**HIV AND AIDS IN THE NEW GLOBAL ERA: A HOLISTIC APPROACH FOR DIGNITY OF LIFE**

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<table>
<thead>
<tr>
<th>Editorial</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
</tr>
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<table>
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<tr>
<th>Special</th>
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<tbody>
<tr>
<td>4</td>
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<tr>
<th>Analysis</th>
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<tbody>
<tr>
<td>8</td>
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<thead>
<tr>
<th>Experience</th>
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<tbody>
<tr>
<td>12</td>
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<tr>
<td>15</td>
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<tr>
<td>18</td>
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<td>21</td>
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<td>24</td>
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</tbody>
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<tr>
<th>Bible study</th>
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<td>26</td>
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Photo Credit: Paul Jeffrey / Ecumenical Advocacy Alliance
HIV AND AIDS IN THE NEW GLOBAL ERA: A HOLISTIC APPROACH FOR DIGNITY OF LIFE

Health and healing ministries through the churches, Christian health care providers, pastoral counsellors and ecumenical advocacy networks and institutions bind together issues of justice, peace and fullness of life. For instance, many efforts are being implemented to address the root causes of the HIV pandemic and to facilitate health care services including palliative care, but in many parts of the world there are many barriers to quality life, justice, peace and affordable health care services. For someone living with HIV and/or other chronic health conditions, this often becomes a matter of life and death.

It is therefore prudent that churches, Christian healthcare providers, ecumenical health networks and secular international governmental agencies like WHO and UNAIDS and national governments work together to restore dignity, justice and health in communities, understanding that partnerships are an essential part of the process of change, transformation and mutually nurturing sustainable collaboration.

The purpose of this Contact magazine issue is to share learned lessons in the ecumenical HIV response. At the 10th WCC Assembly, one of the ecumenical conversations focused on Health and Healing ministries. The official message of the WCC 10th Assembly, themed as “Join the Pilgrimage of Justice and Peace”, is based on: “By the tender mercy of our God, the dawn from on high will break upon us, to give light to those who sit in darkness and in the shadow of death, to guide our feet into the way of peace.” Luke 1:78-79

We start this issue with a special statement by the Latin American Council of Churches, issued at the continental consultation on ‘The Churches and Sexual and Reproductive Rights’. The statement emphasizes the strong link between health and dignity.

The article on page 8 shows how research can feed into concrete action plans. The results of the research in question done by EPN, identifying a lack of information on HIV/AIDS and its treatment among religious leaders, as well as limited involvement of church health services in the provision of ARVs, led to the launch of a treatment literacy programme with impact showing how religious leaders have used their role as shepherds and influenced behaviour and attitudes of their community.

IMA World Health shares how some of their projects in Tanzania and South Sudan have changed the lives of many, restoring dignity, justice and health, while serving the ultimate goal of one day getting to an HIV-free generation.

Putting focus on the social angle to health, the organization called Women’s Health, HIV and AIDS Southern Africa (WHHASA) decided to work with Church leadership to reach out to women in grassroot communities in Zimbabwe. On page 18, read about an initiative driven by women: World Day of Prayer has moved from prayer to action in its response to the HIV pandemic, focusing for example on education about the virus and the pandemic.

From the world of academics, learn about the initiative called ‘base groups’ by St Paul’s University in Kenya: a unique educational concept, contributing towards best practice in mitigations against HIV & AIDS. This concept, established within the framework of a Master’s degree in HIV and AIDS care via reflective practice, has led to many Base Groups living long beyond the duration of the programme and even registering as FBOs and CBOs.

Finally, the International Network of Religious Leaders living with or personally affected by HIV and AIDS (INERELA+) shares how it has built on the power of religious leaders who are openly living with HIV as agents of hope. Also from INERELA+, find inspiration in a Bible Study which shows how women living with HIV and AIDS can be leaders in different places and sectors, driving the objective of getting to zero.

Annie Solis Escalante works at the Health and Healing Program at the World Council of Churches.

Elisabeth Goffin is Communications officer at the Ecumenical Pharmaceutical Network.
We, representatives of churches and ecumenical bodies, full, fraternal and associ- ate members who make up the Latin American Council of Churches, and special guests, coop- erating institutions, theological education cen- tres and other ecumenical bodies, participated in the continental consultation “The Churches and Sexual and Reproductive Rights,” in the city of Havana (Cuba), on 2nd to 22nd May 2013, on the occasion of the 6th General Assembly of the Latin American Council of Churches (CLAI) declare:

- We represent the diversity of our continent, which includes men and women, youth, indigenous people, Afro-descendants and others who belong to different sectors of the population and generations, and are part of civil-society organizations in the countries of our region.
- We have, within the context of committed faith, a role to play as agents of change at the community, national, regional and global levels, safeguarding the dignity and hu- man rights of all people; with our actions, we seek to have an impact on improving their quality of life.
- We promoted in 2012 twenty national consultations and four subregional con- sultations with the participation of leaders of various church bodies and civil society organizations of the respective countries, and the United Nations. The consultations provided a very special opportunity for reflection and analysis, from a biblico-theo- logical, public-health and anthropological perspective, on sexual and reproductive rights as contained in the Cairo Agenda, as well as on issues relative to discrimina- tion and racism, poverty, education, social movements and environmental protection.
- This process has involved intense discus- sions and debates that were reflected in a series of concrete statements, challenges and action proposals conducive to pro- moting the full exercise of human rights and a culture of peace and justice. We believe that we are walking fully in line with the Divine Will that seeks a dignified and abundant life for all its children. In fact, ev- ery human being is made in the image, ac- cording to the likeness of God (Gen 1:26) and is called to live a full, dignified and generous life; this is especially the case of popula- tions experiencing vulnerability and exclusion.
- We are of the view that the treatment of the themes of sexual and reproduc- tive health should be assumed within the context of human rights and should be guaran- teed by governments—be they con- fessional or secular. The prevention of gender and sexual violence, safe mother- hood, sexuality education, prevention and care for people with HIV and Aids, respect for the human body, and family planning. These issues are necessary and relevant to a true transformation of our societies.
- We have today, after intense research, the tools we need to facilitate this process, summarized in the training guide “The Churches and Sexual and Reproductive Rights” for faith communities, ecumenical organizations and networks of civil society organizations.

In this context we denounce the following:

- According to the Economic Commis- sion for Latin America and the Caribbean (ECLAC), Latin America and the Caribbean is the most unequal region in the world, with over 167 million people living in pov- erty and around 66 million living in extreme poverty, which means that approximately one of every three Latin Americans is poor and one of every eight is extremely poor. This is an unforgivable sin.
- Latin America and the Caribbean, with 148 million young people between 15 and 29 years of age, has the largest number of young people in the history of the region. This poses immediate challenges and mer- its urgent actions, as currently one of every 12 persons aged 15 to 24 has not com- pleted primary school and has acquired no skills for finding work, and about one-third of young people live in poverty.
- Maternal mortality remains an issue of great concern in the region, although it has declined (the average rate stands at 85 maternal deaths per 100,000 live births); the disparity between countries is very im- portant. Uruguay reported in 2012 a ma- ternal mortality rate of 20 maternal deaths per 100,000 live births and Guatemala, 120 maternal deaths per 100,000 live births. In contrast, Haiti shows the highest rate in the area with 350 maternal deaths per 100,000 live births. Around 95 per cent of maternal mortality in Latin America and the Caribbean can be prevented.
- Sexual violence against girls and adoles- cent girls is mostly perpetrated by relatives: fathers, uncles or close friends, men who should give them love and protection. The region has the second highest rate of teenage pregnancy in the world - after Africa - and it is estimated that 38 per cent of pregnant women are under 20. Violence against women is also an issue of great importance in the region and also occurs when women are not free to make decisions about their own sexuality. Women have experienced acts of physical and sexual violence perpetrated by their partners or husbands; women’s murders are growing at a rate higher than that of criminal homicide, and most of these acts occur at home.
- In Latin America, there are between 600,000 and 800,000 people, including children, youth and women, in the coun- tries of the region who are victims of traf- ficking for the purposes of sexual exploita- tion and similar activities. International migration and internal displacement have increased and run parallel to an unfavourable and xenophobic climate; one of the biggest challenges we face includes the need to protect the rights of migrants, para- particularly women, youth and girls.
- The current situation regarding the re- sponse to the HIV pandemic and Aids hides profound inequalities within and be- tween countries.
- The growing role of indigenous and Afro- descendant people reveals stark inequali- ties in terms of access to opportunities, exercise of rights, political and cultural recognition, as well as all kinds of stigma and discrimination.
- According to data from the World Health Organization, between 10 to 15 per cent of the population of Latin America and the Caribbean has some degree of violence, affecting approximately 85 million people. It is common to hear stories of sterilization, forced abortions and other custodial mea- sures relative to freedom of choice by this population.
In view of these structural sins, we, representatives of churches and other institutions present in this Continental Consultation, are aggrieved, hurt and challenged to act:

• In all areas of education and leadership training of our churches, we will formulate a concrete proposal for action on sexual and reproductive rights and health from a perspective of respect, to ensure that...
  “No more shall there be in it an infant that lives but a few days, (...) They shall not be... bear children for calamity” (Isaiah 65:20-23). At the same time, we exhort other faith expressions to join in these processes of dialogue and training on human rights, in particular, sexual and reproductive rights.

• Ensuring the full participation of young people as leaders in our faith communities, being at the forefront of development, supporting public policies and promoting their rights and needs in all spheres of life, including sexual and reproductive health, sexual diversity, affectivity and sexuality education, and access to appropriate health services.

• Promoting in the churches, families and society at large the building of training environments and spaces on new masculinities and respect for women and youth, to lessen the impact of widespread violence, gender-based violence and sexual violence on them.

• Advocating public policies and programmes to promote human rights and the eradication of all forms of discrimination, particularly against women, the elderly, the environment, indigenous and Afro-descendant people, migrants, lesbians, gays, transgenders, bisexuals and intersexuals (LGBTI), people with disabilities, and respect for diversity.

• “To contribute to a world where every pregnancy is wanted ... every birth is safe ... and every young person reaches their full potential.”

Submitted, agreed and adopted in plenary session in the City of Havana, within the framework of the continental consultation “The Churches and Sexual and Reproductive Rights,” on the 22nd day of May 2013.

Kate Gilmore, Deputy Executive Director of the United Nations Population Fund (UNFPA) saying a few words at the CLAI General Assembly. At the head table: Rev. Julio Murray, President of CLAI; Mariela Castro Espín, Director of CENESEX-Centro Nacional de Educación Sexual of Cuba; the translator Adolfo Fuentes; Rev. Nilton Giese, CLAI General Secretary; and Jessica Mora, CLAI Youth Ministry Secretary.

A comic strip from the series developed by EPN, addressing issues of HIV and the role of religious leaders in supporting access to treatment.
CHURCH LEADERS MAKING A CHANGE

HIV/AIDS remains an important topic on the global health agenda. In 2011, some 34.2 million people globally were HIV infected, with nearly 65% (23.5 million) of them living in sub-Saharan Africa. AIDS-related diseases accounted for 1.7 million deaths worldwide. Access to treatment and care has improved over the years, but for many people living with HIV and AIDS (PLWHA), life-saving treatment is still inaccessible. In 2011, about 44% of people in need of antiretroviral treatment (ART) in sub-Saharan Africa were not yet receiving it. In low and middle income countries in 2011, effective prophylaxis to prevent HIV infection in newborns was given in 61% of eligible cases during pregnancy and delivery and in only 29% of eligible cases during breastfeeding.

Ecumenical Pharmaceutical Network’s (EPN) HIV Care and Treatment Programme aims to address the gaps and contribute to MDG 6: Combating HIV and AIDS. We acknowledge that religious leaders have a key influence on the community, therefore we focus on empowering them with skills necessary to lead and mobilize communities to respond to issues of access to treatment for PLWHA. We acknowledge that religious leaders are integral to communities and play an important role in the lives of their communities. Investing in them with correct health messages, building their capacity to share valuable knowledge about HIV/AIDS, ART and involving them in fighting stigma is an efficient way to reach those who may otherwise have access to valuable health information. We would also improve the situation for PLWHA and their care takers.

Guided by this information, EPN embarked on a treatment literacy programme for church leaders aiming to fill the knowledge gap among religious leaders, as well as limited involvement of church health services in the provision of ARVs. And yet, religious leaders are integral to communities and play an important role in the lives of their communities. Investing in them with correct health messages, building their capacity to share valuable knowledge about HIV/AIDS, ART and involving them in fighting stigma is an efficient way to reach those who may not otherwise have access to valuable health information. It would also improve the situation for PLWHA and their care takers.

Experiences and success stories

In 2009, EPN facilitated four trainings in Cameroon. Seventeen religious leaders from Eastern and Western Province were trained in Yaoundé. The Eastern Province team conducted a similar training for 21 religious leaders in Batouassam with support from Catholic Church and EEC. The Eastern Province team trained 30 religious leaders and 3 journalists in Batouassam with support from the Catholic Church Coordination for HIV of the Diocese of Batouri. Since 2009, EPN has conducted 5 trainings to over 200 Christian church leaders in Western, Nairobi and Central regions of Kenya. Seventeen of the 24 trained in Kenya in 2011 and 6 out of 26 trained in 2012 have reported back to EPN on how they reached out to their communities to facilitate VCT services, referral to treatment centres, home-based care and adherence support.

Church leaders utilized the skills gained during the training to deliver anti-stigma messages and encourage care and support of PLWHA through preaching. Sermons were delivered by different church leaders in different settings such as church, schools, ‘harambee’ self-help events, seminars and workshops.

“Church leaders and the community should be encouraged to care and support people living with HIV in accessing and adhering to treatment.... It is not the role of the community to judge ... the sick as this causes stigma making the sick shy away from coming out and accessing the treatment they require. God loves His people and that is why through science he has provided ARVs giving hope to the sick for prolonged and healthier life.”

Church leaders also used this platform to warn against religious leaders who mislead PLWHA to abandon life prolonging ARVs by promising them miraculous healing when they plant a ‘seed’ by sending money or by prayers.

“I encourage [PLWHA] to access treatment and stay on it in order to be healthy and prolong their life. I take time to advise those who are cheated through prayer healing and ‘seed planting’ to continue taking their ARVs and proper nutrition so as to boost their immunity.”

Following the 2011/2012 trainings, 15 workshops and seminars for church leaders and community members were conducted in Kenya. Church leaders created women’s groups and youth forums to communicate messages on HIV/AIDS. Participants were engaged in interactive sessions to demystify myths around HIV infection treatment, encouraged to support and show compassion for PLWHA.

“Since the training, I continued sensitization with church members and the PLWHA. We encourage early and regular testing to church members. Patients are encouraged to have their CD4 checked to know when to start treatment. Those on treatment are also encouraged to adhere and take proper nutrition. More than 2000 people are reached with correct information through these activities.”

Support groups are important in encouraging PLWHA to seek and stay on treatment. Members get support emotionally, financially and they share information on HIV/AIDS and its treatment. Following EPN training, two support groups were established in Kenya. Both groups focus on HIV awareness, prevention, spiritual care, home-based care, counselling, nutritional support, treatment adherence support and income generating activities. One of the groups, composed of 2 female members, cooperates with church leaders during church events where they give testimonials of their HIV status, encourage testing and treatment. The group makes beaded baskets for sale to meet their nutritional and travel costs.

A support group enacting a play to pass important messages on HIV.
Church leaders have the will and commitment to invest their time and resources in supporting the fight against HIV/AIDS.

Stigma and discrimination prevent PLWHA from disclosing their status and accessing care and treatment services. It injects fear into people preventing them from accessing counselling and testing and eventually prevention services. Therefore, addressing stigma and discrimination is a key focus in the treatment literacy programmes for church leaders.

**Partnership**

EPN partners with local stakeholders in HIV/AIDS. During the World AIDS Day 2012, EPN supported Kenya Network of Religious Leaders living with or personally affected by HIV (KENERELA+) to promote the new comprehensive HIV prevention model - SAVE (Safe Practices, Education & Care, Voluntary Counselling and Testing, Education & Empowerment). EPN provided 6000 copies of HIV comic books to promote HIV/AIDS awareness to young people.

Increased financial and technical support would benefit successful HIV implementation by the church leaders. From several success stories, EPN has observed that the church leaders have the will and commitment to invest their time and resources in supporting the fight against HIV/AIDS. If they are able to complete these activities with little or no support, then with financial and technical support they would be able to do even more, reach more community members and have a greater impact with activities.

There is a need to come up with a policy that guides programmers and church leaders in addressing faith healing among church leaders and PLWHA as it misleads the latter to abandon the life prolonging drugs and thereafter die while waiting for miracle healing.

**Recommendations**

1. Church leaders command respect and are trusted leaders in their community; therefore, capacity building would ensure delivery of correct and appropriate HIV/AIDS information dissemination to their communities. This is vital for ensuring the decline in HIV/AIDS and fighting the stigma and discrimination that prevents PLWHA from revealing their status, accessing and adhering to treatment.

**Challenges**

1. Stigma is still deeply entrenched in society including in churches, which prevents their leaders from successfully reaching out to the community members and PLWHA.
2. Faith healing is a controversial topic that needs to be dealt with tactfully with evidence as it is a contributing barrier to adherence among PLWHA. Some faiths do not believe in accessing care from hospitals, thus preventing PLWHA from benefiting from ART.
3. There are concerns among church leaders about promoting condom use for married couples and young people.

Ecumenical Pharmaceutical Network (EPN) is a Christian, nonprofit independent organization. It is a worldwide network of associations, institutions, and individuals, committed to supporting the provision of quality, affordable medicines and pharmaceutical services in church health facilities. EPN’s mission is to support churches and church health systems provide just and compassionate quality pharmaceutical services.

**References**


**Guide**

Elisabeth Goffin is Communication Officer at EPN.

Grace W. Gathua is Programme Assistant – HIV Care and Treatment Programme at Ecumenical Pharmaceutical Network (EPN).
HIV AND AIDS: WORKING TOGETHER TO RESTORE DIGNITY, JUSTICE AND HEALTH

Notable progress has been made in the response to HIV and AIDS, and the faith community has played a significant role in these efforts. At IMA World Health, we attribute much success to the spirit of partnership, collaboration and creativity that faith based organizations (FBOs) like us are uniquely able to foster in the environments where we work to support health for the vulnerable.

IMA World Health has been working to reduce the impact of HIV/AIDS since 2000, starting in the Democratic Republic of Congo (DRC) where HIV/AIDS interventions were incorporated into larger primary health care projects. IMA has since expanded its range and methods of addressing HIV/AIDS, impacting hundreds of thousands of people at risk or already living with HIV in DRC, Tanzania and South Sudan.

Nyangeta, 29, is just one of the people whose lives we have touched through our work, and her story helps to illustrate the critical thread of collaboration that runs through our HIV/AIDS work and makes real change possible.

Meet Nyangeta

IMA World Health first met Nyangeta in November 2012 at the HIV/AIDS care and treatment center (CTC) at Musoma Regional Hospital in Tanzania. She was diagnosed with HIV just one year ago, and she was afraid. Nyangeta had depended on her aunts and older brothers and sisters for survival since she was orphaned at age 15, now she was nervous about how her family would react to the news.

“I was so disturbed by these results, it was very difficult for me to disclose to my brothers and sisters,” said Nyangeta. “However, when I joined the Groups for People Living with HIV/AIDS (PLWHA), through sharing, I was empowered, and disclosure was somehow easy. I am now living positively, and sometimes I go to work at the care and treatment center to encourage the newly diagnosed clients.”

IMA’s HIV/AIDS work in Tanzania

Nyangeta is a beneficiary of the Local Partners Excel in Comprehensive HIV & AIDS Service Delivery Project (Project LEAD), an HIV/AIDS care and treatment project that is being implemented through a critical set of partnerships between governments, international FBOs like IMA World Health, local organizations including the faith community, hospitals and clinics, support groups and individuals. Project LEAD (2011-2016) is funded by the United States Centers for Disease Control and Prevention (CDC) and is a follow-on project to AIDSRelief (2004-2012). Through a nearly 10-year history, these projects have provided HIV testing, counseling and treatment services free of charge to people in need as well as built capacity for care and treatment by training health personnel in diagnosis and clinical management, strengthening laboratory capacity and supply chain management, building health management information systems, and providing site management.

With Catholic Relief Services as the prime grant recipient of Project LEAD funding, IMA World Health is a project partner and leads capacity building, site management and technical assistance in 30 public and faith-based local partner treatment facilities in the Mara, Manyara, and Tanga regions of Tanzania. Efforts by IMA have resulted in nearly 170,000 patients enrolled in HIV care and approximately 97,000 started on antiretroviral treatment. Over the next five years, IMA will gradually transfer the management of these clinics to a local faith-based partner – the Christian Social Services Commission of Tanzania (CSSC) – whose capacity IMA has been working to build since Project LEAD’s precursor project, AIDSRelief. Through Project LEAD and AIDSRelief, IMA has not only supported people living with HIV/AIDS (PLWHA) through care and treatment but also is empowering CSSC as a local FBO to do more and more to support PLWHA – creating a more sustainable, locally owned and driven HIV/AIDS effort in line with the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and the United States Global Health Initiative. In this way, IMA and our partners like Catholic Relief Services will be effectively making our role obsolete – a major goal in the process of development.

HIV/AIDS and Cervical Cancer

Partnerships between key players are not the only “relationships” at work in combating the far-reaching effects of the HIV/AIDS epidemic. Rather than focusing on HIV/AIDS as a solitary, vertical public health concern, IMA is ensuring access to critical services for PLWHA such as screening for cervical cancer. Recent research has revealed that being HIV positive increases the risk of developing cervical cancer by at least 50%, as well as contributing to an earlier onset of the disease by 10 years.

Recently, during Nyangeta’s routine checkup at the CTC, a nurse educated her on the risk of developing cervical cancer, especially when one is HIV positive. Nyangeta had not heard of this before. Fortunately IMA World Health and partners began offering a program called “Cervical Cancer Prevention and Control” at Shariyi Memonite Hospital in 2011 and Musoma Regional Hospital in 2012, and the CTC nurse recommended that Nyangeta participate. She started talking with other women who had already been screened and they encouraged her to go for the procedure as well.

At Musoma Hospital, Nyangeta tested positive for cervical cancer using the visual inspection with acetic acid approach (VIA). Using this method of screening, a vinegar solution is applied to the cervix with a large cotton swab and left for 30-60 seconds, after which the cervix is visually examined with the naked eye and a lamp. Normal cervixes without any precancerous lesions do not change color, while precancerous lesions turn white when combined with the vinegar solution. Since the project utilizes a “Single Visit Approach,” Nyangeta also received cryotherapy treatment to destroy the cell. She was thankful for early detection and immediate treatment.

“I thank God for this opportunity,” Nyangeta told IMA afterward. “I would have reported with advanced cancer [if I would not have gotten my cervical cancer screening when I did]. I have already informed my friends through their mobiles. They are on their way, coming for this examination.”

While funding specifically for cervical cancer programs is not widely available, there is a great opportunity to integrate cervical cancer interventions with existing HIV/AIDS efforts. During the first year of the program (2011-2012), IMA trained 11 health workers in cervical cancer screening, treatment and referral techniques. They were able to screen 2,215 women that first year - most of whom learned about the opportunity for screening through their visits to HIV care and treatment centers, or through word-of-mouth from friends enrolled in care and treatment programs.

IMA World Health has been able to add cervical cancer screening and treatment to our Project LEAD efforts thanks to small grants from faith-based partners including Christian Church (Disciples of Christ) Week of Compassion and the American Baptist Churches (USA). These
partners have stepped up to help provide these critical services to people in need, and our hope is that this example of combining HIV/AIDS testing and treatment with related interventions can lead to other opportunities as well.

**Partnering to reduce the impact of HIV/AIDS in South Sudan**

In addition to these efforts in Tanzania, IMA’s HIV/AIDS work in South Sudan is also an example of how governments, donors, organizations, hospitals and clinics, and individuals at all levels can join together to stop the spread of HIV/AIDS and care for those living with HIV. South Sudan is a different context from Tanzania, as it is just emerging from nearly three decades of conflict, population displacements and widespread insecurity. Building an effective health care system is among the biggest challenges for the world’s youngest nation, and HIV/AIDS is among the most neglected issues facing the population.

While the dynamics of HIV/AIDS in South Sudan are not fully understood, it is widely acknowledged that HIV prevalence is increasing. Overall there is low awareness and knowledge about HIV—the result of a longstanding lack of HIV/AIDS interventions. Massive population movements are still taking place, largely from rural to urban areas. Common cultural practices such as polygamy, wife inheritance, tribal markings, and cultural tooth extraction put people at risk. All of these factors contribute to massive population displacement, and widespread insecurity. Building an effective health care system is among the biggest challenges for the world’s youngest nation, and HIV/AIDS is among the most neglected issues facing the population.

The project also worked to educate prisoners and prison personnel through close partnerships with local actors, who conveyed HIV prevention messages through entertaining skits and role playing. They distributed and demonstrated the use of male condoms. Twenty-three people (6 women and 17 men) out of 269 were tested. Two men and one woman were found to be HIV-positive and were referred to the ART clinic for care and treatment through prison administration.

Ensuring that the local health facility is able to properly care for HIV-positive patients is key. Therefore IMA worked with the State Ministry of Health (SMOH) to identify key health facilities that were in need of rehabilitation (expansion and repair) to accommodate care and counseling as well as areas needing construction. IMA and the SMOH also worked together to ensure that these facilities had the appropriate testing supplies and equipment to care for the individuals. Using these methods and partnerships, IMA was able to ensure that each step of the process from testing through treatment would be strengthened to help meet the project’s goals.

One day soon, through our work in Tanzania, South Sudan and beyond, IMA hopes to share the success of an HIV-free generation with the many partners and individuals we have worked with along the way. It is only through such partnerships that this goal will become a reality. 

**References**


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**BUILDING A COLLECTIVE ADVOCACY FORCE FOR WOMEN AFFECTED BY AND LIVING WITH HIV IN FAITH COMMUNITIES**

As HIV and AIDS continue to progress, it has since been realized that it is no longer just a medical condition but also a social challenge that needs to be addressed holistically. It is against this backdrop that Women’s Health, HIV and AIDS Southern Africa (WHHASA) realized the need to reach to communities through the Church.

The Church, which is one of the most organized institutions in any society, has proved to be a window of hope for responding to the effects and challenges of HIV and AIDS. WHHASA, in collaboration with the Ecumenical HIV and AIDS Initiative Africa (EHAIA), held several virtual dialogues with women in faith communities in Zimbabwe from 2012-2013. The objectives of the dialogues were to improve women’s access to sexual reproductive health and rights (SRHR) by informing and mobilizing women around issues of SRHR, and engaging health service providers and church leaders to scale up women’s access to such comprehensive quality SRHR as PMTCT (prevention of mother to child transmission), family planning, maternal health care, and cervical cancer screening and treatment. All the efforts were guided by the Zimbabwe National AIDS Strategic Plan Two (ZNASP II) which is coordinated by the National AIDS Council.

**Cervical cancer**

Research has shown that 80% of women living with HIV are also prone to developing cervical cancer. Cervical cancer is a major cause of mortality among women, in particular those living with HIV. Lack of awareness and unavailability of services is an obstacle to accessing services for women and girls. Many survivors of rape and sexual assault do not access the Post Exposure Prophylaxis because they do not know about it, and even if they do, they cannot access the service because it is only available at major hospitals. Due to the vulnerability of marginalized women – sex workers, migrant and internally displaced women, women in informal settlements, (squatter camps), women in faith communities, and women with disabilities – they typically have no access to HIV prevention, treatment and care services.

Sexual and reproductive health services concern the wellbeing of a woman’s health including the men. Cervical cancer is the most common type of cancer in Zimbabwe. Cervical cancer can be treated if it is detected early through a pap smear test or “Visual Inspection with acetic acid” (VIA) which can be done by a health worker.

Advocacy through community dialogue

The target audience for the community dialogues were women living with HIV, young women, men, health professionals, church pastors and women in faith communities. This strong collective advocacy force by women in faith communities created a platform that allowed women from grassroots communities to join a virtual global community to discuss their experiences, share successful strategies to overcome barriers and develop a shared advocacy message on issues affecting them. This advocacy strategy heightened focus on issues related to women’s health, women living with HIV, affected by and at risk of HIV.
A discussion forum at a Church in Mabvuku High Density Suburb Harare, Zimbabwe.

With support from the church leadership, WHHASA and EHAIA were able to reach out to young women in grassroot communities. The church leadership mobilized their communities to attend and participate in these dialogues. Health workers, who included nurses and doctors from the local clinics, were also invited to participate in the dialogues. They answered questions from the women regarding services rendered and experiences at health centres.

Churches from various grassroot communities in Zimbabwe offered the use of their facilities. Each dialogue addressed different relevant local issues requiring community, national, regional and global advocacy. The topics covered included: (1) Global Plan (Prevention of Vertical Transmission); (2) SRHR; (3) Accelerated Agenda (Gender Inequality); and (4) Overcoming Stigma. Each facilitated dialogue gave participants the chance to discuss their personal experiences and potential strategies to address the issues on a personal, local, national and international level. Some health professionals would rather have women who are HIV positive not to have children and considering that it is too high a risk, especially in the environment of Zimbabwe where treatment is not readily accessible to all those in need.

Capacity building strategies

WHHASA successfully worked with the church leadership in implementing capacity building strategies centered on the empowerment of women on gender inequalities, empowering young women on predisposing factors that make them vulnerable to HIV. The delivery of seminars during the Sunday church service aimed at addressing HIV stigma and discrimination and capacity building workshops for young women, women and lady pastors on SRHRs. There was free discussion on issues of HIV and AIDS which indicates that the Church is generally open minded to discuss such issues. There were a number of challenges that communities are failing to deal with as regards to HIV and AIDS. This is mainly due to inadequate or incorrect information. There are a lot of misconceptions attached to HIV and AIDS. These have heavily contributed to stigma and discrimination of people living positively with HIV. The experiences that the Church leaders shared reflect that the Church has been making a deliberate effort to address HIV and AIDS within its congregations but more is needed as stigma and discrimination are still rife in the church. Stigma and discrimination associated with an HIV positive status and the fear of violence from partners deters many women from accepting on prevention and treatment information, including accessing VCT and PMTCT. This is compounded by the criminalization of non-disclosure.

Women still bear the brunt of the HIV pandemic. They take care of the terminally sick in the family. When the woman is sick, she might go to the clinic and fail to get services, which increases her chances of not getting back to the clinic as she has to attend to household needs of tending for her family at the cost of her health. The percentage of women and girls getting infected with HIV is still very high and women can still not protect themselves from HIV. Women still do not have access to information and services as some are forced to walk long distances to go to a health centre. The girl child is still disadvantaged over the boy child as her needs are given second priority.

A call was made for the Ministry of Health and Child Welfare to invest in SRHR for women and girls because decentralization of services still remains of importance. There is need for mobile clinics to cater for particularly rural women, as well as meaningful involvement of women living with HIV/AIDS, through raising cervical cancer champions and role models from those who underwent the colposcopy cancer treatment to influence uptake of such services and keeping women healthy. A call was made that “No woman must die of cervical cancer”. There is also a need to invest in training the health technicians who administer the cervical cancer treatment processes as currently there is a shortage of these. The women called for the scrapping of user fees for cervical cancer screening and treatment in the same way maternity user fees have been scrapped to encourage the demand and uptake of services aimed at keeping women healthy.

SRHR of young girls is also an area which was being under-resourced. The needs of young women in accessing reproductive health services were poorly understood; therefore they were poorly catered for in existing health institutions. There is also a need to ensure availability of drugs at health facilities and address cultural and religious attitudes that stigmatise and censor young people who seek SRHS, particularly regarding condoms. Young women encounter social, cultural and economic barriers to accessing information and health services. Some of the advocacy messages that came out of these dialogues were:
1. Vital services in the form of counselling from the church through contextual bible study were important to women living with HIV as this helped a lot to reduce stress to cope with that condition.
2. The dialogues helped to make the church community appreciate the level of stigma and how they contributed to the stigma.
3. The church was the place of hope for many living with and affected by HIV and it was also an avenue to address issues of gender based violence against women.
4. Human rights must be upheld and protected at all levels of implementation of the Global Plan.
5. The sexual and reproductive health rights of women living with HIV should be more comprehensively addressed in faith communities. Intimate partner violence must also be comprehensively addressed.
6. Community accountability: women need to have access to full information and have time to make informed decisions regarding their health. Women living with HIV need to be equal partners in the monitoring and accountability for human rights violations and health service quality.
7. Evidence-based planning: there was a call to support consultations with women living with HIV in order to ensure that Global Plan Policy-making responds to experiences at the grassroots level.

Tendayi Westerhof is Regional Coordinator at WHHASA - Women’s Health, HIV and AIDS Southern Africa

About WHHASA

WHHASA was founded by Tendayi Westerhof who is a Zimbabwean woman, an author and an AIDS activist living openly with HIV for over a decade. She reached out to a group of women and men personally affected and living with HIV from various sectors in Zimbabwe. Mrs Westerhof is a member of the International Community of Women Living with HIV (ICW).

WHHASA is a platform of Southern African women and girls personally affected and living with HIV in the 14 Southern African Development Community (SADC) member states. It was created to provide southern African women and girls personally affected by and/or living with HIV, women and girls in faith based communities, sex workers, women in prisons, women in grassroot communities, a home-grown mechanism to meet and discuss common issues that affect their health, outline leadership, joint positioning roles and identify advocacy issues at community, national, country and regional levels in their response to HIV and AIDS. WHHASA is an advocacy platform organised to influence community, national, regional, continental and global processes relating to HIV and Sexual and Reproductive Health and Rights.
PRAYERFUL ACTION: WORLD DAY OF PRAYER Responds to the HIV Pandemic

World Day of Prayer (WDP) is an International movement of Christian women from various traditions who come together to observe a common day of prayer each year. However, the movement goes beyond just prayer, and lasts for more than just one day.

Inspired by the organization’s motto, ‘Informed Prayer and Prayerful Action,’ National Committees across the globe engage in various acts of service to their local, national, and - in many cases - international communities. This action is almost always inspired by the worship celebration which they have just engaged in on the first Friday of March. These celebrations are planned and written by different National Committees who are chosen every five years at the WDP International Committee’s (WDPIC) Quadrennial Meetings.

One of the goals of WDPIC is to encourage women to have greater awareness of the world around them and to be enriched by the faith lives and experiences of other women across the globe. Towards that end, writer countries are encouraged to bring to their worship a focus on women’s issues from within their own countries. Prayers and Bible studies are then linked to those issues in an effort to shed light on instances of injustice and other social concerns that women face within the writer country. It is encouraged that this informed prayer will then lead worship participants to prayerfully consider if and how those same burdens exist within their own borders. This reflection should then lead to the response of prayerful action whereby what has been brought to light will be confronted and called out to be the injustice that it is.

This pattern can be found in each and every World Day of Prayer service and is what led to WDPIC’s focus on the HIV pandemic. The focus really started taking root in 2003 though the effects of the pandemic had been on the radar since at least 1999. In late August/early September of 2003, 215 women from 100 different countries gathered in Swanwick, England to participate in the Quadrennial Meeting for WDPIC. During this meeting, Battu B. Jambawal of the All Africa Conference of Churches, was invited to speak about the impact of HIV as experienced in sub-Saharan Africa and its effect on the experience of women there. Jambawali said, “Furthermore we cannot deal with the [HIV pandemic] without dealing with key variables in the pandemic such as gender vulnerability, violence against women and poverty. It is a reality that HIV is increasingly becoming a disease of the people who are at the margin of society - the very place where many women in Africa live.”

This meeting began a long term focus for WDPIC on the effects and root causes of the HIV pandemic, and in 2005 the Executive Committee of WDPIC wrote a recommendation to all National Committees advocating for a focus on HIV awareness. In this recommendation, the committee says, “We have come to understand that women are disproportionately more vulnerable to this disease because of social conditions, such as poverty, war, military conflicts, and violence against women, to name just a few of the causes.” Adding that more often than not these same women also have the responsibility of caring for the sick and taking in children who have been orphaned by the HIV pandemic. At the time, four recommendations were made:

1. To educate ourselves and our committees about HIV.
2. To identify existing networks already working with HIV efforts and to find ways to support them either physically or financially.
3. To educate churches in order to help them understand the correlation between HIV and women’s rights issues.
4. To understand that when one member of the body of Christ suffers we all suffer with them.

Worship with a purpose

The first worship to follow the above recommendations was in 2006 and was written by WDP South Africa with the theme of “The Signs of the Times.” This worship service and its focus on the South African context re-established connection with the 2003 Quadrennial Meeting and refocused women around the world to the effects and root causes of the HIV pandemic. A prayer from this service galvanized WDP women around the globe into a prayerful response, “Lord, encourage us to reach out to our brothers and sisters in Christ who are suffering from HIV and AIDS. Empower each one of us and your Church to be sources of support and strength. With your help we will be signs of hope and compassion in times of hardship.”

Since 2006, National Committees all across the globe have continued to answer the call to education and to service in light of the continuing pandemic. In fact, after the 2010 worship celebration - written by the women of Cameroon with the theme of “Let Everything That Has Breath Praise God” - the focus on HIV was continued with the WDPIC Executive Committee recognizing that the root causes of HIV are the same as those for Human Trafficking. We continue to track the work being done through our annual journal and the replies are as many and varied as the Committees themselves. What follows is an attempt to summarize the different ways women are finding to respond to the crisis, highlighting some of the responses that best represent the work being done throughout the different communities. These responses seem to follow similar patterns throughout the years and fall into three categories: 1) Education 2) Physical or monetary aid and 3) Prayer.

The overwhelming response has been in the area of education. Committees are not only working to educate themselves about the pandemic, but their churches and communities as well. Many committees are very small so they partner with other more established organizations, like the Salvation Army, YWCA, or denominational organizations, to do this work. The educational opportunities can take many roads yet they always have the same intent: the education of self and others. Many committees began by educating themselves first on what HIV is, how it is spread, the preventative measures that can be taken, as well as the treatment possibilities that exist. For some, this was the first time that they had encountered even the most basic knowledge of the pandemic. Many times these communities expressed surprise at the vast numbers of people living with HIV.

WDP Netherlands said this in their most recent report, “Neither the trafficking nor the AIDS and HIV problems can come to a solution if we are not prepared to share. The only solution is to educate people….” To that end, not just in the Netherlands but also in many other WDP countries around the world, women are working to bring HIV education and awareness to their communities. This is most often accomplished by holding seminars in schools and churches. These seminars will often target the youth of the population. For example, Mauritius organized a weekend residential retreat for youth aged 13-25 to discuss the causes and dangers of HIV and to urge people to live a healthy sexual life by teaching about how HIV is spread and educating the youth on preventative measures.

There are also committees who are working to support different organizations both monetarily and with hands-on help. Communities who find themselves in areas that are especially impacted by the HIV pandemic are able to have a more hands-on response. Many WDP committees in Africa have reported that they are volunteering with hospitals and clinics in their area providing care for the patients and support for the families. Some committees, as was reported by WDP Zambia, are raising money financially to help and support those children orphaned by the pandemic. They collect...
monthly offerings to help provide funding for school fees, for food, for clothing, and other essentials that the families need. Also, Tanzania works closely with a group which deals with distributing antiretroviral treatments to church owned hospitals where people living with HIV can get free counseling and treatment.

WDP committees who find that they are not physically able – either because of distance or other barriers – to provide hands-on relief work are finding ways to reach out financially to communities impacted by the epidemic. Many committees have partnered with other relief agencies and have committed to sending monetary donations that help the agencies do the work of aiding those most affected by this pandemic.

An example of a committee who has done this is Honduras. In 2006, they donated their offering from their WDP celebration to an organization that works with indigenous communities in that country. Honduras reported to WDPIC that the agency used the money for HIV educational campaigns, and non-representation in governmental decision making procedures. In this kind of context of HIV and AIDS, the stigma associated with the pandemic is still so strong and much work still needs to be done in challenging and removing it.

Currently, much focus in the WDP network has turned to how the root causes of HIV are linked to the root causes of human trafficking. As Battu Jambawai reminded us in the earlier quote, it is women who find themselves many times at the margins of society. They will face economic disparity, poor or no access to education, and non-representation in governmental interpretation of data is recognized and celebrated. The purpose of education in the School of Theology, Religious and Islamic Studies is to provide the following opportunities:

First, through the Base Groups, students can find the dual opportunities of both testing the best practice models, which could leave out key issues and key people. To achieve that dialectic, the programme was rooted in the reflective-practice based pedagogy as espoused by Schon, Friere, Argyris, Kolb, and other educators of the phenomenological-interpretive-collaborative-empiricist-collaborative school.

What are “Base Groups”?

Base Groups are groups of 20-25 men and women infected with or affected by HIV and AIDS at the grassroots community level. Each student undertaking the MA degree in Community Pastoral Care and HIV & AIDS at St. Paul’s University, Kenya, is required to form such a Base Group within the local context of his or her professional practice. The purpose of Base Groups is to provide the following opportunities:

HIV and AIDS was declared a national disaster in 1999 and soon after that St. Paul’s University began an education programme both at undergraduate and post graduate level to prepare students to minister to those affected by and infected with the virus. Through developed curriculums, students received a multiparameter approach to HIV and AIDS, whether they were enrolled in an undergraduate and/or a postgraduate programme.

The MA programme in Community Care and HIV and AIDS of St. Paul’s University, Limuru, Kenya has scored a world first in that it became the first programme to offer a full Master’s degree in HIV and AIDS care via reflective practice. This unique initiative, which not only fulfils the theoretical and practical criteria for best practice models, has made a tangible, people-driven impact towards HIV and AIDS mitigations both in Kenya and in several African countries and even in the USA. That initiative is the Base Groups formed by students since 2003 as a requisite towards the MA degree.

In 2000, the Faculty of Theology of the then St. Paul’s United Theological College, Limuru, Kenya decided to launch an MA programme in Community Pastoral Care in the express mission of University Education (CUE). One major highlight of the programme was that it focused on a hitherto rather neglected dialectic between theory and practice in teaching some programmes which could leave out key issues and key people.

A PEOPLE-DRIVEN MITIGATION AGAINST HIV AND AIDS: THE STORY OF THE BASE GROUPS

Base Group is a unique educational concept, contributing towards best practice in mitigations against HIV & AIDS and having been used in the Masters Programme in Community Pastoral Care and HIV & AIDS at St. Paul’s University since 2003. As a result of St. Paul’s University’s unique initiative, Base Groups in Kenya and other countries have grown from 30 to about 400 in the past seven years with a total membership of around 7,000 infected and affected persons. Base Groups have contributed uniquely to best practice by generating sustainable models of mitigations at grassroots levels.
nian and Argyrian paradigms is not so much to protect the infallibility of the given theories, but to question them, and critique them, and to actually test them on the ground to see whether and how far they are true and applicable to the given specific socio-cultural contexts. This is very apt when we do research in the African socio-cultural contexts. For African peoples, culture is something embedded right into the mindsets of the people, their worldview, their value-systems, and even their faith-worlds and health-worlds. Culture is not something ‘out there’ which can be studied objectively and dispassionately. This insight becomes very pertinent when one undertakes research into such a sensitive area as socio-cultural responses to HIV and AIDS. Locally constituted Base Groups can provide the students with the invaluable opportunity of engaging with the dynamics local socio-cultural experience, use that experience as data, and use that data to test earlier given theoretical sets and finally use the entire experience to generate new theoretical sets.

Secondly, Base Groups can provide students with the opportunity to turn concepts into concrete experiences. Take, for example, the war against Stigma and Discrimination in the socio-cultural, religious, and political contexts of HIV and AIDS. On its own, ‘Stigma and Discrimination (or S&D) is merely a concept, even an apparent abstraction. But engagement into real-world situations out there can help one to understand how exactly the HIV and AIDS related S&D is at work in concrete situations, what are some its tangible examples, how exactly it is felt by the victims, and why it should be fought against.

Thirdly, Base Groups provide students with the opportunity to relate classroom-learning to community-experience. Conventional models of education, especially those of professional education, are often accused of becoming like ‘breaks from work.’ In our model, however, Base groups help students to keep engaged with the same society that they would be serving after their education. Students can test the veracity and validity of their classroom learning against real-life experiences in their own communities.

Fourthly, Base Groups can provide students opportunities to create sustainable models of HIV and AIDS mitigations through community participation. Owing to the urgency of the HIV and AIDS related situations, students do not have to wait until they finish their education to work with the communities to find solutions. With the help of Base Groups, students already engage with the community to work on solutions.

Fifthly, Base Groups can become effective tools to help students to acquire lifelong education through reflective practice and action learning. The reflective practice model used at St. Paul’s requires a constant situational analysis, which can be greatly facilitated by Base Groups. Furthermore, these groups can help facilitate action learning for students by helping to locate knowledge in life-experiences. David Kolb, for example, in his ‘experiential learning’ theory has argued that learning takes place in four stages:

1. Immediate concrete experience is the basis for
2. Observation and reflection;
3. These observations are assimilated into a “theory” from which new implications for action can be deduced
4. These implications or hypotheses then serve as guides in acting to create new experiences.

Base Groups can help facilitate this kind of learning.

Sixthly, Base Groups help students to carry out collaborative research through participatory, ideographic and contextual designs. This is especially true when students want to engage in community mapping exercises. Base Groups can mobilize the community to participate in such exercises.

And finally, Base Groups can help to create sustainable models of best practice. With all the above contributions put together, Base Groups can provide the much needed support to students to become best practitioners, which is the ultimate objective of the programme.

As a Masai following a traditional way of life, I have now received information and knowledge that can help us to change positively and fight HIV. I now know how to use a condom.” (Maasai Wellness Programme, Kajiado led by Rev. Gordon Opyo)

“I no longer feel like a sinner and condemned any more for being HIV positive” (Gikigie Community Friendly Group, Othaya led by Lucy Wairimu Ngahu)

“The care delivery by base group members has really improved my life and the lives of the orphans, widows and widowers that the base group has been able to reach out to.” (Mwangaza Group, Mulundu sub-location, Hamisi District, Vihiga County led by Pamela Amalemba)

A Theoretical Framework Driving Base Groups

Butterfly effect/Ripple effect/Domino effect

All theories in the above group are based on the principle of sensitive dependence on initial conditions. In other words, no movement - however tiny - whether in the natural environment, or in the social environment, or even in the mathematical environment, cannot happen without causing another movement and thus triggering a chain of resultant phenomena. Put in the layman’s language, the flapping of a butterfly’s wing in Brazil can cause a storm in Texas (or delay or postpone the storm, for that matter). Computer scientists at Cornell University have applied the butterfly effect theory to the worldwide web context and argued that a single e-mail in Brazil can cause a social chain reaction in Texas.

On the social scientific canvas, the “sensitive dependence” group of theories can explain the phenomenon of social “ripple effects.” A small initiative, for example, by a forgotten community in a remote village can cause a chain reaction of mutually dependent events and multiply the tiny effects of the initiative into a community-transformative impact. In the case of St. Paul’s MA programme in Community Pastoral Care and HIV & AIDS since 2003, the students began with some 30 Base Groups in 2003. Today their ripple effect has multiplied to some 400 such groups actively involved on issues of HIV and AIDS.

The Success of Base Groups

The Base Group experiment has been greatly successful at St. Paul’s in that since the inception of the programme in 2003 today we have nearly 400 active Base Groups in Kenya involving 6,000-7,000 men and women. Interestingly most Base Groups have continued operating even after the founding students graduated. Many Base Groups have now been registered as FBGs and CBGs. The authors have visited many of the base groups as far as Atlanta (USA) formed by a former student Sandra Thurman.

The Late Rev. C. B. Peter, BTh, BD, MTh, was a Senior Lecturer in the Faculty of Theology at St. Paul’s University. At the time of his demise he was finishing his doctoral thesis on “The Role of Mapping in Theological Reflection.” Prof Esther Momoho, PhD, DD (Hon Caus.), is currently the Deputy Vice Chancellor (Academic Affairs) of St. Paul’s University and an Associate Professor in the History of Christian-ity and lecturer in Gender, HIV and Theology.

References and notes

3. ‘Butterfly effect’ actually refers to the Lorenz Curve (in the shape of the flapping wings of a butterfly) brought to the world’s attention by the MIT professor Edward Lorenz, proponent of Chaos Theory. According to this theory even the slightest variance (to the 5th decimal point) in the input data can change a mathematical equation to vast and unpredictable proportions.
LIVING WITH OR DYING OF: BUILDING RESILIENCE SOCIAL CAPITAL

I was diagnosed as HIV positive in 1999. The most common motif about HIV and AIDS in those years was the reality of death. It took a lot of healing and liberation to reach a point where I chose to live with HIV instead of preparing for my death. Religious communities are still struggling to develop positive messages in the era of HIV that will promote inclusiveness and healing for all key populations.

From wounded healers to agents of hope

One of Henri Nouwen’s books titled, “The Wounded Healer: Ministry in Contemporary Society,” emphasizes the importance of recognizing that our woundedness can be a source of strength in our healing ministry. Carl Jung developed the concept of a wounded healer. He believed that “The measure of one’s ability to heal both self and others is determined by their ability to recognize their own pain and need for healing.” This is one of the pillars that I used to turn my life around. In 2002, I was present when a conscious decision was taken to form a network that can bring about individual healing for us as Religious Leaders living with HIV (RULH) and our families. When we as Religious Leaders share our own stories, people are inspired and begin to perceive their own journeys in a more positive light.

INERELA+

The International Network of Religious Leaders living with or personally affected by HIV and AIDS (INERELA+) was born exactly to empower and engage religious leaders to live positively and openly. It is important for all Religious communities to realize the power of religious leaders who are openly living with HIV as agents of hope. Offering us appropriate and non-paternalistic support is part of the calling and the mandate of the Faith Community. May we all earnestly participate in the pilgrimage that will make us a community that cares and strives for the UN-AIDS getting to zero.

These empowered religious leaders were instrumental in the identification of the barriers that made it difficult for People living with HIV to live their lives to the fullest. It became very clear that anti-SSDDIM strategies had to be developed. SSDDIM stands for the evils that led to the unnecessary loss of lives within communities, namely, Stigma, Shame, Discrimination, Denial, Inaction and Misaction. The 28 country networks that are spread across the globe are committed to the promotion of anti-SSDDIM strategies.

SAVE Prevention Strategy And Toolkit

INERELA+ also developed a new non-moralistic life promoting prevention strategy popularly known as SAVE. The ABC (abstain, be faithful, use condom) strategy focused on one mode of transmission, which is sexual intercourse. There was recognition of the fact that one of the gaps and important issues that had to be addressed was the development of a comprehensive strategy that people could use to protect themselves.

SAVE is an abbreviation that stands for Safer practices (A+B=C=PMTC+ Safe blood+ Safe injections+ Safe circumcision), Access to treatment (STIs + ART + nutrition + clean water), Voluntary testing and counselling (routine counselling, stigma issues and treatment), and Education and Empowerment (gender justice + policies + rights).

An important part of the SAVE methodology is that SSDDIM are often the reasons that individuals and communities respond to HIV in ways that are life diminishing and life denying. Once again, whenever individuals and communities encounter SAVE they will also be challenged to recognise SSDDIM and to change their attitudes and behaviour. The Global Working Group to SAVE lives, which was spearheaded by Canon Dr Gideon Byamugisha, has also made a commitment to promote pro-SAVE and anti-SSDDIM programmes and interventions.

INERELA+ has developed a toolkit to address all these issues. At least 1000 Religious leaders globally have been trained on how to use the Toolkit.

Christian Aid, Ecumenical HIV and AIDS Initiative in Africa (EHAIA), KwaZulu Natal Christian Council (KZNC) and many other partners at local, district and national levels are forming strategic networks and partnerships to collaborate in rolling out the SAVE campaign.

Groundbreaking initiatives

INERELA+ Zambia has developed its first sustained involvement with the Islamic community in Africa. This has been an exciting journey that started with a single HIV positive woman, realising the need for access to SAVE information. Through her work with women and young people – initially girls and then boys who were drawn into the circle of influence – the Grand Mufti of Zambia became interested and lent authority to the various programmes carried out through the Lusaka Islamic Women’s Fellowship. This sustained and long-term relationship is a real credit to the INERELA+ Zambia National Team.

Support for Sexual and Reproductive Health and Rights continues to be a unique focus of the INERELA+ SAVE Methodology. As such a number of partners are committed to increasing the capacity of INERELA+ to deliver more comprehensive sex, sexuality and gender education. INERELA+ representatives from Zambia, Zimbabwe, South Africa and Kenya have been trained as part of a 3-year project of training and mentoring. A number of the exercises in the SAVE toolkit were developed in partnership with some of these partners and this ongoing relationship has strengthened our capacity considerably. There has been improved training of religious leaders in SAVE as well as support to religious leaders in the implementation of programmes at congregational level.

Gender-based violence and gender justice have always been folded into the SAVE methodology but have been given renewed focus. INERELA+ has embraced the “Thursdays in Black” Initiative and, along with other partners, will develop this during this year’s “16 Days of Activism”.

Conclusion

Choosing to live with HIV as opposed to dying of it has been the catalyst for the successful programmes that are led specifically by religious leaders, ordained or lay, who are living with HIV. We are committed to ensuring that the next generations do not go through the struggles that we went through. INERELA+’s vision, which was developed long before the UNAIDS’ “getting to zero” theme is: INERELA+ envisions a world where HIV- and AIDS-related stigma, infections and deaths are eliminated.

It is important for all Religious communities to realize the power of religious leaders who are openly living with HIV as agents of hope. Offering us appropriate and non-paternalistic support is part of the calling and the mandate of the Faith Community. May we all earnestly participate in the pilgrimage that will make us a community that cares and strives for the UN-AIDS getting to zero.

Phumzile Mabizela is Executive Director at INERELA+

References

WOMEN LIVING WITH HIV AND AIDS

POSITIVE USE OF RELIGIOUS TEXT

With regard to HIV and AIDS, inequality is one of the pertinent issues that have driven a sense of self-stigma. This has made it difficult for religious leaders to become victors and agents of transformation. The distortion of the sacred texts has led to the belief that if you are affected by HIV and AIDS, you are not worthy of God's grace. For African women, what we refer to as triple oppression has made it even more difficult for them to lead the agenda in an HIV and AIDS era. The three layers of gender, race, and class are heavy on their own. Adding HIV on top of these layers has almost been unbearable for some.

At this point I would like to share an example of a text that can be used either positively or negatively to advocate for the engagement of all citizens irrespective of their gender, class or HIV status. Luke 10: 38-42 is one of the texts that have been used to compare decisions taken by women. It tells the story of sisters Martha and Mary when Jesus visits them. Martha, who is busy serving the guests, complaints to Jesus about Mary, who has chosen to sit at Jesus’ feet. Jesus’ response in verses 41 and 42 reads: “Martha, Martha, you are worried and distracted by many things, there is need of only one thing. Mary has chosen the better part, which will not be taken away from her.”

This text has been interpreted and used in many ways. One common interpretation has been that Jesus vindicated Mary for being her disciple and abandoning her domestic responsibilities. Another interpretation has been that true discipleship has a combination of spiritual and domestic service. This has brought about a lot of confusion and division to women, especially those who are living with HIV, who are called to serve in either one of these callings.

Elizabeth Schussler-Fiorenza proposes that we should use both the hermeneutics of suspicion and hermeneutics of remembrance to oppressive functions and implications of this text. She further asserts that employing these tools will help us to: “Break the dualistic construction of the Lukan text and to celebrate the two female characters as historical and independent apostolic figures in their own right... it allows us to reclaim the speech as well as the theological agency of these two women.”

It is important for us to use these texts to mobilize women, key populations and other minority groups to stand in solidarity and fight together for their freedom to choose where and when they want to lead.

According to Jane Schaberg, in, “Women’s Bible Commentary: Expanded Edition with Apocrypha,” it is stated that Martha and Mary appear in a different light in the book of John. In John 11:1-45; 12: 1-8, Martha, who serves at the table, makes the central christological confession of this Gospel, of Jesus as the Christ (cf. The confession of Peter in the Synoptics), and Mary, who also enters into dialogue with Jesus, performs the prophetic role of anointing Jesus’ feet. In John’s portrait of the two sisters, diaconia of the table and of the word remain integrated.”

Therefore women living with HIV and AIDS can be leaders in different places and sectors; this is the only way we will achieve balance and do away with the unfortunate incident of undermining their leadership according to our own stereotypical priorities, especially in the HIV and AIDS era. We all have an important role to play if we are committed to getting to zero: zero infections, zero discrimination and zero HIV and AIDS related deaths.

Phumzile Mabizela is Executive Director at UN Women.

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