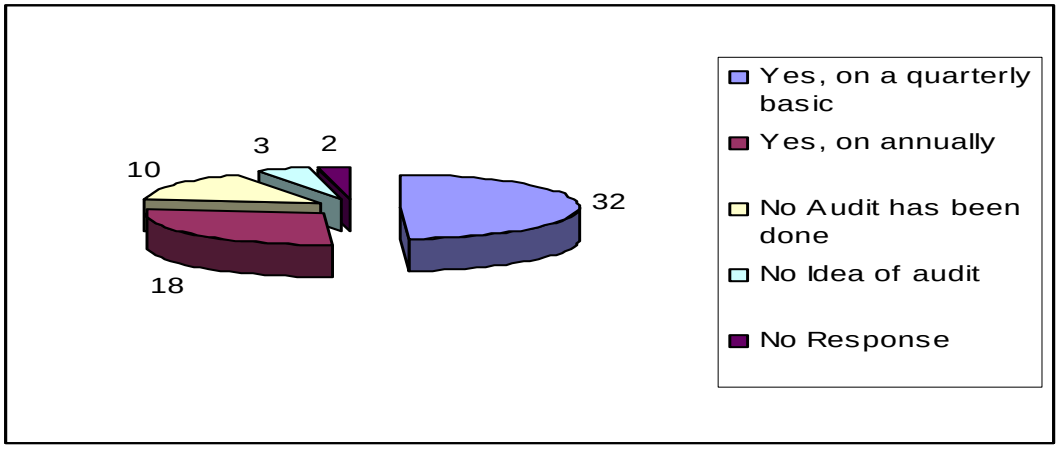
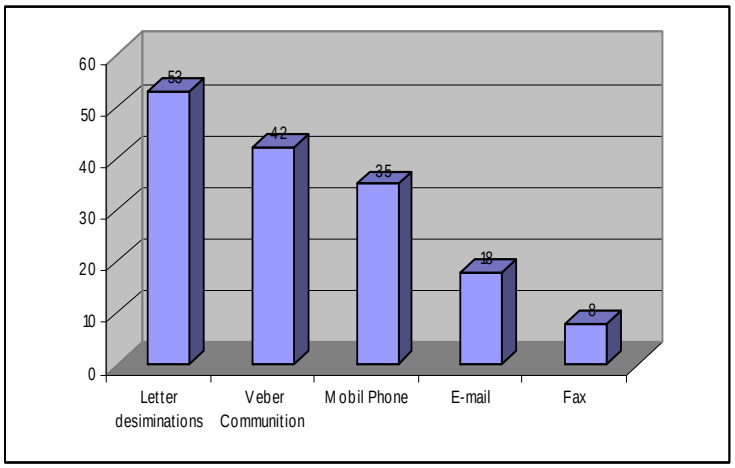


Table 4.7.5: Institution having Offices

Response to Having Office	# of Churches	Rating
Yes, program have office	60	92%
No, office space	0	0%
No Response	5	8%
Total	**65**	**100%**

Chart 4.7.3: Means of Communications



Phone, E-mail, letter Dissemination and fax were identified by the validation as the mediums of communication by the Christian faith-based institutions to partners/donors. ***See Chart 4.7.3***

Table 4.7.6: Institutional Capacity

Faith-based Institutional Capacity	N0	Score in %
Ranking of church/ program intervention	7	66%
Community Participation	9	57%
Production of News Letters/ Report	11	45%
Program having development plan	12	36%
Support (both material & financial)	13	28%
Program receiving funds from proposal	14	45%
Average Score		46%

The SAS has identified ranking of program interventions, community participation, production of news- letters/reports, programs having development plans, material & financial support and the receiving of funds from proposal as other means of their program capacity have an overall average score of 46%. This suggests that these areas need to be strengthened as part of institution capacity building process.

4.8 HIV/AIDS Stigma and Discrimination

Table 4.8.1: Reaction to Stigma and Discrimination

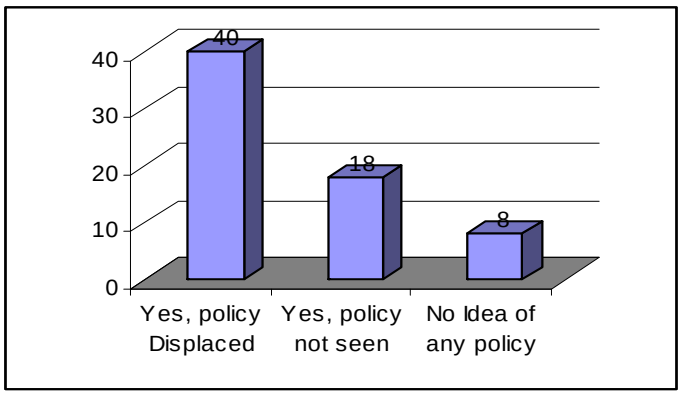
Responses	Children with sick parents		Children with dead parents		Family Member		Preacher		Buying Goods	
Support not equal	R	%	R	%	R	%	R	%	R	%
	6	11.5%	4	8%						
Love is conditional	4	8%	5	10%						
Mistreated	2	4%	4	8%						
Treat them good	6	11.5%	5	10%						
Secret					15	29%				
Orphanage			5	10%						
No Secret										
Allowed to preach							38	73%		
Buy from them									34	65%
Help them					24	46%				
Total	18	35%	23	46%	39	75%	38	73%	34	65%

*On the issues of stigma & discrimination, results gathered did not come out as expected because the question was posed to program implementers from the Christian faith-based institutions who themselves are Christians. And as Christians they believe that love, care and support are Christian obligations. However, if the question were posed to PLWHAs themselves, there response would be fundamentally different to some extent as indicated in **Table 4.8.1** of the SAS findings. To the contrary, during the validation excises some discussants in the FGDs gave two claims: acceptance, love, care and support on the one hand and rejection, discrimination and stigmatization by both church members and authorities on the other hand.*

HIV/AIDS stigma and discrimination were also confirmed by participants in the PACANet conference during the discussion of the draft SAS report. The participants furthered that the following must be carried out:

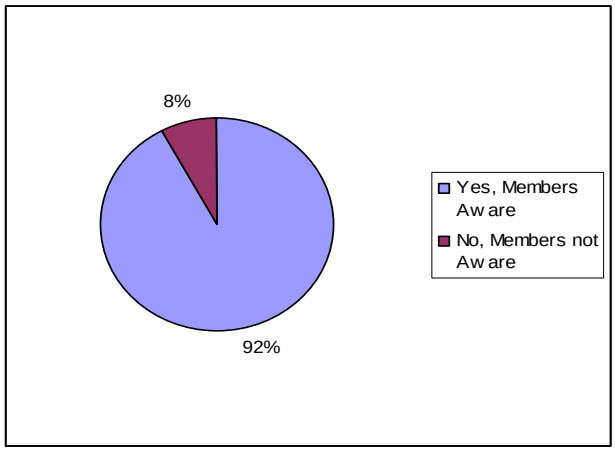
- *Counseling must be carried out in the churches;*
- *Caregiving; that is, medical support, nutrition and ARV drugs must be provided to PLWHAs;*
- *Providing micro-finance schemes for IGAs;*
- *Providing of psychological/spiritual support;*
- *Integrating PLWHAs into various church programs; and*
- *Providing awareness for both the affected and unaffected.*

Chart 4.8.1: Institution Having Policies or Strategies



Accordingly, some policies have been developed by the Christian faith-based institutions regarding stigma and discrimination and that members of their respective churches are aware of these policies. ***See Chart 4.8.1*** *for findings.*

Chart 4.8.2: Church Members Being Aware of Policies *or Strategies*

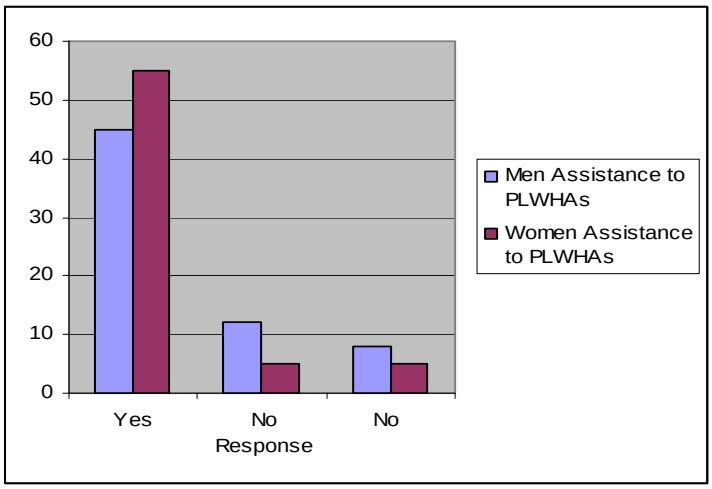


It has been indicated by respondents that policies have been developed regarding stigmatization and discrimination and that institution members are aware but cultural fears and reasons about people living with HIV/AIDS has to be overcome. As reflected in ***Chart 4.8.2*** *of the sixty-five (65) respondents carrying out interventions activities, nine-two percent (92%) percent said* ***yes*** *to have written policies that guide them in dealing with PLWHAs and that their memberships are aware of the policies while eight percent (8%) were not aware of any policy.*

4.9: Gender and Culture

For the success and sustainability of any community based program, the issues of gender and culture are very crucial. People have likes, dislikes; while others suffer domination and bad rule. As such they even kill each other solely because of certain characteristics that make one group of people different from the other. For us in Liberia, people do morally repugnant things to others because they have different faiths, speak different languages, practice uncommon habits or have different values and beliefs which sometimes shape the focus of programs activities. As such, the concept of culture and gender in the implementation of the HIV/AIDS programs is very crucial and significant; thus, needs careful examination the studies therefore looked at the role each sex plays in caring for people living with HIV/AIDS, their children, in the community.

Chart 4.9.1: Assistance to PLWHAs



Results gathered from the SAS show that both sexes (men & women), render some level of assistance to PLWHAs in their respective communities. Assistance rendered include care and support, home visitation, provision of Health care services, making referrals and conducting counseling for PLWHAs to accept the reality and live with it as well as preventive methods to those whose cases have not been identified. ***See Chart 4.9.1, Table 4.9.1.*** *And* ***Table 4.9.2*** *for comparison between male and female assistance.*

Table 4.9.1: Men Assistance to PLWHAs

Assistance to PLWHAs By Men	Response
Yes	45
No Response	12
No	8
Total	**65**

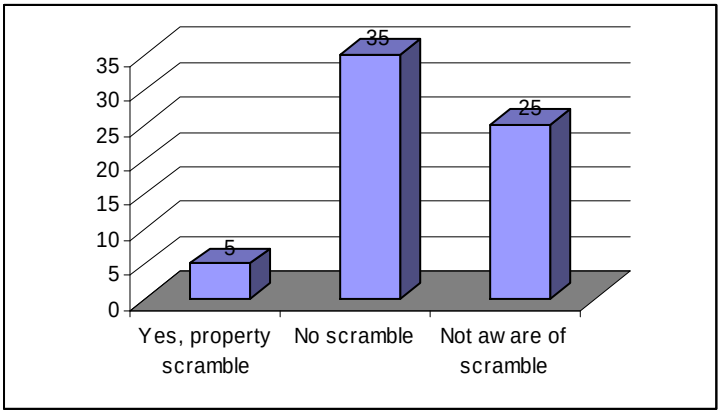
Table 4.9.2: Women Assistance to PLWHAs

Assistance to PLWHAs By Men	Response
Yes	55
No Response	5
No	5
Total	**65**

Table 4.9.3: Assistance Rendered:

HIV/AIDS Assistance Rendered By Faith Based Institutions	Response
Conducting Counseling	21
Give Care and Support	14
Visit them	12
Providing Health Care Services	10
Make referrals when necessary	8
Total	**65**

Chart 4.9.2: Reaction of Relatives of Males Who Died of HIV/AIDS to Wives of the Dead



This question provokes cultural clash i.e. traditional and western. In most traditional cultures, men own property. In a western culture the couple own property. The answers provided indicate property scramble, no scramble and not aware of situation.

As such, the issues of gender and culture are very crucial and significant and needs careful examination. In addition to the above information, various concerns have been made including caring for women whose husbands died from HIV/AIDS. However, cultural beliefs and stigma that come with this epidemic cause neglect and rejection and contradicts cultural belief dictating that when the husband of a woman dies, she must be cared for by the family of the husband.

In confirmation of these beliefs, information gathered reflect 35 of the sixty-five (65) respondents interviewed as saying there is no property scramble or mistreating meted against the wife of a man dying form HIV/AIDS, while 25 said they are not aware of any property scramble among any family whose relatives died as a result of HIV/AIDS as compared to 5 saying **yes**.

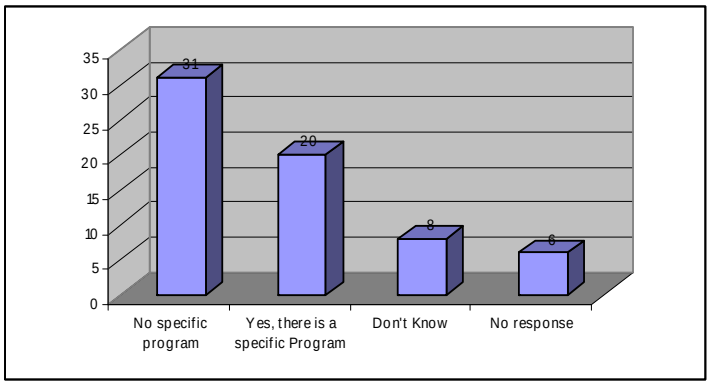
*On the contrary, **Table 4.9.4** below gives mixed view on the position of church members towards PLWHAs. As reflected in this table, an average score of 69% said yes to treating PLWHAs with no difference (Good) while 25% said they are treated with difference and 2% could not said **yes** or **no** on this issue.*

Table 4.9.4: The Position of Church Members to PLWHAS:

Response	Yes %	No %	No Response %
Remains in Secret	75%	24%	1%
Allow to preach	71%	16%	13%
Buy from them	70%	29%	1%
Bathing them	65%	33%	2%
Consider as punishment from God	50%	50%	0%
Deserve Compassion or support	55%	45%	0%
Shake their hands	100%	0%	0%
Average Score	**69%**	**25%**	2%

4.10 Identification of specific program for women/girl affected or infected with HIV/AIDS In the church

Chart 4.10.1: Specific program identified for female PLWHAS



As indicated in **Chart 4.10.1** institutions interviewed as it relates to their programs having specific activities for females that are infected or affected with HIV/AIDS, responses gathered show that twenty (20) respondents said *yes* to their institutions having a specific program for female PLWHAS. The program includes sewing, tie & dying and soap making.

On the contrary, thirty-one (31) respondents said *no* to having any specific program for female living with HIV/AIDS due to the lack of support, and the fear of creating discrimination while 8 said they are not aware of such program and 6 others did not respond to this question. In addition to the above, the 31 respondents saying no also expressed their willingness to establish similar program when the necessary funding is gathered.

4.11: General Challenges/ Problems/ Gaps in implementation

Table 4.11.1: Challenges/ Problems and Gaps Identified from the survey

Problems/ Gaps Identified	Score in %
Negative attitude towards PLWHAs	45%
Inadequate resource/ funds	43%
Lack of material resource	40%
Limited staff/ personnel capacity	21%
High expectation from PLWHAs	19%
Poor Accountability of resources	18%
Discrimination and stigma	16%
Limitation of appropriate skills	14%
Average Score	27%

Table 4.11.1 presents an average summary of 27% as the expressed views of the respondents interviewed. The results identified negative attitudes towards PLWHAs; inadequate resources/funds; lack of material resources; limited staff/ personnel capacity; poor accountability of resources; stigma and discrimination; high expectation from PLWHAs and limitation of appropriate skills as major challenges facing them in the implementation of programs. This information was verified/validated using the FGDs targeting a cross section of church members. Results gathered show 28% challenges/gaps facing the church in implementing the HIV/AIDS program. The problems identified in addition to those in the table are indecisive leadership, limited IEC material and the lack of testing materials.

5.0 STRATEGIES ADOPTED BY CHURCHES/AGENCIES TO OVERCOME CHALLENGES:

Table 5.1.1: Adapted Strategies

Improvement Strategies	# of Churches	Percentage
Identification of more funding sources	21	32%
Build staff capacity	18	28%
Church/ community sensitization	12	18%
Staff compensation	9	14%
Mobilization of youth Support	5	8%
Total	65	100%

Table 5.1.1 *represents results of adopted strategies by Institutions interviewed for this survey. These church related agencies stressed the identification of funding sources, building of staff capacity, church/community sensitization, staff compensation and mobilization of youth support as the means of overcoming challenges being encountered by their respective programs.*

These Christian faith-based agencies stated that when these needs are addressed, their interventions will have meaningful impact on the wider community. As reflected above, the adapted strategies include the identification of funding which account for 32%; building staff capacity 28%; church/community sensitization 18%; staff compensation 14%; and mobilization of youth support 8%.

5.1 Activities Funded

The funded activities as illustrated in this section, identified prevention activities as the highest funded activities, followed by home based care, OVC support and counseling. But to fully address the issue of HIV/AIDS, results obtained also show that more is needed to be done, mainly support for funds and especially in building organizations' capacities in all spheres, providing care and support to those affected and infected with this epidemic as well as providing more incentive for volunteers involved in HIV/AIDS awareness activities and providing those infected or affected with the necessary skills to engage in some meaniful IGAs to reduce the economic burden/stress posed by this epidemic. **See Chart 5.1.1** for details.

Chart 5.1.1: Activities That Need Funding

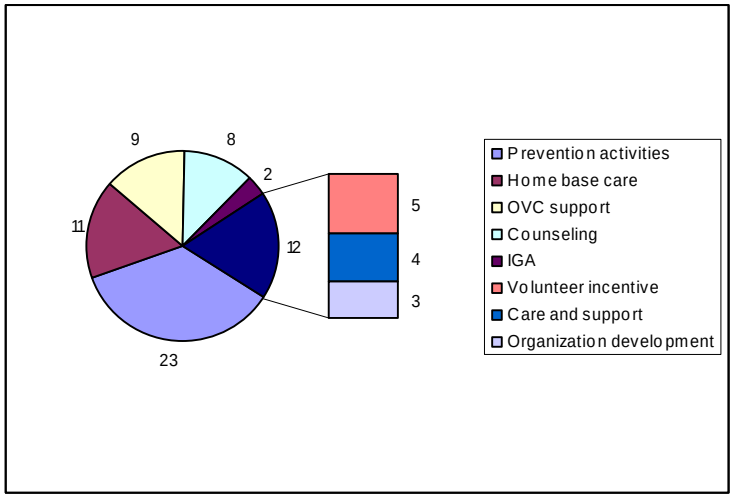


Chart 5.1.1 *indicates the need to scale up support in building organization capacity/ development, care and support, IGAs, counseling, volunteer incentives, OVC support, staff training (VCT), resource material and life skills so as to prioritize activities stated in* ***Table 5.1.1.***

Table 5.1.1: Priority area that needs funding

Funding Needs	Response
Building Organization Capacity	17
Care and Support	14
Counseling	9
Volunteer incentives	8
Resource material	4
Treatment of PLWHAs	7
Human Resource Development	2
Education (awareness) and sensitization	2
Man power Development	2
Total Response	**65**

Table 21: Recommendations to Get More Funding:

Funding Strategies	Respondents	Percentage
Mobilize more Local church support	28	43%
Seek individual contributions	15	23%
Identified more funding sources	14	22%
Appeal to local institutions/ corporation	8	12%
Total	65	100%

The study has proven that finding funding sources for program implementation is a very crucial aspect that needs careful planning.

As such the Christian faith-based agencies interviewed recommend the need to mobilize more local church support, seek individual contributions, identify more funding sources and appeal to local institutions/ corporations. Additionally, the stability of the country these agencies believes will also bring more support for the program in Liberia.

5.4 Conclusion and Recommendations:

The SAS was structured and comprised six sections; including identification of intervention, identification of resources, assessment of institutional capacity; HIV/AIDS stigma and discrimination, policy and strategies and Gender and culture.

Based on the findings, it has been indicated that 67% of the respondents say their institutions are involved in preventive activities, while 57% are involved in care and support and 54% are involved in advocacy and networking.

Under identification of resources, human, materials and institutional resources were emphasized. The finding reveals 82% of the respondents say Christian institutions have some limited level of human and material resources and institutional capacity. However, about funding or material resources, 57% admitted having limited funds, 17% have the needy funds for program activities, while 65% confirmed having limited material resources and 25% as having the needy material resource for program implementation. The study also reveals that 57% of respondents indicated that Christian institutions have limited capacity to implement HIV/AIDS activities in their respective communities.

According to the study, HIV/AIDS stigma and discrimination are major issues identified even though the Christian institutions visited and interviewed for the structured questionnaire did not see them as major, perhaps for two reasons. The first is that the church feels called to love, care and serve. The second is that the questionnaire did not address the issue with the PLWHAs nor the communities in which the churches/Christian-based institutions operate. However, during the verification in Monrovia the PLWHAs talked with gave two claims; one of acceptance and support; and the other of rejection, discrimination and stigmatization in the church and during the PACANet conference in Monrovia participants agreed that HIV/AIDS stigma and discrimination are indeed major issues to be addressed.

On policy and strategies the study reveals that 89% of the respondents say Christian institutions confirmed having policy while 75% are aware of the established policies. Nevertheless, some of these policies were not readily available for exhibition.

Under gender and culture, an average of 77% of both sexes indicates care for PLWHAs. Based on the findings, summarized above, it can be deduced that the Christian institutions in Liberia need organized and functional network, increased training and support.

The following were also noted as indicators for best practices.

- House to house awareness campaign done with peer groups including children, youths, young adults, adult males and females.

- Some community networks, i. e. groups in Gbarnga, Ganta, Buchanan and Zorzor are working together and sharing information.

- The allocation of time by pastors for HIV/AIDS awareness during worship service.

- Resource mobilization on self-help basis at local congregational level to fight HIV/AIDS.

- The church presents an ideal community for inter-cultural, inter-ethnic care and support for PLWHAs.

- Training of traditional healers in HIV/AIDS awareness and prevention.

In view of the key findings summarized in the conclusion, it can be recommended that;

a) The intervention activities, prevention, care and support, advocacy and networking need to be strengthened and continued.

b) The question of resources, human, material and institutional, remain the main obstacle and needs to be addressed through training, financial and material provisions either through proposal or grants.

c) The Christian institutions involved with the fight against the spread of HIV/AIDS need a structured and functional network increased capacity building training in the intervention activities resource mobilization and management and sufficient information on donors supporting the fight against HIV/AIDS.

d) Any future SAS should also be directed to PLWHAs and the local communities where Christian faith-based institutions operate so that they can give their own assessment of the operations of these faith-based institutions and on the degree of HIV/AIDS stigma and discrimination within the church community.

e) To help overcome HIV/AIDS stigma and discrimination, that PLWHAs be employed with church related institutions; including but not limited with HIV/AIDS programs; and encouraged to take active part in church related activities.

f) The Gender and Culture in the SAS emphasized support and care for PLWHAs in local church communities and the response given affirmed care. However, we need to deepen gender and cultural issues relative to HIV/AIDS i.e. widows and widowers are culturally allowed to marry in the families of their demised spouse without a medical report on the cause of death thereby placing either of them at risk. Also traditional marriages pre-arranged by parents to teen ages, place the teen ages at risk; here awareness, training and advocacy need to be emphasized.

g) Most of the documents referenced as literature and desk review mainly national HIV/AIDS policy and situation analysis from the Liberian government still remain draft acts; and need to be ratified, passed into law by the national legislature and disseminated to all institutions as clear policy direction to guide and accelerate combined national fight against HIV/AIDS. Equally, clearly documented policies from both national government and Christian institutions must be developed, disseminated and widely taught to avoid future problems of stigma and discrimination.

h) There is urgent need to address the stated factors contributing to HIV in Liberia, including environmental cultural social and individual.

References:

- NACP (2006) Liberia HIV/AIDS Situation Analysis, Monrovia: NACP
- (2003) Republic of Liberia: HIV/AIDS Policy, Monrovia: NACP
- MOH (2002) Liberia: HIV/AIDS Legislation, Monrovia: MOH
- RECEIVE (2006) Lutheran Church in Liberia HIV/AIDS Programme IDP Project: Mid Term Evaluation Report, Monrovia: RECEIVE
- HIV/AIDS Legislation (Nov. 30, 2002) Liberia, PP. 4 & 8
- HIV/AIDS policy (March 2003) Republic of Liberia, PP. 5
- HIV/AIDS situation analysis (Feb. 2006), PP. 8 -25
- Tellewoyan, Joseph K. The Years The Locusts Have Eaten: Liberia 1816 – 2004 (http://pages.prodigy.net/jkess3/History.html)

Appendixes

A. Questionnaire for the situation Analysis:

RECEIVE/PACANET BASELINE SURVEY

The Pan African Christian AIDS Network (PACANet), a coordinated Christian response to the HIV/AIDS epidemic across the African continent exists to link churches, Christian organizations and networks to enhance their HIV/AIDS responses by sharing resources, ideas, skills, experiences and stimulating strategic partnerships. PACANet wishes to conduct this Situation Analysis of Church Response to HIV/AIDS in Liberia with the aim of supporting both country networks and service organizations to empower, equip and facilitate grassroots church-based interventions to ultimately provide credible, comprehensive and quality services.

RESPONDENT: CHURCH LEADER/PROGRAMME LEADER

RESPONDENT NUMBER	
CHURCH NAME AND/OR AIDS PROGRAMME NAME	
TYPE	Church Head office or diocese Network Umbrella body Partners Para church organization
DENOMINATION/AFFILIATION	Anglican Pentecostal Evangelicals Catholic SDA None/Not appropriate Para church organization Lutheran Methodist Other _____
COUNTY OF LOCATION	
RESPONDENT NAME	
CONTACT PERSON	
CONTACT ADDRESS	
POSITION	

SECTION 1: IDENTIFICATION OF INTERVENTIONS

A. TYPES OF INTERVENTIONS:

1. Is your church/programme involved in any HIV/AIDS activities?

Yes 1

No 2

Don't know 3

If yes, proceed to question 2 and 3.

(If no proceed to question 4,5 and 6).

2. If yes, what HIV / AIDS activities is your church/programme doing? Please x the appropriate numbers.

(i) <u>Prevention</u>

	Yes	No
(a) General awareness and sensitization.	1	2
Life skills (youth).	1	2
Voluntary counseling and testing (VCT).	1	2
Condom distribution.	1	2
PMTCT (Prevention of Mother to Child Transmission of HIV/AIDS.	1	2
Promoting Abstinence	1	2

(g) Other (specify) ……

(ii) Care and support

Is your church providing any of the following care and support services to the community?

	Yes	**No**
a. Provision of Home care.	1	2
b. Counseling support	1	2
c. Treatment of opportunistic infections.	1	2
d. Income generating activities.	1	2

e. Shelter construction.	1	2
f. Vocational skills.	1	2
g. Linkages with health units and other service providers.	1	2
h. Spiritual support for those affected and infected by HIV/AIDS.	1	2
i. Social support groups.	1	2
j. Material support to those infected and affected.	1	2
k. OVC(Orphan and Vulnerable Children) support (educational, material)	1	2
l. Medical / health care services	1	2

Other (specify) ……

(iii) Advocacy and Networking

	Yes	**No**
Was your church engaged in the development process of the OVC or HIV/AIDS policy/strategy framework	1	2
Has your church undertaken any actions to secure the rights, and well being of people living with HIV/AIDS and OVCs?	1	2
What is the role of the church in HIV/AIDS advocacy for PLWHAs and OVCs? (Probe and write) Is any member of your church trained in any advocacy skills? Does your church participate in any HIV/AIDS networking/coordination structure? If No why? (probe and write) If yes What is the role of your church in these coordination and networking structure? (probe and write)	1 1 1	2 2 2

3. What aspects of HIV/AIDS are you not addressing and would like to address?
   ……
   ……
   ……

4. If no why are you not doing so.	**Yes**	**No**
a. Lack of human resources	1	2
b. Lack of financial resources	1	2
c. Lack of material resources	1	2
d. No interest at all.	1	2
e. HIV / AIDS is not a problem in our church.	1	2
f. Others are doing it.	1	2
g. Do not know what to do?	1	2

(g) Others specify ……

5. Do you have any plan to start addressing HIV/AIDS aspects in your church? (Please explain)

……
……

6. What aspects of HIV/AIDS would you like to address or to do?

……
……

B. GENERAL CHALLENGES/PROBLEMS/GAPS IN IMPLEMENTATION

	Yes	**No**
7. What challenges does your church/agency/programme face in implementing its HIV/AIDS initiatives?		
Inadequate resources/funds	1	2
Limited staff/personnel capacity.	1	2
High expectations from the congregation/community.	1	2
Discrimination and stigma.	1	2
Limited appropriate skills.	1	2
No vision about HIV/AIDS.	1	2
Poor accountability of resources.	1	2
Too much workload.	1	2
Negative attitudes and teaching of church leaders	1	2

(j) Others (specify) ……

8. What does your church/agency suggest/adopt to overcome these challenges?	**Yes**	**No**
Access to funding/resources.	1	2
Training in technical skills.	1	2
Sensitization to the church to deal with stigma and discrimination.	1	2
Facilitating staff/personnel.	1	2
Training in financial management skills.	1	2
Training in organizational management skills.	1	2
Mainstreaming and integrating of HIV/AIDS in on going church programmes/ activities/responses	1	2

(g) Others/ specify ……

9. What does your church/agency consider as its strength in responding to HIV/AIDS.	**Yes**	**No**
Voluntarism	1	2
Access to resources/services with the agency and outside environment.	1	2
Committed people.	1	2
Good leadership.	1	2
Established networks and referrals.	1	2
Support by the congregation.	1	2

(g) Others/ specify ……

SECTION 2: IDENTIFICATION OF RESOURCES

Financial Resources

10. Do you receive any HIV/AIDS funding resources? Yes 1

No 2

Don't know 3

11. How do you fund your HIV activities?	
International donor	1
Sister churches overseas	2
Congregational' contributions	3
Government	4
Private sector contributions	5

(f) Others/ specify……..

12. What successful methods/strategies have you used to get funds for your	**Yes**	**No**

work?		
a. Submitting proposals to donor partners	1	2
b. Local fund raising events	1	2
c. Contacting private companies	1	2
d. Using individual contacts	1	2
e. Going through a network	1	2
f. Going through denomination contacts	1	2
g. Congregational support	1	2

(g) Others/ specifies……

13. Have you had any problems in getting funds? What were the problems?	**Yes**	**No**
a. No problems	1	2
b. Proposal not accepted	1	2
c. Delays in receiving funds	1	2
d. Lack of information on where to go for funds	1	2
e. Miss-match between donor priorities and church priorities	1	2
f. Too many donor requirements	1	2

(g) Others (please specify)……

14. Which of your activities are funded and which still require funding? (Please X)

Activities	**Receiving funds**	**Need more funding**	**Would undertake as a priority if funding were available**
Prevention activities			
Home-based care			
OVC support			
Life skills training			

Counseling			
IGAs (What is this?)			
Resource materials (Behavior change communication and information education communication materials or IEC)			
Volunteer incentives			
Organizational development			
Core support (operational)			
Infra-structure			
VCT			
Training			

Others/ specify ……

15. Do you have any recommendations on how churches could get more funds for HIVADS activities?

Material Resources

16. Do you use any HIV/AIDS resource materials?
Yes 1
No 2
Don't know 3

17. If no, why not?	
a. Not available	1
b. Not required	2
c. Not relevant	3
d. Wrong messages	4
e. No funds to purchase	5

(f) Others/ specifies……

18. If yes, which materials and where do you get these materials? (E.g. source)

Name/Type of material	Source

19. Please rate the materials you use.

Factor	Good	Fair	Poor
(a) The language is easy to understand	1	1	1
(b) It is relevant to target group	2	2	2
(c) It is culturally sensitive	3	3	3
(d) It is easy to use	4	4	4
(e) It covers the necessary information	5	5	5

(f) Others/ specifies……

20. What other material would be useful or do you need? ……

Human Resources and programme capacity

21. Does your church/programme use volunteers?
Yes 1
No 2
Don't know 3

22. If yes how many? ……

23. If no why? ……..……

24. Do the volunteers receive any incentives?

	Yes	No
a. None	1	2
b. Regular financial incentive	1	2
c. Christmas/ Easter gift	1	2
d. Food	1	2

e. Other material (bicycle, umbrella, shoes)	1	2
f. Recognition	1	2
g. Certification	1	2
h. Travel allowance	1	2

(f) Others/ specify: ……..

25. Do you have any staff working on HIV/AIDS?
Yes
No

26. (a) If yes, how many? ……

(b) What nature of staff working on HIV/AIDS does your Church have?

	Yes	**No**
(a) Full time	1	2
(b) Part time	1	2
(c) Local	1	2
(d) Expatriate	1	2
(e) Consultants	1	2

27. If no, why……

f. Others/ specify ……

28. What training has been received by staff and volunteers and what is still needed? Please tick.

Area	**Volunteers trained in this**	**Volunteers need training**	**Duration**	**Staff trained in this**	**Staff need training**	**Duration of training**
Basic HIV Information and awareness						
Prevention interventions						
Home-based care						
Psycho-social support						
Counseling and						

testing						
Developing IECD/BCC materials						
Financial management						
Organizational development (management)						
Prevention of mother to child transmission (PMTCT)						
Vaccine trials						
Networking and advocacy						
Anti retroviral treatment (ART)						

Others/ Specify ……

SECTION 3: ASSESSMENT OF INSTITUTIONAL CAPACITY

29. Does your church programme/Agency have a constitution/policy?

	Yes	**No**
a. No Constitution	1	2
b. Some principles written down	1	2
c. Written constitution, not approved or non-functional	1	2
d. Approved Constitution which guides organization	1	2

30. Do you have a Committee or Board that meets and makes decisions?

Yes 1

No 2

I don't know 3

31. If yes do they meet and make decisions	

No meetings	1.
Rare meetings; few decisions	2.
Regular meetings and frequent decisions	3.

32. Does your church programme have treasurer/ Accounts personnel who supervise the finances?

a. No Treasurer/accounts personnel	
b. Treasurer accounts personnel appointed but does not do the work.	2.
c. Treasurer Accounts personnel supervises the finances	3.

33. Does your church keep accounts and make reports?

No accounts kept			
Accounts monitored and presented annually	2.		
Accounts are kept monthly or quarterly and presented regularly	3.		

34. Does your church/programme have a bank account?

a. Has no account	1.	
b. Has funds but no account	2.	
c. Uses someone's personal account	3.	
d. Has its own bank account	4.	

35. Are your accounts audited?		
Not audited	1.	
Not audited every year	2.	
Audited annually	3.	

36. Does your church/programme have its own office base?		

No office	1.	
Access to shared office	2.	
Own office	3.	

37. Tick if your church/programme has the following:	**Yes**	**No**
a. Telephone	1	2
b. Fax	1	2
c. Computer	1	2
d. Email and internet	1	2

Others Specify:……

38. Does your church plan the development of its HIV/AIDS activities?		
a. No planning	1.	
b. Occasional planning	2.	
c. Organization regularly plans its HIV/AIDS activities	3.	

39. Does your church/programme produce any reports (newsletters/annual reports)		
No information produced	1.	
Some information given out	2.	
Regular reports distributed	3.	

40. Does the church/programme have monitoring systems for its HIV/AIDS activities?		
a. No monitoring	1.	
b. Occasional monitoring activities and\ reports	2.	
c. Monitoring undertaken at least monthly	3.	

41. Does the church/programme keep records and documentation of its activities?	
a. No records or documentation kept	1.

b. Records kept but incomplete	2.
c. Records are complete and accessible	3.

42. Are members of the wider community participating in your HIV/AIDS activities? E.g members of church, Pastors, and other leaders, administrators, spiritual overseers, deacons, and other stakeholders, external to the institution/agency e.g community leaders, government officials, etc.	
a. No participation by the wider community b. Some participation c. Active involvement and participation	1. 2. 3.

43. Does the church obtain financial or material support from outside the community for HIV/AIDS work?

a. No support from outside	1.
(b) Infrequent support from outside	2.
© Frequent and strong support from outside.	3.

44. Has the church/programme ever submitted and received funds from a proposal? (Refer to 13)	
Never submitted a proposal	1.
a. Submitted a proposal but received no funds	2.
(c) Successfully submitted a proposal	3.

45. Has your church/programme ever received technical support from an external source?	
(a) No external support	1.
(b) Have participated in external workshops	2.
(c) Have received training from an external source	3.
(d) Receive regular support from outside.	4.

46. Do the relevant government departments know about and support your HIV/AIDS activities?	
a. Unaware of activities	1.
b. Aware but no support	2.

c. Occasional support	3.
d. Regular government support	4.
47. Are you affiliated to and supported by any network?	
a. No affiliation or support	1.
b. Affiliated to a network/forum but no support received	2.
c. Affiliated to a network and some minimal support received	3.
d. Affiliated to a network and receive regular, strong support	4.
48. How do you rank this church/programme intervention in HIV/AIDS activities	
a. Basic (with no funding, no work plan, no committee, etc).	1.
b. Developing (with some funding, organized committee, etc)	2.
c. Full scale (with funding, scaling up, good work plan, staff in place).	

SECTION 4: HIV/AIDS STIGMA AND DISCRIMINATION

No.	Questions and filters	Coding categories	Code
Q49	Do you think that the Church treats differently children whose parents are sick?	YES NO DON'T KNOW NO RESPONSE	1 2 8 9
Q50	If yes to Q49, how does the church treat children whose parents are sick differently? **Probe for more responses** **MULTIPLE RESPONSE POSSIBLE**	Favoring those whose parents are not sick Support provided not equal Mistreat them Treat them kindly Favor children whose parents are sick	01 02 03 04 05 06

		Love given is conditional	07
		Children with sick parents have to work for any form of payment	08 98
		Other (Specify) ----------	99
		DON'T KNOW	
		NO RESPONSE	
Q51	Do you think that the church treats differently children whose parents have died than other children?	YES NO	1 2
		DON'T KNOW	8
		NO RESPONSE	9
Q52	If yes to Q51, how does the church treat children whose parents have died (i.e. orphans) differently? *(Probe for more responses)*	Favoring those with parents	01
		Support provided not equal	02
		Mistreat them	03
		Treat them kindly	04
		Favor orphans	05
		Love given is conditional	06
		Orphans have to work for any form of payment	07
		Other (Specify) ----------	08 09
		DON'T KNOW	10
		NO RESPONSE	
Q 53	Do you agree or disagree with the statement that HIV/AIDS is a punishment from God?	Agree	1
		Disagree	2
		Undecided/ not sure	3
Q 54	Do you agree, or disagree, that people who have HIV/AIDS do not deserve compassion or support?	Agree	1
		Disagree	2

		Undecided/ not sure	3
Q55	Would your church members shake hands with a person they knew was living with HIV/AIDS?	YES	1
		NO	2
		DON'T KNOW	4
		NO RESPONSE	5
Q 56	If a member of your family got infected with HIV/AIDS, would the church want it to remain a secret?	YES	1
		NO	2
		DON'T KNOW	3
		NO RESPONSE	4
Q 57	If a religious leader / preacher has HIV/AIDS, should s/he be allowed to continue preaching?	YES	1
		NO	2
		DON'T KNOW	3
		NO RESPONSE	4
Q 58	Would your church members buy goods from a person they knew was living with HIV?	YES	1
		NO	2
		DON'T KNOW	3
		NO RESPONSE	4
Q 59	Would your church members help someone you knew was living with HIV to bathe?	YES	1
		NO	2
		DON'T KNOW	3
		NO RESPONSE	4

SECTION 5: POLICY AND STRATEGY

Q60	Does your church have an HIV/AIDS policy or strategy or a common position on HIV/AIDS in place?	YES	1
		NO	2
		DON'T KNOW	3
		NO RESPONSE	4
Q61(a)	If yes, are all the church	YES	1

	members aware about this common position or policy?	NO DON'T KNOW NO RESPONSE	2 3 4
(b)	If no Why is there no common position or policy? (probe and record)		

SECTION 6: GENDER AND CULTURE

Q 62	**How often do women participate in the following activities? Would you say their participation is often, sometimes or never?**			
	Caring for orphaned children?	Never 1	Sometimes 2	Often 3
	Caring for families that are affected by HIV/AIDS	1	2	3
	Caring for neighbors children who are needy	1	2	3
	Visiting and caring for people in the neighborhood or community who are seriously ill?	1	2	3
	Volunteering with a community/religious group that provides care and support to people living with HIV/AIDS	1	2	3
	Participating in a HIV infected and/or affected support group	1	2	3

Q. 63	**How often do men participate in the following activities? Would you say their participation is often, sometimes or never?**			
	Caring for orphaned children?	Never 1	Sometimes 2	Often 3
	Caring for families that are affected by HIV/AIDS	1	2	3
	Caring for neighbors children who are needy	1	2	3
	Visiting and caring for people in the neighborhood or community who are seriously ill?	1	2	3
	Volunteering with a community/religious group that provides care and support to people living with HIV/AIDS	1	2	3
	Participating in a HIV infected and/or affected support group	1	2	3

Q. 64. Has property of any female member of your Church been grabbed by relatives because of the death of the Husband caused by HIV/AIDS?
Yes
No

Q.65. Are there any deliberate programs that are specific for women/Girls affected or infected by HIV/AIDS in your Church?
Yes
No

Q. 66. If Yes, what are some of the activities?.....

Q.67. If No, why? .....

Q. 68. Are there any efforts/plans to start such programs by your church?

Yes
No ***THANK YOU***

B. FOCUS GROUP DISCUSSION GUIDE

A number of Churches are engaged in HIV/AIDS Interventions, what are some of these interventions?

What have been the most effective HIV/AIDS interventions implemented by the Church and why?

What have been the least effective HIV/AIDS interventions implemented by the Church and why?

What are some of the challenges/Problems/Gaps the Church is experiencing in implementing these HIV/AIDS interventions?

How has the Church funded its HIV/AIDS interventions and what are some of the challenges?

What type of training does the Church require in order to effectively implement its HIV/AIDS activities?

Are there any forms of stigma and discrimination which exist in the Church and what has the Church done to address them?

What gender concerns are being addressed by your church in handling the HIV/AIDS issues?

C. List of Interviewees & Faith Based Institutions/ Organizations

Institution	Location	Respondent Name	Contact Person	Contact Address	Position	Contact Number
Bopolu United Pentecostal Church	Bopolu Gbarpolu	Jerry F. Nyanguoi	Jerry F. Nyanguoi	Bopulu UPC	Pastor	
Youth in Action for the Prevention of HIV/AIDS	Bopolu Gbarpolu	James W. Morlu	Harris M. Cokie, Jr.		Executive Director	06-551-511 077-021-586
Standard A.G. Pentecostal Church	Buchana Grand Bassa	Sam Suku	Rev. Thomas S. Quaye	Standard AG Church	Pastor	
New Testament Baptist Church	Buchana Grand Bassa	Samuel S. Gballah	Okedah Flogar	Central Buchana	Youth President	
Standard A.G. Pentecostal Church	Buchana Grand Bassa	Rev. Thomas S. Quaye	Rev. Thomsa S. Quaye	Standard AG Church	Pastor	05-568-116
Thankful Baptist Church	Buchana Grand Bassa	Emma J. Clarke	Rev. Clarence O. Reeves	Thankful Baptist Church	Pastor	
St. Peter Claver Health Hospital	Buchana Grand Bassa	Michael Bolar	S.S. Carmen Nava	St. Peter Claver Health Hospital	Administrator	
World Wide Mission Clinic	Buchana Grand Bassa	Dr. Abba G. Karnga	Dr. Abba G. Karnga	WWML-CEFL	Coordinator CEFL	
First Church of Open Bible	Buchana Grand Bassa	Pastor Tom Tenlyon Logan	Pastor Tom Tenlyon Logan	First Church of Open Bible	Pastor	
St. Peter Claver Church	Buchana Grand Bassa	G. Moses Jackson	Rev. Fr. Francis Johnson	St. Peter Claver Church	Priest	
St. Peter's Church	Buchana Grand Bassa	Resanna Massau	Rev. Fr. Francis Johnson	St. Peter's Claver Church	Priests	
Liberia Agriculture Company Hospital	Buchana Grand Bassa	Dr. Emmanuel Sandoe	Dr. Emmanuel Sandoe	LAC Hospital	Medical Director	06-538-676
Bethel World Outreach Ministries	Ganta Glenyeluu Nimba	Pastor Armah G. Karmo	Rev. John Baryogar	Rev. John Baryogar	Head Pastor	
Methodist/Ganta Mission	Ganta Nimba	Rev. James Z. Labala	Rev. Herbert L. Zigbuo	Mission Station	District Station	
Bethel World Outreach Ministries	Ganta Nimba	Rev. John Baryogar	Rev. J. Macmarley	Bethel World Outreach	Overseer	06-449-445
Ganta Methodist Church	Ganta Nimba	Yah Gorgboyee	Rev. James Z. Lablah	GOMPA District	District Superintendent	
Ganta UMC Hospital	Ganta Nimba	Rev. John N. Togba	Allen Zomonway	Ganta UMC Hospital	Supervisor/Public Health Training	

YMCA/ Adolescent Reproductive Health	Ganta Nimba	Nau K. Boar	Peter Kamie	YMCA/ Ganta	General Secretary YMCA	
Gbarnga YMCA	Gbarnga	Mr. Edwin Jallah	Francis Kempeh	Gbarnga YMCA	Executive Director	06-489-294
St. John Gbarnga UMC	Gbarnga	Rev. David T. Bondo		Cutton Tree Community	Associate Pastor	
St. Mark's Lutheran	Gbarnga Bong	Marline Tokpa Jarwoe	Alfred P. Jarwoe	St. Mark's Lutheran Gbarnga	OIC	06-436-015
St. John UMC Gbarnga	Gbarnga Bong	Marris M. Kollie	Rev. M. Barcon Borbor	St. John UMC Gbarnga	Chairperson Board of Trustee	
St. Mark's Lutheran Church	Gbarnga Bong	Deacon Albert M. Hegbee	Rev. Isaac S. Dowah	St. Mark's Lutheran Church	Senior Pastor	
Price Memoral UMC	Grand Behwan Grand Kru	Joseph G. Gwana	Augustine S. Jimmy	Barclayville Health Center	County Health Officer	
J.B. Robertson UMC	Grand Cess Grand Kru	Rev. Benjamin Toe	Augustine S. Jimmy	Barclayville Health Center	County Health Officer	
Newaken Clinic (Lutheran)	Grand Kru	Wilson Wleh	Kay Sieh Smith	Dougbo Grand Kru	Coordinator Parish Health Program	
Grand Kru Parish LCL	Grand Kru	Josiah N. Blayon	Kay Sieh Smith	Dougbo Grand Kru	Coordinator Parish Health Program	
YMCA	Kakata Margibi	Francis Senkpenie	Francis Senkpenie	YMCA, Kakata	Youth Director	
LWF-LCL AIDS	Kakata Margibi	Joshua Miller	Rev. Tarnue Kesselly	LCL Office	Resident Pastor	
St. Paul Lutheran Parish	Kakata Margibi	Rev. Tarnue Kesselly	Rev. Tarnue Kesselly	St. Paul Lutheran, Kakata	Pastor	
Lutheran Church in Liberia	Monrovia Montserrado	James Y. Gayflor	James Y. Gayflor	LCL	General Secretary	
Association of Evangelicals of Liberia	Monrovia Montserrado	Oretha Traub	Oretha Traub	AEL, ELWA Compound	Supervisor	
Lutheran Church in Liberia	Monrovia Montserrado	George Kparteh	George Kparteh	LCL Compound	Chief Accountant	
Association of Evangelicals of Liberia	Monrovia Montserrado	Edward P. Bropleh, Sr.		AEL, ELWA Compound	Project Officer HIV/AIDS	
Lutheran Church in Liberia	Monrovia Montserrado	Rufina Paye	Rufina Paye	LCL Compound	Counsellor HIV/AIDS Program	
Liberia Council of Churches	Monrovia Montserrado	Yilaa Wloti Se	Yila Wloti Se	LCC Compound	Coordinator HIV/AIDS	
YMCA	Monrovia Montserrado	Garrison Kerwaillon	Garrison Kerwaillon	YMCA, Crown Hill	Director	

Seventh Day Adventist	Monrovia Montserrado	Amos Young	Amos Young	SDA Hospital	Lab Technician	
Lutheran Church in Liberia	Phebe Bong	Mrs. Belekula Jeogbor	Rev. Moses T. Jeogbor	Phebe Compound	Pastor St. Luke's	
Phebe Hospital	Phebe Bong	Rev. G. Victor Padmore	Phebe Administration	Phebe Hospital	Chaplain	
St. Andrew Lutheran Church	Pleebo Maryland	Deacon Samuel Hinneh	Kay Sieh Smith	Dougbo Grand Kru	Coordinator Parish Health Officer	
Grant UMC Women Department	Pleebo Maryland	Sarah Davis	Kay Sieh Smith	Dougbo Grand Kru	Coordinator parish health Officer	
J. Grand UMC	Pleebo Maryland	Rev. T. Nyanti Toe	Augustine S. Jimmy	Barclayville Health Center	County Health Officer	
Palipo Parish Clinic	River Gee	P. Toe Sneh	Kay Sieh Smith	Dougbo Grand Kru	Coordinator Parish Health Program	
Palipo Parish Lutheran	River Gee	Paul Jarbo	Kay Sieh Smith	Doubgo Grand Kru	Coordinator Parish Health Program	
Anglican Church	Robertsfield Grand Cape Mount	Verney Sherman	Rev. Fr. Hamsford	St. John' Irving Memorial Episcopal church	Father	
LGH??	Tubmanburg Bomi	Dr. M.M. Dukuly	Dr. M.M. Dukuly	LGH Tubmanburg	Director of Nursing & HIV/AIDS	
UMC Wemah Church	Tubmanburg Bomi	Mrs. Mends	Roosevelt C. Mends	Weamah UMC Tubmanburg	Lay Reader	
Concern Christian Community	Tubmanburg Bomi	Maria Massaquoi	Maria Massaquoi	CCC	Supervisor	
St. John Lutheran Church	Zorzor Lofa	K. Miller Gargue, Sr.	Mr. Sumo Woyee	Zorzor Lofa	Parish Council Chairperson	
Lutheran Church in Liberia	Zorzor Lofa	Steven Z. Korvah, Jr.	Rev. Mulbah F. Zayzay	LCL Compound	Program Coordinator	
St. John Lutheran Church	Zorzor Lofa	Deacon David W. Kezelee	K. Miller Gargue	St. John Lutheran Church	Parish Deacon	

D. *RESPONDENTS ANALYSIS*

Churches/Institutions	*# of Respondents*
AEL	2
Baptist	1
Bethel World Outreach	2
CCC	1
Episcopal	1
LAC Hospital	1
LCC	1
LGH	1
Lutheran	16
Methodist	10
Open Bible	2
Pentecostal	3
Phebe Hospital	1
SDA	1
St. Peter Claver	3
World Wide Mission	1
YMCA	4
Youth in Action	1

Counties	*# of Respondents*
Bomi	3
Bong	7
Gparpolu	2
Grand Bassa	10
Grand Cape Mount	1
Grand Geddeh	-
Grand Kru	4
Lofa	3
Margibi	3
Maryland	3
Montserrado	8
Nimba	6
River Gee	2
Rivercess	-
Sinoe	-
Total	**52**

E. INSTITUTIONS VISITED FOR THE VALIDATION

#	Name of Faith-Based Institution	Location
1	Bethel World Outreach	Oldest Congo town
2	Episcopal Church	Broad Street
3	Free Pentecostal Global Mission	Gardnerville, Chicken-soup Factory
4	Liberia Baptist Convention	Oldest Congo Town
5	Prison Fellowship- Liberia	12th Street, UMC Compound
6	Salvation Army	17th Street, Sinkor
7	Samaritan Purse	9th Street, Sinkor
8	Seventh Day Adventist	Camp Johnson Road
9	St. Joseph Catholic Hospital	Oldest Congo Town
10	UCCA-AIDS	Randall Street & UN Drive
11	UMC/LAC	12th Street, Sinkor
12	Wesleyan Church	Steven Tolbert Estate
13	Liberia Inland Church	Old Road, Sinkor