Treatment Adherence and Faith Healing in the Context of HIV and AIDS in Africa

Training Manual for Religious Leaders

World Council of Churches

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IN THE CONTEXT OF HIV AND AIDS IN AFRICA
Training Manual for Religious Leaders

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Acronyms

ABC	abstain, be faithful, use a condom
AIDS	acquired immunodeficiency syndrome
ANERELA+	African Network of Religious Leaders Living with and Personally Affected by HIV and AIDS
ARASA	AIDS Rights Alliance for Southern Africa
ART	antiretroviral therapy
AWET	Apostolic Women Empowerment Trust
CHAZ	Churches Health Association of Zambia
CMC	Christian Medical Commission
EPN	Ecumenical Pharmaceutical Network
FBOs	faith-based organizations
GBV	gender-based violence
HIV	human immunodeficiency virus
INERELA+	International Network of Religious Leaders Living with Or Personally Affected by HIV and AIDS
IRCU	Inter-Religious Council of Uganda
NACC	National AIDS Control Council
NEPWHAN	Network of People Living with HIV/AIDS in Nigeria
NINERELA+	Nigeria Network of Religious Leaders Living with or Personally Affected by HIV/AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PLWHIV	people living with HIV
SAVE	safer practice, access to treatment, voluntary testing and counselling, empowerment
SRHR	sexual and reproductive health and rights
SSDDIM	stigma, shame, denial, discrimination, inaction, and mis-action

UAC	Uganda AIDS Commission
UCMB	Uganda Catholic Medical Bureau
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNERELA+	Uganda Network of Religious Leaders Living with or Personally Affected by HIV and AIDS
UPMB	Uganda Protestant Medical Bureau
WCC	World Council of Churches
WCC- EHAIA	World Council of Churches–Ecumenical HIV and AIDS Initiatives and Advocacy
WFP	World Food Programme
WHO	World Health Organization
YWCA	Young Women's Christian Association
ZANERELA+	Zambia Network of Religious Leaders Living with Or Personally Affected by HIV and AIDS
ZAOGA-FIF	Zimbabwe Assemblies of God Africa–Forward in Faith

Foreword

This manual seeks to challenge the false dichotomy that places antiretroviral therapy and faith healing at opposite ends of the spectrum. The intent is to mobilize religious leaders to regard antiretroviral therapy as an integral part of God's healing strategy. Further, it enjoins religious leaders to play a critical role in promoting HIV testing, treatment uptake and adherence in the context of HIV and AIDS.

The World Council of Churches (WCC) is grateful for all those who have spoken out to say that faith communities can do more to equip or deepen religious leaders' theological perspectives on antiretroviral therapy and faith healing in working closely with people living with HIV and their care-givers.

Since the early 1980s, the WCC has responded to the massive challenges of HIV and AIDS through its member churches and partners. This manual marks an important next step in ongoing efforts by churches to address issues confronting people seeking to offer effective treatment to those living with HIV and AIDS.

The WCC is indebted to the PEPFAR-UNAIDS Faith-Based Organizations Initiative for financial resources and for taking seriously the major contributions made by faith communities in global HIV response in a wide variety of ways. The council values collaboration and partnership that bring added value to the pilgrimage of justice and peace and in particular in building compassionate faith communities engaging with HIV.

Health, healing, and wholeness of life are gifts that we as people of faith can offer others and ourselves when we are fully open to learning from and with each other. As such, this manual helps us to equip ourselves with life skills that will help our communities become healthy and inclusive for all.

Rev. Dr Olav Fykse Tveit
WCC General Secretary

Preface

This manual emerged out of the realization that exclusive claims of faith healing in the context of HIV and AIDS in sub-Saharan Africa are compromising adherence to antiretroviral therapy. It recognizes that religious leaders are strategically placed to promote adherence (following through on the use of medication as suggested by a treating doctor) to antiretroviral therapy and to challenge stigma and discrimination.

The manual consists of practical, user-friendly units designed for use with faith communities, theological institutions and theological education by extension. It is a living document and is adaptable to different contexts. It is the product of a series of consultations held in Kenya, Zambia and Uganda facilitated by WCC's Ecumenical HIV and AIDS Initiatives and Advocacy (WCC-EHAIA) in collaboration with faith communities, national AIDS councils, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the American President's Emergency Plan for AIDS Relief (PEPFAR). We have also received invaluable comments and suggestions for improvement through a pilot testing and training workshop in Zambia in collaboration with UNAIDS Zambia alongside the National AIDS Council (NAC), which included practitioners of faith healing in the context of HIV.

In partnership with St Paul's University (SPU), Limuru, Kenya, WCC-EHAIA has engaged a community of theologians, theological educators and religious leaders living with HIV for their inputs. Moreover, the SPU theology department has introduced the manual to theological students from seven African countries and a wide range of denominations in a series of seminars. We are pleased that the All Africa Theological Education by Extension Association (AATEEA) has enthusiastically affirmed that the manual will be a key resource in their HIV and AIDS modules as members of the association continue to respond to HIV and AIDS challenges in their communities.

We invite you to participate in making use of this manual in your faith communities and to share your experiences and send feedback to ehaia@wcc-coe.org.

Prof. Dr Isabel Apawo Phiri
WCC Deputy General Secretary,
Public Witness and Diakonia

SECTION 1
Introduction

UNIT 1
Introduction and Purpose of This Manual

"Is there no balm in Gilead? Is there no physician there? Why then has the health of my poor people not been restored?" (Jer. 8:22)

This manual has been prepared to foster and enhance religious leaders' knowledge, skills, and attitudes around antiretroviral medication in the context of HIV and AIDS. It emerges out of an initiative by the World Council of Churches–Ecumenical HIV and AIDS Initiatives and Advocacy (WCC–EHAIA), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the President's Emergency Plan for AIDS Relief (PEPFAR). The initiative seeks to strengthen the distinctive contributions of religious leaders in support of adherence to antiretroviral medication in the treatment of HIV in Africa and to challenge harmful approaches to faith healing. Such harmful approaches tend to discourage some people living with HIV from initiating or continuing with antiretroviral therapy (ART).

This manual seeks to encourage religious leaders to play an active role in promoting treatment adherence in the face of HIV and AIDS. It recognizes the following:

- Many religious leaders have been actively involved in addressing HIV and AIDS stigma and discrimination.
- Some religious leaders have caused pain and death by discouraging people living with HIV from taking their antiretroviral medication by claiming that only faith healing or miraculous healing is acceptable.
- Some people living with HIV have defaulted on their medication due to problematic theological pronouncements by some religious leaders.
- Many religious leaders have not been sufficiently alerted to the specific needs of adolescents living with HIV and the challenges they face relating to treatment.

- Religious leaders are well placed to interact with significant other players to continue to promote the health and wellbeing of people living with HIV.

This manual has the following purposes:

- To motivate religious leaders to be actively involved in promoting HIV testing, treatment uptake, and adherence by people living with HIV
- To encourage religious leaders to recognize the complementary nature of faith healing and life-saving medication.

What Makes This Manual Different?

Many resources on HIV and AIDS in general, and on religious leadership and HIV and AIDS in particular, have been developed. However, very few have sought to address the specific issue of treatment adherence.[1] This manual addresses this need by initiating focused discussions on HIV treatment in the context of faith healing. It provides theological reflections on life-saving medication and encourages religious leaders to form effective partnerships with other individuals and institutions to support people living with HIV.

The overarching goal of this manual is to equip (or deepen) religious leaders' theological perspectives on ART. It seeks to challenge the false dichotomy that places ART and faith healing at opposite ends of the spectrum. The manual endeavours to mobilize religious leaders to regard ART as an integral part of God's healing strategy. Further, it enjoins religious leaders to play a critical role in promoting HIV testing, treatment uptake, and adherence in the context of HIV and AIDS.

1. One very effective resource is the Ecumenical Pharmaceutical Network (EPN), *HIV and AIDS Treatment Literacy Guide for Church Leaders: Bridging the Gap* (Nairobi: Ecumenical Pharmaceutical Network, 2009).

UNIT 2

Background: Faith Healing in the Context of HIV and AIDS in Sub-Saharan Africa

"My people are destroyed for lack of knowledge . . ." (Hos. 4:6)

This manual emerged out of the realization that exclusive claims of faith healing in the context of HIV and AIDS in sub-Saharan Africa are compromising adherence to ART. It recognizes that religious leaders are strategically placed to promote adherence (following through on the use of medication as suggested by a treating doctor) to ART and to challenge stigma and discrimination. The manual is informed by the following observations:

- It is critical for religious leaders to understand or appreciate the factors associated with treatment adherence (people observing the times and doses of their medication) in the context of HIV and AIDS. Religious leaders play a critical role in counselling, leadership, and advocacy.
- Whereas religious leaders have provided valuable leadership in the response to HIV and AIDS, the issue of making exclusive claims of faith healing has brought back the notion of religious leaders being "part of the problem" and not part of the solution.
- Given the fact that many people living with HIV have identified religion as a resource, it is critical for religious leaders to develop life-giving theologies that promote adherence in the context of HIV and AIDS.

Adherence is vital for the prescribed medication to be effective. This is as true for all other health conditions as it is for HIV and AIDS. However, the key question is: What is adherence? Simply put, it is to keep on taking your medicines for the rest of your life.

In the case of ART, an adherence level of 95% to this therapy is critical in obtaining its full benefits, which include maximum and durable suppression of viral replication, reduced destruction of CD4 cells, prevention of drug resistance, promotion of immune reconstitution, slow progression of disease, and reduction of transmission rates. Therefore, it is crucial for all faith leaders and persons working and living with people living with HIV (stakeholders) to promote treatment adherence in the context of HIV and AIDS.

Adherence is defined as the extent to which a patient's behaviour coincides with the prescribed health-care regimen as agreed upon through a shared decision-making process between patients and the health-care provider. This includes taking them at the right time and in the right amount. (WHO)

Although many factors affect adherence to HIV medication (patient-related factors such as acceptance, disclosure, and family support; accessibility of medical centres; social support, etc.), the exclusive claims of faith healing or miraculous healing of HIV and AIDS has emerged as the leading issue in relation to religious leaders. In many parts of the region, numerous people living with HIV have abandoned or defaulted on their medication because they were told by religious leaders that they had been healed miraculously – that the HIV had been expelled from their immune system. They are told to discontinue medication, and refusal to discontinue is presented as a lack of faith.

Some of the emerging controversies relating to the exclusive claims to faith healing of HIV and AIDS include the following:

- Unnecessary and untimely deaths due to AIDS after some people living with HIV abandon their medication
- Development of resistance to medication after some people living with HIV have defaulted on their treatment
- Claims of exclusive miraculous healing of HIV and AIDS on public and private television stations, resulting in many people seeking the services of those who make such claims
- Competition among religious leaders leading to aggressive advertising and huge claims of healing HIV and AIDS (As a result, such religious leaders discourage the uptake of antiretroviral treatment of HIV and AIDS.)
- Absence of the confirmation of the faith healing of HIV and AIDS by competent bio-medical specialists (This brings the whole process and the church into disrepute.).

Exercise

Exercise objective: By the end of this exercise, participants will have increased their awareness of the challenge of exclusive claims of healing of HIV and AIDS through faith.

Method: small group discussion; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will divide participants into groups of not more than six participants and allow the groups to reflect on the impact of claims by some religious leaders to heal HIV and AIDS exclusively through faith.

1. As you scan the media (word of mouth, radio, television, text messages, posters, banners, etc.), what are some of the major claims being made about the so-called miraculous healing of HIV and AIDS?

2. Who are some of the religious leaders (traditional healers, Christians, Muslims, and others) claiming to have the power to heal HIV and AIDS through faith?
3. What have been some of the unfortunate consequences of the claims of the so-called miraculous healing of HIV and AIDS in your families, communities, and nations?
4. Discuss the role of religious leaders in promoting adherence to ART in the context of HIV and AIDS.
5. Are there people who claim to have been healed through prayers? Are there people who have died after discontinuing ART treatment due to the influence of faith healers? (Share these stories and testimonies).

Strategically Placed: Religious Leaders Promoting Treatment Adherence in the Context of HIV and AIDS

This manual is based on the observation that despite some leaders generating concern over their claims relating to the so-called miraculous curing of HIV and AIDS, religious leaders remain strategically placed to encourage and accompany their followers to take their medication. There is evidence that religious leaders have been playing a major role in the overall response to HIV and AIDS.

Who is a religious leader?

Religious leaders are community, national or global religious leaders who have important roles within faith communities, especially those with an organized hierarchy and who are formally designated to represent these communities.[2]

Religious leaders can play the following roles in promoting treatment adherence in the context of HIV and AIDS:

- Maximizing their influence as highly respected members of the community by communicating positive messages about ART: e.g., articulating the view that this therapy is part of God's plan to address HIV and AIDS
- Contributing towards awareness-raising in relation to the dangers of abandoning or defaulting on treatment
- Being aware of factors that promote adherence, such as belief and knowledge, HIV and AIDS education, and supportive networks (They must enhance these factors.)
- Utilizing the religious space to promote knowledge of the positive effects of ART, its side effects, as well as management strategies

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2. UNAIDS, *Partnership with Faith-Based Organizations: UNAIDS Strategy Framework* (Geneva: UNAIDS, 2010), 7.

- Broadcasting positive messages that do not stigmatize the use of bio-medicine and do not pose an artificial demarcation between faith healing and medical healing
- Using the media to challenge harmful messages relating to exclusive claims of exclusive healing of HIV and AIDS through faith
- In using the media, adopting creative strategies such as mobile short message service (SMS), or texting, to promote ART adherence
- For those religious leaders living with HIV, promoting support for congregants and other members of the community who are living positively (These leaders are well-placed and play a critical role in addressing stigma and discrimination.)
- Acquiring and deepening knowledge of factors that act as barriers to adherence, such as stigma and discrimination, nondisclosure, food insecurity, religion (faith healing), side effects of medication, misinformation, staff and drug shortage
- Collaborating and networking with relevant stakeholders such as health specialists, community leaders, activists (including sex workers), and others in order to promote treatment adherence.

> "It is worrying to note that in the past two to four years, we have witnessed a significant number of people living with HIV stopping their medication being motivated by faith healers; that is, pastors and prophets, *n'angas* (traditional healers), among others. Let us use this platform to introspect on what is taking place in our community, with a view of coming up with a common position and messaging. There is, therefore, need to understand and embolden the role of religion and the church in the fight against HIV, including HIV-related stigma and discrimination." (Statement by a religious leader in Kadoma, Zimbabwe, at a workshop bringing together religious leaders with people living with HIV)

The manual, therefore, seeks to mobilize religious leaders to promote HIV testing, treatment uptake, and adherence in the context of HIV and AIDS. It recognizes that religious leaders can challenge harmful beliefs that have the effect of stopping some people living with HIV from using ART. It encourages religious leaders to be creative theologically, pastorally, and practically in order to ensure that all those who need to access ART are encouraged and assisted in doing so.

Recognizing that often religious leaders operate within their sector, the manual also seeks to equip religious leaders with the skills to establish or deepen

partnership and collaboration with other relevant players in facing the issue of exclusive claims of faith healing of HIV and AIDS.

Overall, then, the manual seeks to empower religious leaders in addressing the challenge of exclusive claims of faith healing of HIV and AIDS. It endeavours to provide such leaders with knowledge and skills to become more effective in dealing with this challenge and coming up with more creative and sustainable responses.

UNIT 3

How to Use This Manual

Then Isaiah said, "Bring a lump of figs. Let them take it and apply it to the boil, so that he may recover." (2 Kings 20:7)

This manual consists of three sections with 14 units. The first section has four units providing an overall introduction to the manual for facilitators and participants on issues discussed in the whole training manual. Section 2 has seven units, which describe what people living with HIV experience in the context of treatment adherence and faith healing. Section 3 has three units: these closing units of the manual focus on encouraging the spirit of working together between different organizations in order to respond compassionately to HIV and AIDS in communities. They also address motivating different stakeholders in medical fields and religious institutions to be true partners and collaborating toward holistic healing for the longevity of lives. Further, the units discuss the advocacy and communication to be taken seriously by all faith leaders and other community leaders with people living with HIV, thus displaying transformed leadership for holistic healing. The units are designed to help facilitators prepare learning activities. Preparation is crucial in determining the success of the training process. Therefore, facilitators must have full understanding of the objectives of each unit, the means of delivery, the tools and materials needed to carry out the learning activity, the reading materials required to manage the discussion, and the key messages to be emphasized in each unit.

Each unit consists of the following:

Outcome

This subsection explains what is to be achieved in the unit – be it a change in knowledge, in attitude, or in skills. Knowing and remembering the objective or purpose of the unit will help facilitators focus on the outcome of learning itself. In other words, this will help avoid the tendency to discuss things that are off topic, not a priority, or unimportant.

Method

The method is the way we choose to deliver the learning materials to achieve the desired objectives of the unit. Depending on the outcomes we want to accomplish, these training sessions can utilize a variety of methods, such as brainstorming, group discussions, plenary discussions, case studies, role play, and demonstrations.

Brainstorming

Facilitators propose questions to the participants that aim to encourage them to discuss ideas, concepts, and solutions related to the topics presented.

Discussion or group work

Discussions are held in small groups typically consisting of four to six people. Facilitators provide questions to be discussed by participants in small groups. After the small group tasks are accomplished, one member of each group will present the summary or result of the discussion to the whole group (all participants). After each small group has presented their findings, the facilitator will conclude, structure, or summarize the agreement of the whole group.

Case study

The case study provides a detailed description or stories of people (testimonies), groups, or situations. It is used when there is a need to invite participants to understand and analyze a problem or its solution. Facilitators initially provide questions to guide the participants' discussions in a case study.

Role play

In this method, participants come to understand the problem by putting themselves in the position of the person facing the challenge. Participants are asked to play the role of the other person in front of all the other participants. Through role play, the real situations that certain people face are brought to life for the participants (both the role player and the audience) of the training.

Interactive presentation

In this method, which is the most frequently used in trainings, facilitators present structured ideas or information through power point presentations (or other tools such as flipcharts and white boards). Presentations need to be done interactively to avoid one-way communication, otherwise they may become boring for the participants.

Several things need to be remembered by facilitators to create an interactive presentation:

- Speak in a fairly loud voice, with clear articulation and intonation (rise and fall of the voice) that is appropriate to the message given. This will enliven the presentation.
- Use simple language so that it is easy for participants to understand.
- Maintain eye contact with participants. Eye contact will encourage interaction. Conversely, lack of eye contact will make participants feel left out.
- Ask questions to encourage interaction and discussion.
- Avoid reading the presentation word by word: the participants can do that on their own. Likewise, do not read all the notes written on your "cheat sheet." These are only meant to help you remember important points and the flow of the discussion.
- Avoid standing in one place for a long period of time: approach the participants and move from one place to another. Approach participants who ask questions or those who are not paying attention. Ask them questions to engage them in the discussion.
- Use images in the presentation. But not too many: one image for each slide is enough.
- Give detailed information to participants in reading texts or handouts.
- Be yourself. Stay relaxed and approachable so that participants are encouraged to speak up and ask questions.

Tools and Materials

This section indicates the tools and materials needed in the facilitation of the units, which is closely related to the method used. This manual is designed to be used by religious leaders across different communities. Bearing this in mind, we propose the use of easy-to-get tools, that is, flipcharts, sheets of paper, markers, and pens. However, in other settings, audio and visual methods can also be used: requiring laptops, LCD projectors and screens, speakers, television and video players, as well as short movies/clips or music.

Process

This is the series of steps through which facilitators must guide participants based on the method chosen in order to achieve the outcome of the unit. The step-by-step process is designed to ease the facilitators' planning of the units, and to ensure that they do not miss any steps. For new facilitators, these steps of the units will give them a picture of what needs to be done in each unit.

Key Messages

This part repeats and emphasizes the messages from each unit that should be "taken home" by the participants.

Note to the Facilitator: This manual comes with many exercises and activities, but these are only guidelines. The facilitator's decision on how many exercises to do in the course of the training must be informed by the nature of the group. However, we strongly recommend that all units be done through a training workshop. Facilitators are encouraged to be flexible and conversant with their group to determine the number of exercises and time allocated per exercise without undermining the substance of the training.

UNIT 4

Getting Started

It shall be said, "Build up, build up, prepare the way, remove every obstruction from my people's way." (Is. 57:14)

Unit Objectives

At the end of this unit participants will:

- Know each other
- Understand the objectives of the training workshop
- Have developed rules of engagement that will make the training workshop a success.

Background

- Make the training participatory from the beginning. If you involve participants and make them feel they own the training, then they will listen and be listened to.
- Facilitation is demanding, so be well prepared. Familiarize yourself with the information and data before you meet the group.
- Facilitators can vary the times suggested for each activity depending on the context and groups of participants. This manual provides guidelines that are not cast in stone.
- The exercises in this unit can help set the tone and mood of the training workshop.

1. Participant introductions
2. Opening ceremony
3. Expectations of participants
4. Objectives of training
5. Rules of engagement

Introduction of Participants and Workshop

It is very important that participants get to know each other well enough to begin bonding for the duration of the training and beyond. In participatory-type training that, participants must be encouraged to lower their defences and become more open to interact and engage on a level playing field. This session deals with self-introductions, opening remarks, participant expectations, objectives of the training, and rules of engagement in order to create a favourable environment for the participants to freely, honestly, and actively participate in the proceedings. The facilitator can adopt or choose any method of self-introduction to make the exercise interesting and participatory. This is particularly important for sessions that address the "heavy" issue of HIV and AIDS.

Facilitation of Exercises for Participants

Exercise 1: Introducing Participants

Exercise objective: By the end of this exercise, participants will know at least five of their peers.

Methods: partnering introduction; full group introduction

Aids: flip chart, small pieces of paper, and pens

Duration: 30 minutes

Since the training will be participatory, it is important to give participants a feel of what it means to be involved in a participatory training workshop by allowing them an active role in this section of introductions. There are two methods that can achieve this very well:

- Participants can be divided into pairs and take turns interviewing each other or listening to the other speak about themselves. Participants will need pens and small pieces of paper to write down key information about their partner, which they can then use to introduce their partner to the plenary. This will provide participants with intimate knowledge of at least one participant, thereby building a team and collegial spirit among them. The "taxi" method can also be used. In this, the facilitator calls out "taxi" and participants must pretend to ride a taxi with two others, during which time they must introduce themselves to each other. After the taxi ride, they will take turns introducing each other to the larger group.
- Participants can introduce themselves to the whole group following an agreed-upon formula. If this is chosen as the method of introduction, the facilitator will begin by asking participants to suggest things they think should be included in the introduction and then writing them on a flipchart for everyone to see. Participants will then follow the flipchart guidelines when introducing themselves. See example below.

Interactive introductions will help in bonding and team building for the group undergoing training.

Examples of Self-Introduction Headings

Full names
Preferred name for the training
Institution
Position and role in the institution

Exercise 2: Opening Ceremony

Exercise objective: By the end of the exercise, participants will understand the context of their training.

Method: direct address to the participants; question and answer

Duration: 25 minutes

While it is important for participants to feel very comfortable within the training venue through the encouragement of significant informal engagement between them and facilitators, participants must also appreciate the seriousness of the training upon which they are embarking. To this end, on the opening day of training participants should be addressed by the leader of the organization planning and executing the training and some of their partners (e.g., WCC, UNAIDS, government minister of host country) about the current state of the HIV epidemic in the country and the response. How seriously participants will take the training will also depend on the persons who address them, hence the importance of the most senior officials showing their support by coming to make this address, highlighting the key role of the faith community and religious leaders in supporting the national HIV response.

The leaders need not spend the whole day with the participants, as their presence can inhibit participants' active participation in the proceedings. The ideal situation, therefore, is for the leaders to come in and address everyone and then immediately be excused for the duration of the training, perhaps making another courtesy call at the end.

Exercise 3: Participant Expectations

Exercise objective: To gauge what participants expect to gain from the training.

Method: plenary discussion; pre-evaluation form

Aids: small pieces of paper, flipchart, pre-evaluation forms, pens, markers

Duration: 30 minutes

Often facilitators make the mistake of thinking that they know what people coming for training like and expect. When this happens, participants can disengage from the whole process because they do not feel they own it. This, however, does not mean that facilitators should come unprepared. Instead, it is important for facilitators to create an environment for participants to contribute to the planning and execution of the training programme by allowing them to share their expectations and fears early in the programme. Facilitators can then reconcile these findings with their planned objectives, making necessary adjustments to the training programme to deal with the genuine expectations and fears of the participants. It is also important that facilitators be clear and honest about the expectations that the training is not designed to cover. The facilitator can undertake this either through a group discussion or through a pre-evaluation form (see example below) that participants collect when registering, fill in, and submit.

To achieve the objective, the facilitator can try one or more of the following tasks:

- Read out the pre-evaluation forms, highlighting the common ideas and putting them on a flipchart.
- Where no pre-evaluation forms are present, ask participants to write down their hopes and fears for the training (one each), then read these out to the larger group (see example below).
- If facilitators want to take an oral approach, have participants orally express their expectations by asking each one, "What do you expect to gain from this training?"

The facilitator must make sure that key points and those overlapping are written on a flipchart for all participants to see. These expectations, hopes, and fears must remain visible to the participants throughout the training; where necessary, the facilitator must highlight, at appropriate times, when the expectations are being dealt with during the course of the training.

Pre-Evaluation Form

This form will be filled in anonymously.

1. What do you understand by faith and healing? (provide space for answer)
2. Can someone living with HIV and AIDS be healed? Explain briefly. (provide space for answer)
3. What are your expectations coming to this training? (provide space for answer)
4. What are your fears about this training? (provide space for answer)

Examples of Expectations

- To understand the relationship between healing, curing, and treatment
- To develop skills of engaging with people living with HIV in the context of faith-healing claims
- To learn and reflect on diverse ways of defining healing, especially based on experiences of people living with HIV

Examples of Fears

- That some will hold back their views for fear of being labelled faith-weaklings
- That we may fail to develop convincing understanding to encourage all people on treatment to adhere to their treatment
- That the time allocated for sessions will be too short for engaging discussions

Exercise 4: Training Objectives

Exercise objective: To have participants understand and appreciate the overall goal of the training by allowing them to compare the facilitator's objectives with their own expectations from the previous exercise.

Method: plenary discussion

Aids: flipchart, markers

Duration: 15 minutes

The facilitator must bring well-thought-out objectives to the training. These must be made visible to all the participants either through projecting them or writing them on a flipchart (see example below). The facilitator will walk the participants through the objectives to engender a clear understanding. At this stage, it is vital that the participants recognize the facilitator's intentions in proposing these objectives; however, the facilitator must not force the objectives on the participants.

After presenting the objectives, the facilitator must allow participants to compare these objectives with their own expectations and highlight common areas as well as those that are not common. It is important to take note where participants expect more than what is offered and to clearly address such expectations: either through adjusting the programme and activities or by showing why it will not be possible to address their expectations in this particular training.

Training Objectives

1. To equip participants with adequate evidence-based information on the dangers of faith-healing claims made by some religious leaders
2. To equip participants with alternative understanding of faith healing in the context of HIV and AIDS
3. To provide participants with skills to provide appropriate alternative understanding as a basis for treatment adherence for people living with HIV

Facilitators must also discuss start and finish times as well as meal times with participants in order to inculcate participant ownership of the programme. This is especially important in workshops and trainings where participants are coming from home, as opposed to live-in participants.

Exercise 5: Rules of Engagement

Exercise objective: By the end of this exercise, participants will have come up with rules of engagement or a code of conduct for how they will engage during the entire training programme.

Method: small groups; plenary

Aids: flipcharts, markers

Duration: 30 minutes

When several participants are invited to a training programme, many dynamics are immediately at play. If these are not properly managed, they can disrupt and destroy all the good work invested in the training. The various dynamics include the following: each participant is an individual with their own expectations and ego; the participants form a group as peers with certain aspects in common; and finally, the participants look upon the facilitator as a leader. The relations among individuals, the group, and the leader need to be managed appropriately to make the training a success. Furthermore, the participants themselves are composed of dominating types and shy types. These need to be carefully managed to ensure a successful participatory approach, otherwise the dominating types will do all the talking while the quieter ones observe from the sidelines.

In order to make the participatory approach successful, the facilitator must allow the participants to negotiate the rules of engagement (see example below) or a code of conduct that allows all participants to listen and be listened to, to be understood, and to be respected throughout the training. To do this, the facilitator divides participants into small groups of not more than six. Each group appoints a chair and a secretary, who will write down the rules and pres-

ent their group's proposals to the plenary. During plenary, the facilitator will write down the common and overlapping rules on a flipchart that is visible to all participants throughout the training to remind them of their commitment to uphold the rules.

Examples of Rules of Engagement

- Punctuality is a virtue.
- Phones will be on silent or switched off.
- We will not undermine opinions and personality of peers.
- Brevity is a virtue.
- Listening is respecting. Don't interrupt; listen well.

SECTION 2

Unpacking Holistic Healing in the Context of Exclusive Claims to Faith Healing of HIV

UNIT 5

Narratives and Testimonies: The Impact of Faith Healing in My Life

"Truly I tell you, wherever this good news is proclaimed in the whole world, what she has done will be told in remembrance of her." (Matt. 26:13)

Unit Objectives

By the end of this unit, participants will:

- Have listened to the stories of people living with HIV and their understanding of faith healing
- Be able to articulate the dangers of exclusive claims to faith healing through narratives of near-death experiences caused by treatment non-adherence
- Be able to articulate the positive understanding of the complementarity between faith healing and treatment adherence.

Background

At the consultation in Kampala in 2017, individuals drawn from Nigeria, Kenya, and Uganda were invited to share their personal stories of living with HIV and the impact of religion or faith in their respective journeys. This unit will give voice to the stories shared in Kampala and will also create a platform for stories from among the participants to be shared in the context of the training workshop, especially during this unit's exercises.

Personal narratives and testimonies must not be coerced but given voluntarily by participants who are ready to share their own personal journeys.

In the event that no-one among the participants is ready to share their own personal journeys, participants can also share the journeys of people they know – ensuring, however, that they do not disclose names unless they have been given permission by the affected persons to do so.

Following each personal testimony and narrative, an exercise allows participants to engage with the narrative to develop an understanding of key issues that are the focus of the training workshop.

The Narratives and Testimonies

Aisha, Nigeria

Aisha, a Muslim woman from Nigeria, shared her personal narrative of life living with HIV in Nigeria. Aisha went through female genital mutilation (FGM), or, as some would call it, female circumcision. Aisha shared that, as a result of FGM, she never enjoyed sex in marriage. She was married as a young girl to an older man who was very violent toward her. She eventually divorced this man and later married again. Her problems did not end, however, and hence she divorced again and married a third man, who was living with HIV but did not disclose his status to Aisha. She contracted the virus from her husband; and when she was diagnosed as HIV positive, she was looked upon by her faith community as an outcast and disgrace. When she became sick, she was locked up in a room for two years, quarantined from the outside world because the community did not want outsiders to know that one of their own was living and suffering from the effects of HIV. She was neglected and rejected by her faith community and not even her siblings came to her rescue. She was locked up in that room to die, and the only thing she was given to accompany her was a small radio. However, the radio became such torture to her – as she constantly heard stories of religious and community leaders condemning people living with HIV – that she decided not to listen to it again.

Christians lived in her community, and one day a Catholic sister was told of the woman who was locked up in a room because she had HIV. This woman, Sister Johana, came and took Aisha to her church, where she nursed Aisha and bought her drugs. Through love, care, and antiretroviral therapy (ART), Aisha gradually regained her health. When she was strong, Sister Johana asked the church to employ her so that she could earn a living and sustain herself. Throughout the period that Sister Johana cared for Aisha, she never asked her to convert to Catholicism – she simply cared for the human being created in the image of God. Another man proposed to Aisha and they were married in 2006, and they remain a married couple. The new husband accepted her for who she is. Now, Aisha prides herself as a mother and grandmother to HIV-orphaned children in Nigeria.

She concluded her testimony by highlighting that faith communities and the media – through the radio she had been given – contributed seriously to stigma and discrimination. She also highlighted that through the Roman Catholic Church, especially Sister Johana, she had experienced positive faith healing. She defined faith healing as a state of self-acknowledgement brought about through the care, love, and ART she had been introduced to, which all contributed to breathing new life into a body that was close to giving up on life.

Exercise

Exercise objective: By the end of this exercise, participants will have engaged with the story of Aisha to understand what people living with HIV go through and how they see faith healing.

Method: small group discussion; plenary

Aids: flipchart, markers

Duration: 20 minutes

The facilitator will divide participants into groups of not more than six participants and allow the groups to read the story of Aisha and then to reflect on and discuss the following questions and points:

1. List the bad things that Aisha experienced in her life and identify who (person or institution) was responsible for such experiences.
2. Why was Aisha locked up in a room by her family and community? Besides being locked up, what other experiences have people living with HIV had in your community?
3. What could Aisha's community have done to help her, instead of locking her up?
4. Aisha says she is healed: How did she achieve healing? Does Aisha's understanding of healing mean she no longer takes her ART medication?
5. In your thinking, is Aisha healed?

Maureen, Kenya

Maureen is a young woman, mother, and wife, and a Christian. Maureen's father was polygamous and her parents divorced when she was still young. She had two younger siblings. After divorce, her mother remarried and Maureen and her siblings went to live with their maternal grandmother. Life became very difficult because her mother could not care for them fully, as she was now focusing on her new life. Her uncles never accepted Maureen and her siblings; they rejected them and did not take care of them. The situa-

tion worsened when her mother died. Maureen then had the responsibility of caring for her younger siblings. To do so, she took a job with the Young Women's Christian Association (YWCA) as a peer educator. She thought this was good because she could care for her siblings with her earnings. But the job demanded that she do a lot of travelling on YWCA programmes, which meant that she sometimes had to sleep away from home. Her uncles accused her of bed-hopping, suggesting that she was lying about her work commitments and that she was actually "sleeping around." The uncles then chased her and her siblings from their maternal grandparents' home. The orphans were left with nothing and no place to call home. Maureen had to find a place to rent so she could remain with her siblings.

She then entered into a relationship with a young man. Because she lacked the skills to search for an appropriate partner or negotiate the terms of the relationship, premarital sex became a reality for her. Her boyfriend was arrested and jailed for two years, but by then she was already pregnant with her first child. She then got married, and when she became pregnant with her second child, found she was sickly most of the time. During ante-natal visits to the clinic, she was tested for HIV and diagnosed HIV positive. She was shattered. Afraid of how her husband would react to the news, she went from the clinic to a trusted friend's place, confident that she would not reject her. Her friend was very supportive when she heard the news. From her friend's place, she called her husband and told him the news of her test result. Unbeknown to her, the husband already knew he was HIV positive, and when she told him, he accepted the situation and became very supportive of her.

Husband and wife then were put on ART and helped each other to adhere to their treatment regimens. Thanks to ART, their baby was born HIV negative and a third baby is on the way. Throughout her ordeal, after being diagnosed as HIV positive, Maureen found strength in her pastor. He encouraged her to go on ART and to adhere to her treatment while he prayed for her to have the strength not to default. The prayers from her pastor, combined with strict adherence to ART and the support and care from friends and husband, have brought about healing for Maureen.

Exercise

Exercise objective: By the end of this exercise, participants will have listened to and reflected on the challenges that traditional customs bring to young children and the magnitude of suffering caused by such customs and practices.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 20 minutes

The facilitator will divide participants into groups of not more than six participants and allow the groups to read the story of Maureen and then reflect on and discuss the following questions and points:

1. What traditional customs and practices do you think caused the problems that Maureen and her siblings experienced? Why do you think this?
2. In what ways did the actions of adults in Maureen's life lead to her being infected with the virus?
3. While Maureen will live for the rest of her life with the virus, she feels she is healed. Identify elements in her life that make her feel she is healed. Do you understand her understanding of being healed?
4. As a religious person, do you agree with the understanding of healing being achieved by people who continue to be on treatment?

Jemimah, Uganda

Jemimah is a young woman from Uganda who is in a committed relationship and expecting to be married soon. Jemimah belongs to the generation of children born before the widespread availability of ART and drugs to prevent mother-to-child transmission. Consequently, she was born HIV+. Her mother became infected through a blood transfusion and her father was HIV-. When he discovered that his wife was now HIV+, he did not desert his family but became a pillar of strength.

Jemimah was put on medication early on in her life but she faced the serious challenge of stigma and rejection by peers and friends once they found out that she was sickly because she was HIV+. The stigma she suffered made her abandon her medication, and her health deteriorated. She was also denied food by the other students at school: they would quickly share the food on their table and return what was supposed to be Jemimah's share to the chefs, thereby starving her. She grew so weak that when her father visited her at the school, he had to carry her in his arms to take her to hospital. Her viral load had increased so much that she would have died without proper and timely care. As the school was no longer a safe place for his daughter, her father sent her instead to a fashion and design college. She is now a fashion and design artisan.

When she was taken to hospital, Jemimah was put on ART treatment. Jemimah was encouraged by her father to adhere to her treatment. At college, she met a young Ugandan man from the north and they fell in love. That young man is now her fiancé. When they first met, she found it very difficult to disclose to her boyfriend that she was living with HIV. She had to devise a plan to share the news. She came up with a "worst case scenario" question for her boyfriend: "If you heard that I had cancer, would you still love me?" His

answer was yes. "If you had that I cannot bear children, would you still love me?" His answer was again yes. This gave her some confidence, so she finally broke the news, "You know what I was born HIV+ and I am living with the virus." Her boyfriend said he still loved her! Once their relationship became known in their community, the boy's pastor called him to discourage him from continuing with the relationship since the girl was HIV+ while he was HIV-. He was told that by entering into this relationship, he was signing his own death warrant. Despite this, her boyfriend has been a pillar of strength and a source of healing. He makes it a point to remind Jemimah every single day to take her medication without fail. According to Jemimah, the boyfriend has always said to her, "Take your medicine and believe that you are healed!" She feels healed and is full of life and looking forward to starting her own family and having her own children. Her family has remained very supportive of her and encourages her to take her medicine without fail.

One problem for Jemimah, however, is that her boyfriend's family has not warmly accepted her because of a skin condition she has developed. She is worried that if they are uncomfortable with this skin condition, they will react badly when they finally come to know she is HIV+. She and her boyfriend have been trying to think of the appropriate time to break the news of Jemimah's HIV status to his family. Despite this, they are both convinced that they are meant for each other.

Exercise

Exercise objective: By the end of this exercise, participants will have engaged with the multiple layers of challenges faced by children born with HIV who have now grown up to be adults in a society that continues to look at HIV as a virus from which there is no healing.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 20 minutes

The facilitator will divide participants into groups of not more than six participants and allow the groups to read the story of Jemimah and then reflect on and discuss the following questions and points:

1. What do you find most challenging about Jemimah's narrative and why?
2. In her narrative, from whom and where did she encounter serious cases of stigma and rejection?
3. Who are Jemimah's heroes/heroines? What makes them stand out?
4. Jemimah was once sickly but now looks healthy: Is she healed? What is your understanding of being healed?

Victor, Nigeria

Victor is a young man from Nigeria who grew up living with what he thought were his parents in a slum area of Lagos. His father was polygamous. Victor thought he was the only son of his mother and father, but he had always been called a bastard by his father and never fully understood why. At age ten, Victor was thrown out of the family home. He went to live with his father's younger brother, who sexually abused him. He reported the abuse to his mother, who informed his father. But his father, unable to believe his brother had sexually abused Victor, responded by having Victor's mother arrested. The sexual abuse continued until his mother took Victor to a church, where he had his first experience of healing from the depression and trauma caused by the abuse. The church also helped him to remain resolute, and as he was intelligent, he continued with his education and was accepted into university.

It was while at university that he finally learned his true story and identity. The people he had always known as his mother and father were not his biological parents: his biological mother had been his adopted mother's best friend, but she died in labour. During the final hours of her life, she had asked her best friend to promise that she would take care of her baby. She agreed and that is how Victor ended up with his adopted mother. When she met her husband, he said he would only marry her if she had one child but not two, so she confessed that she actually had only one child and that Victor was an adopted son of a late friend. So the man agreed to marry her. In the eyes of this man who Victor grew up knowing as father, then, Victor was a bastard – especially when he had done something bad. This explained why his father never really treated Victor as his own son.

While at university, Victor began a relationship with a girl with whom he engaged in unprotected pre-marital sex. When he went for an HIV test, he was diagnosed as HIV+. He almost lost his sexual drive. But when he informed his girlfriend, she assured him she would never leave him, perhaps because she assumed she also was HIV+. They went for an HIV test together and their results were discordant: Victor was HIV+ and the girlfriend was HIV-. Not long after this, the girlfriend suggested that they go for 17 days and 17 nights of mountain fasting, which would require Victor to abandon his medication, but he refused. The girlfriend then left Victor. For some time, Victor struggled over how he was going to disclose his status to his family. He eventually told his younger sister, who was very supportive. With her support, he then disclosed the news to family. Instead of being rejected, his family embraced him and showed him great love. This again contributed to his healing.

Realizing that many young people were ignorant of the facts surrounding HIV, Victor went into advocacy. The father was not pleased and asked Victor to avoid using their family name, fearing that their name would become stig-

matized. It was only when Victor started making international trips that the father allowed him to use their family name.

Victor was always very active in the church. But when his pastor started stigmatizing people living with HIV, he left the church. Realizing the damage that could be done if the church learned his status from the pastor, he disclosed the news himself, and this helped others who were also living with HIV within the church to disclose their status as well. The church became a real refuge and safe place.

Victor says, "I am alive because I take my pills religiously. That is my miracle!" Victor is a bubbly and lively young man, exhibiting signs of being healed even as he remains on treatment.

Exercise

Exercise objective: By the end of this exercise, participants will have engaged with multiple experiences of Victor, which will help them in fighting HIV and AIDS and the tributaries fuelling the pandemic.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 20 minutes

The facilitator will divide participants into groups of not more than six participants and will allow the groups to read the story of Victor and then to reflect on and discuss the following questions and points:

1. List the factors that contributed to Victor becoming infected with HIV.
2. What is a discordant couple?
3. Identify the different points at which Victor experienced healing in his life.
4. What is healing based on Victor's experience?

Exercise

Exercise objective: By the end of this exercise, participants will have attempted to define and distinguish healing from treatment.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will divide participants into groups of not more six participants and allow the groups to reflect on the stories that they have read in this unit and discuss them, focusing especially on the two aspects of treatment based on ART and healing. The facilitator should emphasize the following key points as they send the groups out to work:

- In all four narratives, the individuals appear to suggest that there is a difference between treatment and healing.
- The stories seem to suggest that healing does not necessarily mean the end of treatment or elimination of sickness-causing agent.
- The stories imply that healing is achieved through a combination of a number of factors.
- The stories suggest that treatment and adhering to treatment regimens is an important part of achieving healing but that it is not the only part.

Having highlighted these key points, the facilitator can now send participants to work on the following questions and points in their small groups:

1. According to these narratives, what elements are important to achieve healing even if a person is HIV+?
2. Based on these narratives, what would you say is the difference between cured and healed? Can ART lead to one being cured or healed?
3. Based on the stories, what message can religious leaders give to people living with HIV?
4. Is ART a miracle from God? Should people living with HIV expect a miracle cure, as promised by some prophets?

UNIT 6

Understanding Faith Healing and Faith Curing/Treatment

"O Lord, do not rebuke me in your anger, or discipline me in your wrath. Be gracious to me, O Lord, for I am languishing; O Lord, heal me, for my bones are shaking with terror. My soul also is struck with terror, while you, O Lord – how long? Turn, O Lord, save my life; deliver me for the sake of your steadfast love." (Ps. 6:1-4)

Unit Objective

At the end of this unit, participants will understand the difference between faith healing and faith curing/treatment in the context of the HIV and AIDS pandemic.

Background

- The technological advances of the past century tended to change the focus of medicine from a caring, service-oriented model to a technological, cure-oriented model.
- There is a difference between healing and curing. Healing is a natural process and is attributed to faith and is within the power of everyone. Curing and managing disease is what doctors are called upon to do. This usually consists of an external treatment; medication or surgery is used to mask or eliminate symptoms. In the case of HIV, medication is not a complete cure, but is a way to eliminate symptoms, prolong life, increase quality of life, and eliminate the chance of transmitting HIV to sexual partners.
- Healing goes deeper than curing and comes from within. It addresses the imbalance that underlies the symptoms. Healing brings together the often-hidden aspects of a person's life as they relate to their illness. Healing is different from curing, though curing and the restoration of physical function may accompany healing.
- We can be healed without being cured. Not being cured does not eliminate the possibility of healing.
- We are aware that most indigenous languages, as well as the Bible, do not distinguish between healing and curing. Recognizing this, this manual is not opposed to faith healing in general but to *exclusive claims* to faith healing of conditions such as HIV. Such claims can be understood as claims to faith curing of HIV.

Faith Healing or Faith Curing? ". . . He came and took her by the hand and lifted her up. Then the fever left her, and she began to serve them." (Mark 1:29-31)

- The notion that prayer, divine intervention, or the ministrations of an individual healer can cure illness has been popular throughout history. Miraculous recoveries have been attributed to a myriad of techniques commonly lumped together as "faith healing."
- Some people interpret the Bible, especially the New Testament, as teaching belief in, and practice of, faith healing. There have been claims that faith can cure blindness, deafness, cancer, HIV and AIDS, developmental disorders, anaemia, arthritis, corns, defective speech, multiple sclerosis, skin rashes, paralysis, and various injuries. These claims rightly point to claims of "faith curing."
- Faith healing refers to the ability of faith to help restore balance to human beings by addressing psychological, biological, social, economic and spiritual issues that bring about the lack of such balance. Faith healing is holistic and compliments treatments prescribed by medical and psychiatric professionals.
- Exclusive claims to faith healing or faith curing refer to the ability of faith to eliminate the physical, biological, and mental sickness and sickness-causing agents from the body of a person who is sick. Faith curing presents itself as an alternative to psychiatric and medical responses to sickness. Faith curing sees itself as competing with other medical service providers.
- In the midst of increasing reports of "faith curing" in sub-Saharan Africa, where people living with HIV and AIDS are told by faith leaders that they have been cured of HIV and AIDS, high morbidity and mortality are recorded. People who are encouraged to discontinue treatment get sick and die.
- The cases of many people dying because they failed to adhere to treatment due to exclusive faith-curing claims means we must advocate for faith healing that is complementary to other forms of healing as opposed to exclusive faith-healing claims. Faith healing is a holistic approach to HIV and AIDS, encouraging both prayers and treatment adherence.

Theological Meaning of Faith Healing

- Healing is different from curing/treatment. Healing is about re-establishing the balance of the body, spirit, and soul. Healing is about our whole lives as God's children. Curing wounds and fevers can be a part of it, but *only* a part. Therefore, curing is not the same as healing.
- The gospel is about healing, even though it includes both curing and healing. For instance, Simon Peter's mother-in-law had a fever, and Jesus healed

her (Matt. 8:14-15). She is not just restored to her normal daily work; she's restored to fellowship and to participation in the ministry of Jesus. She becomes part of the good news, part of the gospel, part of the community of God's people. That is healing.

- We can notice that as Jesus goes through Galilee, he spends a lot of time curing the sick, but he spends a lot of time praying and preaching and talking, too. This is because curing people is only one part of the package. Jesus does not just want the fever gone and the broken leg fixed – he wants more than that. He wants to heal us. Not just as individuals, but as a community and as a world. He wants us to be *whole*. He wants us to be renewed.
- Sometimes, healing means learning to live with what can't be cured. Sometimes, healing means accepting that things *can't* be fixed – and accepting that you are a beloved child of God even still. This means that there are times when we should say "Get thee behind me Satan" to those who promise cures for that which cannot be cured but from which we can be healed.

Exercise 1

Exercise objective: By the end of this exercise, participants will be able to distinguish between faith healing and curing/treatment.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 20 minutes

The facilitator will divide participants into groups of not more than six participants and allow the groups to reflect on the difference between faith healing and faith curing/treatment claims.

1. What is faith healing? Which aspects of human life benefit from faith healing?
2. Can faith without medicine cure HIV and AIDS?
3. What would you say to faith leaders who say they can cure HIV and AIDS?

The Importance of Faith Healing and Faith Curing/Treatment in the Context of HIV and AIDS

Faith heals and medicine sometimes cures – and it's all to the glory of God! Regardless of what people may believe and teach, what does the Bible tell us about using medicines? Does the Bible teach that it is sin to use them or that their use constitutes a lack of faith?

To begin our survey, let us take note of **Genesis 37:25,** which mentions that the Ishmaelites were trading with "balm." What is meant by the word "balm"? What is it and how is it used? **Exodus 30:34–35** gives us part of the answer.

We read Jeremiah's complaint in **Jeremiah 8:22**: "Is there no balm in Gilead? Is there no physician there? Why then has the health of my poor people not been restored?"

Jeremiah 46:11 states: "Go up to Gilead, and take balm, O virgin daughter Egypt! In vain you have used many medicines; there is no healing for you."

For proof, take note of **Jeremiah 51:8**: "Suddenly Babylon has fallen and is shattered; wail for her! Bring balm for her wound; perhaps she may be healed."

It is clear from the above biblical examples (though few) that faith healing does complement physician curing/treatment as a holistic approach to the wellbeing of any person. Therefore, it is important for people living with HIV to be encouraged to religiously take their medication as well as to pray. Such a holistic approach leads to holistic healing, even if a cure is not possible.

Exercise 2

Exercise objective: By the end of this exercise, participants will understand the complementary roles of faith healing and physician treatment.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 40 minutes

The facilitator will divide the participants into groups of not more than six and allow them to read the texts mentioned above and to reflect on and discuss them using the following questions as guidelines:

1. Does the Bible condemn healing/treatment or curing through medication?
2. Give examples of "balm" from your context, both traditional and Western/imported?
3. Is treatment adherence a sign of lack of faith or a sign of faith in the abilities endowed on physicians by God?
4. Is your country leadership/government aware of this phenomenon of faith healing only? Are they addressing it and how?
5. In view of your understanding of this unit, what would be your advice to governments regarding individuals who preach (in churches, on TV, or through electronic and print media) against treatment adherence to their HIV-positive congregants?

UNIT 7

ART Is God's Miracle

"He said, 'While the child was still alive, I fasted and wept; for I said, 'Who knows? The Lord may be gracious to me, and the child may live.'"
(2 Sam. 12:22)

Unit Objective

At the end of this unit, participants will recognize and accept the theological significance of ART in the context of HIV.

Background

The timing and importance of ART qualifies it be to be designated as "God's miracle."

- There is an emerging trend where some religious leaders have discouraged people living with HIV from using ART. They suggest that ART is not "of God," or that it has been developed by secular scientists.
- In some instances, they argue that abandoning ART serves as confirmation of "total faith" in God. In this perspective, not using ART is seen as a demonstration or confirmation of faith in God.
- The tendency to put faith healing and ART on opposite ends of the spectrum has caused many unnecessary deaths in the region. In other instances, it has led to drug resistance, resulting in complications.

Lest We Forget: AIDS-Related Deaths Prior to the Accessibility of Antiretroviral Therapy (ART)

The 1990s were characterized by high numbers of deaths due to AIDS. Many families and communities in Africa were decimated as a result of AIDS. This engendered a great deal of fear, as being diagnosed HIV positive was often experienced as a "death sentence." In the absence of ART, many people played the "waiting game," whose end result was the "visit" by death. During this period, many countries in eastern and southern Africa experienced very high death rates due to AIDS. Some urban councils began discussing the shortage of burial land. The high death rate led to many children being orphaned and left vulnerable. The effects of

the failure to access ART on time continue to be experienced in many African countries. During those days pastors also prayed for healing, but we did not hear of miracle cures. Eventually, everyone with HIV and without treatment died

Exercise

Exercise objective: By the end of this exercise, participants will have gained a deeper appreciation of the positive impact of ART in the management of HIV and AIDS. Participants will reflect on how AIDS decimated many communities and nations, and on how the availability of life-saving medication had positive health outcomes for individuals, families, communities and nations.

Method: small group discussion; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will divide participants into groups of not more than six participants and allow the groups to reflect on and discuss the period prior to the advent of ART, using the questions below as guidelines.

Younger participants can be assisted by providing them with data on AIDS-related deaths in the earlier period. Country-specific data is more effective than global statistics.

It is also very important for the facilitator to be aware that the exercise might generate deep emotions in some participants. Therefore, they must prepare adequately for such a possibility, for example, by ensuring that qualified counsellors are on stand-by.

1. What were the effects of not having access to ART in your community?
2. Comment on the impact on your community of the high death rate due to AIDS (if any) on some of the major practices associated with death.
3. How do you feel about the people (including relatives, friends, neighbours, and others) who died due to not having access to ART?
4. Reflect on what the situation would have been if the death rate due to AIDS had remained the same (or if the death rate had risen).

The Lazarus Effect: ART and the Restoration of Life

One of the most captivating stories in the Bible is that narrating the raising of Lazarus (John 11:1-44). It has been the focus of some popular songs that seek to retell the miracle of the raising of Lazarus. Lazarus, who had been lost to the living, is brought back to life by Jesus. In the context of HIV and AIDS,

there is need to recognize the miraculous effects of ART. Many people who were virtually on their death beds were brought back to life owing to ART. Individuals whose bodies were affected by HIV and AIDS had their physical features restored because of ART. The many deaths that characterized communities were stopped because of the effectiveness of ART. The effects have been so remarkable that medical doctors and communities refer to the introduction of ART as the Lazarus effect.

Exercise

Exercise objective: By the end of this exercise, participants will reflect on the impact of ART on the lives of people living with HIV: their families, communities, and countries. In particular, they will understand the fact that HIV has largely become a manageable disease, allowing people living with HIV to lead a normal life, produce children without transmitting HIV to their partner or the child, and remain economically active.

Method: small group discussion; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will then divide participants into groups of not more than six participants and will allow the groups to reflect on the impact of ART on the lives of people living with HIV, their families, communities and countries, using the questions below as guidelines. If there is a song that derives from the story of Lazarus, participants might sing it in plenary.

1. How has the availability of ART changed the lives of people living with HIV?
2. Comment on the health and economic effects of ART (noting also that people on ART can conceive and bear children without transmitting HIV with proper medical advice).
3. How accessible is ART in your community? If there is limited access, suggest possible solutions.
4. What has been the impact of faith healing on people living with HIV in your community?
5. What has been the impact of stigma and discrimination of people living with HIV (and those affected by HIV and AIDS) in your community?

"God's Miracles Take Various Forms": Antiretroviral Therapy as God's Miracle

Across many parts of Africa, some religious leaders (from African Traditional Religions, Christianity, Islam, or other religions) have compromised treatment adherence by claiming that only faith healing is from God. Alternatively, they maintain that abandoning or not initiating ART and relying exclusively on

faith healing is a confirmation of one's total reliance on God. Unfortunately, this had led to unnecessary deaths, complications, and generally negative attitudes towards ART. This is a tragic development, especially given that many Africans were actively involved in the struggle to make ART more accessible. Why should some religious leaders now discourage ART, when it has become more accessible and is saving lives?

Exercise

Exercise objective: By the end of this exercise, participants will appreciate the perspective that ART can rightly be regarded as a miracle from God. Consequently, faith healing is not the sole form of God's intervention in the context of HIV and AIDS.

Method: contextual Bible study[3]

Aids: Bible, flipchart, markers

Duration: 45 minutes

Read 2 Kings 5:1-15 to all participants. Then divide participants into groups of not more than six participants and allow the groups to reflect on the reading, using the questions below as guidelines.

The story includes some very powerful people such as Naaman, commander of the army of the king of Aram; the king of Aram; and the king of Israel. However, it is the humble people, particularly the young girl, who are critical in enabling Naaman's healing. They are also central to his new understanding of healing. God's prophet Elisha comes up with a form of healing that Naaman is not expecting. Naaman is expecting a form of healing that is dramatic; however, God provides a practical, simple but effective healing.

- The facilitator must emphasize that the discovery of ART has removed the "death sentence" that was formerly associated with HIV and AIDS. It is possible for individuals to be returned to good physical health, through both treatment and prayer, while HIV remains in our body.

Healing is different from a cure. There is currently no known cure for HIV. However, God's miracles occur in different ways for different people. We have prayed for God to help doctors find a way to treat HIV infection. ART is God's miraculous provision, now available to millions (up to 70% in sub-Saharan Africa).[4] All healing comes from God, and the God who is behind scientific discoveries is the same God behind spiritual healing.

1. What kind of healing was Naaman expecting from the prophet Elisha? Why was Naaman at first unwilling to follow Elisha's advice?

3. https://learn.tearfund.org/en/resources/publications/footsteps/footsteps_91-100/footsteps_98/bible_study_healing_and_antiretroviral_therapy_art/

4. UNAIDS Factsheets June 2017

2. How did Naaman's servants help him?
3. Are there people among us like those in the story? Who encourages people to go for testing and treatment? Who helps people to continue taking their ART?
4. What kind of treatment and healing has God provided for those of us living with HIV? Why is it important to continue with treatment and prayer even when we feel better?
5. As religious leaders, what must we do to promote health and healing for those of us living with HIV?

UNIT 8

Who Needs Healing? A Theology of Accompaniment

"While Peter was still thinking about the vision, the Spirit said to him, 'Look, three men are searching for you. Now get up, go down, and go with them without hesitation; for I have sent them.'" (Acts 10:19-20)

Unit Objective

By the end of this unit, participants will have engaged with the multiple effects of HIV and AIDS on different people to develop a holistic response to healing from HIV and AIDS.

Background

- We all know that there are people living with HIV. Some years ago, many of these would have seen their conditions develop into AIDS. However, due to the availability of ART, most people living with HIV lead very healthy and normal lives. We know that once the virus enters one's system, it will not depart, even though it is being successfully suppressed. Normally, we think these are the only people who are in need of healing.
- We also know that people living with HIV are members of families, communities, and countries. Their status affects all these communities in different ways. Do these communities and people living with HIV need healing as well?
- Families are affected because they see one of their own now living with a virus that refuses to leave their immune system. They sometimes must accompany their relative to clinics and hospitals for medical check-up and treatment. In most cases, they are the ones who will help their relative adhere to their treatment. And in cases where their relative falls sick, families are responsible in most cases for home-based care.
- Faith communities also face the challenges brought about by HIV. Faith communities are renowned for having the most durable bonds to individuals in good health and in sickness. Faith communities sometimes provide care for infected and affected members. Within faith communities are various professionals – such as nurses, doctors, counsellors, and many others – who often provide expertise in caring for infected and affected members.

- Health institutions, both state and church/faith-run, are critically involved in the care and treatment of people living with HIV and those with AIDS. Doctors, nurses and chaplains play a very important role in making health institutions, such as clinics and hospitals, integral in the care and treatment of people living with HIV and AIDS.
- Religious leaders who lead faith communities also sometimes double up as chaplains in clinics and hospitals. They play an important role in the care and treatment of people living with HIV and AIDS. Their words can give life – but sometimes their words can also kill those who still had life in them.
- The points raised above show that both people living with HIV and those affected by HIV are all in need of healing. In meeting this need, we should be guided by our understanding of healing as different from curing or treating. Healing is broader, encompassing treatment, cure, but also social, psychological, economic, and religious elements of human wellbeing.

Exercise 1

Exercise objective: By the end of this exercise, participants will have identified which groups of people need healing from the effects of HIV in their communities.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 20 minutes

The facilitator will divide participants into groups of not more than six participants. In these groups, the participants will choose a moderator and note-taker who will write down agreed points and also present the group findings to the plenary. The following questions and points will help the groups in their deliberations:

1. Identify the groups of people that need healing from the effects of HIV in your community.
2. Arrange the identified groups in order of priority for healing, with the first group being the one that is in greatest need.

Exercise 2

Exercise objective: By the end of this exercise, participants will have identified specific healing needs of the different groups affected by HIV in their communities.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will divide participants into groups of not more than six participants. In these groups, the participants will choose a moderator and note-taker who will write down agreed points and also present the group findings to the plenary. The following questions and points will help the groups in their deliberations:

1. List the different forms that healing takes for different people (e.g., economic empowerment).
2. Identify what form of healing the different groups identified in Exercise 1 need. A group may be in need of more than one form of healing. List all the forms that you think are applicable to each group.
3. Put the different forms of healing into two categories: category 1 includes healing that the community can implement without outside help; category 2 includes healing that the community would need outside help to implement.
4. What can religious leaders and faith communities do to heal communities and individuals affected by HIV and AIDS?

Theology of Accompaniment as a Necessary Tool for Faith Healing

- Having realized that many people in our faith communities have suffered and been scarred by the effects of HIV and AIDS, faith leaders and members of faith communities are called upon to become companions to all those living with HIV and affected by HIV. This is the basis for a theology of accompaniment, which must become visible in our communities.
- Theology refers to the ways in which we think, reflect, and talk about God. This means we all theologize every day of our lives.
- Accompaniment means walking together with someone or with others in solidarity. Their journey becomes our journey also. Through accompaniment, we become willing companions. People experiencing the effects of HIV and AIDS are on a journey, and faith communities are invited to accompany them in this journey (Acts 16:1-40).
- As believers, we believe that God accompanies us wherever we go and in whatever we do. And since God wants us to imitate God always, we believe that God also wants us to accompany others on their journeys. This is especially true if they are journeys of life and death, journeys that would be scary when undertaken in isolation (Jer. 1:7-8).
- Nowhere do we learn the significance of this better than "on the road to Emmaus" (Luke 24:13-53), when Christ accompanies the two men and even sits at a table with them. Accompaniment is a great way of living and preaching the gospel of life to those who feel isolated.

- As believers, accompaniment takes several forms, among them being:

1. Accompaniment through Prayer

Pray for those who may especially be in need of accompaniment due to the effects of HIV and AIDS (Gen. 20:1-18). Examples could include those who

- Have lost loved ones
- Feel lonely
- Are isolated
- Are abused
- Struggle with faith
- Have been abandoned
- Are incarcerated
- Are in nursing homes
- Are dying
- Are ill
- Are in times of transition.

2. Accompaniment through Study

Read Luke 2:1-20.

- What does it mean that God became fully human?
- What does this imply for us with regards to accompaniment?
- What does it mean to be in accompaniment with someone?

Read Genesis 2-3.

- Who created all things in the universe?
- How do the actions of God become a template for accompaniment?
- What can we learn from God's actions as we look for what to do for people suffering from the effects of HIV and AIDS?

3. Accompaniment through Worship

In the story of the road to Emmaus, Jesus walks alongside his disciples. Walking together, in a very literal sense, can be a form of worship. Consider taking a walk around the neighbourhood, praying for those in it. The hymn "We are Walking Together" is a powerful hymn for worship for accompaniment (Here facilitators must also find local hymns that express solidarity and togetherness.). Do not only pray for those in need of accompaniment, but worship with them as well. Make them trust that you include them in your prayers in their absence; make them feel they are not alone in the journey of faith by worshiping with them.

4. Accompaniment through Encouragement (Matt. 28:18-20)

People living with HIV and those affected by AIDS may become tired of life itself as a result of the stresses and difficulties they are encountering. Such people need to be encouraged so that they do not give up on life, on God, and on community. We accompany them by encouraging them and sharing our experiences of being accompanied also.

- What words or phrases of encouragement could you use with someone as you accompany them?
- What is your story of accompaniment? Who has accompanied you and how has that changed you? Your story may be a source of encouragement to others.
- Who are those in your faith communities who need encouragement and a reminder that they are not alone? How could you reach out to them?

5. Accompaniment through Serving (Matt. 23:11)

We are aware of people who can no longer do everything for themselves. We can become companions to such people by finding time to be with them in order to help them do things they cannot do for themselves. As believers, we are called to serve, as Christ also served.

- What are volunteer opportunities to practise accompaniment in your local setting?

Examples could include visiting nursing homes or jails, teaching Sunday school, working with confirmation, volunteering with programmes at schools, visiting affected people in their homes (helping with laundry, preparing a meal, etc.). These seemingly unimportant services are powerful manifestations of accompaniment.

6. Accompaniment through Giving (Deut. 24:19-22)

The effects of HIV and AIDS have left many people vulnerable, especially because HIV and AIDS left many elderly grandparents caring for young children orphaned as a result of AIDS-related deaths. Some of these grandparents are too old to work to provide for their grandchildren. In other cases, young children have been left to fend for themselves, with older siblings acting as heads of households.

- In such cases, accompaniment may also mean providing material things such as food, clothing, and shelter to those vulnerable persons. Consider making such provisions to some vulnerable families as you accompany them.

7. Accompaniment through Empowerment (Gen. 12:7)

Orphans, widows, and grandparents have been the most affected by HIV and AIDS, especially because most of them have not been able to fend for themselves economically. Accompaniment to these persons can also take the form of empowerment. For example, resources can be provided to them to help them sustainably fend for themselves and their families. This accompaniment can include:

- Payment of tuition and examination fees for orphans
- Providing seed money for widows and grandparents taking care of orphans to start small income-generating projects.

Exercise

Exercise objective: By the end of this exercise, participants will have understood the importance of accompaniment and drawn up action plans of how they will accompany persons affected by HIV and AIDS in their community.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will divide participants into groups of not more than six participants. In these groups, the participants will choose their moderator and secretary who will write down agreed points and also present the group findings to the plenary. The following questions and points will help the groups in their deliberations:

1. What does accompaniment mean to you in the context of HIV and AIDS?
2. Which groups of people in your community are in need of accompaniment?
3. What can you do to accompany people affected by HIV and AIDS in your community without outside help?
4. What would you want to do to accompany people affected by HIV and AIDS in your community but for which you need outside help?

UNIT 9

Children, Adolescents and Young People, and Faith Healing in the HIV Context

"For you, O Lord, are my hope, my trust, O Lord, from my youth. Upon you I have leaned from my birth; it was you who took me from my mother's womb. My praise is continually of you. I have been like a portent to many, but you are my strong refuge." (Ps. 71:5-7)

Unit Objectives

By the end of this unit, participants will:

- Understand how children, adolescents, and young people who are HIV infected and HIV affected are impacted by concepts of faith healing
- Learn how children, adolescents, and young people living with HIV can live a positive life in the context of this epidemic
- Understand how stigmatization and discrimination continue to affect children, adolescents, and young people infected and affected by HIV and AIDS.

Background

- Adolescents and young people constitute one of the most invisible populations affected by HIV in sub-Saharan Africa and the world over.
- Besides the young people who continue to be infected because of various economic, religious, social, and political reasons, there is also now a generation of young adults who were born with the virus. The rise of Prevention of Mother to Child Transmission (PMCT) treatment has seen the rise of a generation of HIV negative children born to HIV positive parents. However, before this scientific achievement, many children born HIV positive were then introduced to ART and have grown into young adults.
- How must religious leaders address the reality of these youngsters: their sexuality, faith healing, and ART? For a long time, faith communities have tended to ignore children and adolescents whenever sexuality comes up for discussion. Often sexuality is discussed with young adults in rigid terms, with a call for abstinence until marriage even when the message is no longer applicable or when young people – young women in particular – have no

choice over their sexual partners. In these latter cases, others choose for them or force sexual activity upon them.

- How can religious leaders create an environment where stigma is not a stumbling block for the wellbeing of these children, adolescents, and young people? AIDS-stigma is a critical obstacle to HIV prevention and AIDS care, and some research has investigated the impact of the attitudes of faith institutions towards people living with HIV. The religious sector has been faulted for delayed responses, for failure to acknowledge the scope of the implications of rising HIV infection rates, and for moralistic, judgmental, and socially conservative stances towards HIV and AIDS that have contributed to silence and secrecy. The association of HIV infection with poor moral or reckless behaviour and the failure to openly discuss the root causes underpinning HIV transmission – particularly differentials in power – have contributed to the stigmatization and discrimination of people living with HIV and AIDS within the church.

Adolescents Living with HIV and Christian Institutions

- The status of adolescents living with HIV and AIDS in Christian institutions is a sad story when related to the negative attitude they face in their churches. That Christian institutions preach the message of abstinence is beyond doubt, but how they translate this message in relationship to those already living with HIV is doubtful. The negative view that HIV and AIDS are a curse from God for permissiveness has defined how Christian theologies have interpreted the Bible in relation to HIV and AIDS. Sometimes adolescents and young people living with HIV are included in church registers, but in real terms they are excluded on serious church matters. Stigma and discrimination against people living with HIV range from subtle to direct, and are usually manifested in the pastors' sermons, healing altar calls, and Bible study teachings.
- Some young people living with HIV give up their ART treatment after being told by church pastors to rely on faith healing, which is presented as faith curing and therefore exclusive of ART treatment. Healing is central to many churches, and there is a radical belief in the power of prayer and miracles. These young lives struggling with HIV stigma and discrimination are being falsely persuaded that if they drop their ART treatment and increase their prayers and faith, then they will be cured of HIV. Many such adolescents and young people end up on their death beds as a result of their coerced failure to adhere to their treatment regimes. In some cases, parents have been coerced into stopping their young children's ART treatment as they are promised a miracle cure for their children.

"Miracle Cure"

Sixteen-year-old Oliver (not his real name) said he was told by a pastor to swap his HIV medicine for a plastic bottle containing water that would heal him. He said many others had faced the same pressure: "I've been to other churches where . . . the pastor stands forth there, and he says, 'Come take this water . . . if you drink it for this certain amount of days, you are going to be healed.'" Later, after his mother experienced what he believed was a miracle cure, Oliver stopped taking his medication, and his condition quickly deteriorated. He has since gone back to his medication and said he believes he must combine his medication with his belief in faith healing. Health workers and institutions need to stay engaged with families and understand that their faith is an important part of the support they get for their condition.

- It is very wrong for faith leaders to actively encourage their congregants living with HIV to stop taking their medication.
- Prayer is not a substitute for HIV treatment. Instead, prayer compliments ART treatment to achieve holistic healing.
- A great potential exists within the religious sector to provide care, comfort, and unique spiritual support to communities living with and affected by HIV and AIDS.
- It is essential that faith leaders engage with HIV as an issue and provide effective and truthful support and communication around the subject. Faith organizations can make a positive contribution to raising awareness of HIV, highlighting the benefits of testing and effective ART adherence to all adolescents living with HIV especially when it is complimented with prayer and faith.

Survival Life Skills for Adolescents in the Context of HIV and AIDS

- In the case of the generation of adolescents and young people born HIV positive or HIV negative, religious leaders need to impart the life skills and correct information that will equip them to negotiate safer sex and adhere to treatment regimens (where necessary) to avoid infections or re-infections.
- Adolescents who are HIV positive can use both faith and bio-medical treatment as a survival life skill. Bio-medical treatment, which is the use of modern medicines, works in tandem with the invocation of supernatural forces and not against them. It is important to impress upon young people and adolescents that these are not exclusive of each other.
- HIV counselling and testing (HCT) is vital for providing comprehensive HIV prevention, treatment, care, and support. It encourages adolescents,

individual adults, couples, families, and communities to know their HIV status and supports positive living, healthy lifestyles, and good nutrition. It also helps identify and reduce behaviours that increase HIV transmission risks.

- Religious leaders must work with health service providers and adolescents and young people to inculcate health-seeking behaviour among those testing positive (e.g., linking them to care services and supporting adherence to ART). This implies equipping religious leaders with skills to impart CSE or Sexual and Reproductive Health and Rights (SRHR) to adolescents and young people.
- Religious leaders must develop partnerships with adolescents and young people, who can become peer educators on testing, disclosure, and treatment adherence.
- The church can be a valuable partner in responding to adolescents living with HIV. It can augment and collaborate through supplication of prayers, psychosocial care, and support. The health sector provides medical support and health promotion campaigns. Discerning what God is saying to Christians in the midst of HIV and what their response should be is properly the responsibility of the whole church. To this end, adolescents must have positive faith whilst taking their medication or adhering to treatment.

Exercise

Method: small groups; plenary
Aids: flipchart, markers
Duration: 30 minutes

The facilitator will divide participants into groups of not more than six participants and allow the groups to reflect on adolescents and faith healing in the context of HIV and AIDS. They will also reflect on and discuss promoting a family approach to HIV care; HIV-infected adolescents in Christian institutions/churches; and HIV and AIDS awareness and survival life skills for adolescents, using the following questions and points:

1. As a family, how would you handle or relate to an HIV positive family member?
2. How are adolescents living with HIV (if there are any in your church) dealt with or related to?
3. Do you see any stigmatization and marginalization against HIV-positive adolescents or young people in your church?
4. Do adolescents and young people in your church have access to ART? What are the challenges and opportunities relating to young people's access to ART?
5. How can faith communities reach out to accompany learners (adolescents) living with HIV in schools, including boarding schools?

UNIT 10

Re-defining Faith Healing for Transformative Faith Communities

"The Spirit of the Lord is upon me, because he has anointed me to bring good news to the poor. He has sent me to proclaim release to the captives and recovery of sight to the blind, to let the oppressed go free." (Luke 4:18)

Unit Objective

At the end of this unit, participants will have an understanding of transformative faith communities after re-defining faith healing in a holistic perspective.

Background

This unit offers an understanding of faith healing that is much broader than curing, as defined before. It acknowledges that the HIV virus, once absorbed into the blood stream, will remain there for good, until a medication is found that can expel it. However, we believe, as people of faith, that people living with HIV can be healed where healing means getting to a stage where individuals:

- Can manage HIV and its effects
- Can lead normal lives like everybody else, including getting married and having children
- Are not stigmatized or discriminated against but integrated into society and community
- Are able to economically fend for themselves and their dependents.

In this case, persons living with HIV would be in a position to accept themselves (overcome self-stigma) and be accepted by society and community like anybody else. Such persons are healed but not cured. Faith healing, therefore, focuses on helping people living with HIV to access all the services they need in order to lead normal lives. When faith communities play this role, they become transformative: They work with all other professionals to bring about holistic healing to people living with HIV. Such healing filters down to people affected by HIV as well.

Re-defining Faith Healing

- Re-defining faith healing can be understood as the third therapeutic system that co-exists with the well-documented bio-medical and traditional systems.

- Biblical allusions to healing also help to put the essence of faith in context. The advent of HIV and AIDS has brought new dimensions to spirituality and healing which have somehow exposed multitudes (Christians and non-Christians alike) to charlatans disguised as healers, pastors, and prophets who claim that the Holy Spirit defeats all illnesses. Their prescription of prayers and use of oil, holy water, and other agents to effect healing sometimes defeats attempts to contain the spread and potency of HIV and AIDS, as those who are said to have been healed stop taking ART and ending up dying. This practice is not faith healing, and it should be opposed by all right-meaning Christians in the context of HIV and AIDS.
- Christians and their communities have a role to play in the fight against suffering, especially in the era of HIV and AIDS. Healing is not only physical but also spiritual. If individuals believe that they are healed, and society accepts them as being healed, then indeed they will be healed. Just as was the case with lepers who were condemned to the periphery of existence because of their condition, HIV and AIDS can only be subdued if healing ceases to be an individual effort. Everyone must be involved, including professionals such as doctors etc., with the church as a partner and not a competitor.
- People should be enlightened that ART is God's plan in conquering HIV and AIDS, and that doctors – like prophets, healers, and pastors – are God's vessels. Healing comes through the intervention of supernatural and natural forces. God's intervention comes in many forms. What is important at the end is the realization that the totality of healing is not an individual effort.
- Bio-medical healing, which is the use of modern medicines, is as natural as the use of holy oil, water, mud, leaves, and roots. It works in tandem with the invocation of supernatural forces and not against them.
- Faith healing refers to the ability of faith to help restore balance to individuals by addressing the psychological, biological, social, economic and spiritual issues that create the lack of balance. Faith healing is holistic and compliments treatments prescribed by medical and psychiatric professionals.
- Communities must remember that true prophets of God are agents of life and not death. If anyone claims to be a prophet of God yet proclaims and encourages a message and action that brings death, then that prophet cannot be a true prophet of God. False prophets encourage people on ART to discontinue treatment, leading to deterioration of health and death.

Characteristics of Transformative Faith Communities

A great potential exists within the religious/faith societies and communities to provide care, comfort, and unique spiritual support to HIV- and AIDS-infected/affected communities. Furthermore, transformative faith communities live out their teachings. These teachings encourage the love of one's neighbour and

those less fortunate, compassion, acceptance of others, and tolerance of "others" who may be different in terms of religion, race, and creed. Transformative faith communities oppose all forms of stigma and discrimination against HIV and AIDS affected people.

- **Transformative faith communities are members of different faith communities**. They are called by God to affirm a life of hope and healing in the midst of HIV and AIDS. The enormity of the pandemic itself has compelled them to join forces despite their differences of belief. Their traditions call them to embody and proclaim hope and to celebrate life and healing in the midst of suffering. HIV and AIDS is an affliction of the whole human family, a condition in which they all participate.

- **Transformative faith communities are called to love.** God does not punish with sickness or disease but is present together with his people as the source of their strength, courage, and hope. The God of their understanding is, in fact, greater than HIV and AIDS.

- **Transformative faith communities are called to compassionate care.** They must assure that all who are infected and affected by the pandemic (regardless of religion, race, class, age, nationality, physical ability, gender, or sexual orientation) will have access to compassionate, non-judgmental care, respect, support, and assistance.

- **Transformative faith communities are called to witness and do justice.** They are committed to transform public attitudes and policies, supporting the enforcement of all communities' cultural and national laws to protect the civil liberties of all persons living with HIV and AIDS and persons with disabilities. They further commit to speak publicly about HIV and AIDS prevention, treatment adherence, and compassion for all people.

- **Transformative faith communities promote prevention.** Within the context of their respective faiths, they encourage accurate and comprehensive information for the public about HIV transmission and means of prevention. They vow to develop comprehensive HIV and AIDS prevention programmes for youth and adults.

- **Transformative faith communities acknowledge that they are part of a global community.** While HIV and AIDS are devastating to communities and societies, their effects are much greater in magnitude in other parts of the world community. Transformative faith communities recognize and appreciate partnerships and collaborations with others in the world.

- **Transformative faith communities deplore the sins of intolerance and bigotry.** HIV and AIDS is not a "discriminating" pandemic. It affects men, women, and children of all races. Transformative faith communities reject the intolerance and bigotry that have caused many to deflect their energy,

blame those infected by HIV and AIDS, and become preoccupied with issues of sexuality, worthiness, class status, or chemical dependence.

- **Transformative faith communities challenge their society.** Because economic disparity and poverty are major contributing factors in the HIV and AIDS pandemic and barriers to prevention and treatment, these communities call upon all sectors of society to seek ways of eliminating poverty in a commitment to a future of hope and security.
- **Transformative faith communities are committed to action.** They will seek ways to respond, practically, to the needs around them.
- **Transformative faith communities promote holistic faith healing.** By reading the scriptures, the church supports the infected and affected persons morally and spiritually and also prays with and for them. It gives support through the scriptures, which are read to encourage and motivate the infected and affected. Furthermore, it supports them through deploying the theology of accompaniment.
- **Transformative faith communities adhere to the bio-psycho-socio-spiritual approach to healing.** Such communities acknowledge the roles of various players – such as physicians, nurses, counsellors and pharmacists – to achieve holistic healing of the infected and affected persons.

Exercise

Method: small groups; plenary
Aids: flipchart, markers
Duration: 30 minutes

The facilitator will divide participants into groups of no more than six participants and allow the groups to reflect on re-defined transformative faith communities and the characteristics of transformative faith communities, using the following questions and points:

1. Do you think it is important to re-define faith healing in the context of the HIV and AIDS pandemic?
2. Do you think the re-definition of "faith healing" provided in this unit is adequate? If no, what would you add to the provided re-definition of "faith healing"?
3. In your opinion, do you think the characteristics of transformative faith communities can be justified?
4. What are your views in relation to churches in your communities vis-à-vis the characteristics of transformative faith communities?

UNIT 11

Strategies for Holistic Healing: Adopting a Bio-Psycho-Socio-Spiritual Approach to Healing

"Be gracious to me, O Lord, for I am languishing; O Lord, heal me, for my bones are shaking with terror. My soul also is struck with terror, while you, O Lord – how long? Turn, O Lord, save my life; deliver me for the sake of your steadfast love." (Ps. 6:2-4)

Unit Objective

By the end of this unit, participants will understand the multiple effects of HIV and AIDS and how to achieve holistic healing for those infected and affected by HIV and AIDS.

Background

This unit introduces holistic healing, which is an attempt to eliminate all forms of affliction that human beings experience in their lives that cause them to be not only sick but also unwell. Holistic healing can only be achieved if we all come together to address all the different things that affect people.

Multiple Effects of HIV and AIDS

HIV and AIDS have affected individuals, families, and communities in many ways. The effects have made communities sick in various ways. It is difficult, if not impossible, to find people who have not been affected by HIV and AIDS today. The following are some of the ways in which people have been affected by HIV and AIDS:

- Some people have been infected by the virus. These must live with the virus for the rest of their lives because there is no cure.
- Some people have died from AIDS-related illnesses. Others continue to die from the same in many communities, although the numbers of those dying have been drastically reduced owing to ART.
- Some people have fallen sick and been unable to work as their immune systems have been attacked by HIV. Their inability to sustain themselves and their families makes their families vulnerable to poverty.

- Most communities and families have seen their productive generations killed by AIDS, leaving them seriously understaffed in production areas. This makes the communities vulnerable to poverty as well. Such communities are left with young children not yet ready for serious productive work and elderly people who are already past their productive age.
- Having lost the productive generations, most societies have witnessed cases of child labour, as young children heading their families are forced to work to sustain their siblings. Elderly people also continue to work past their pensionable ages, as they seek to sustain their grandchildren.
- Many societies have seen psychologically scarred children, traumatized by seeing their parents sick and wasting away to death while they transitioned prematurely from being children to becoming heads of families.
- Some grandparents have also been scarred psychologically, as they witnessed their children dying while they were re-called to the difficult business of caring for children at a time they were hoping to be cared for by their adult children.
- Faith communities have been severely shaken as they witnessed the warriors of faith succumb to AIDS, especially since faith communities once (and some continue to) proclaimed that AIDS was a sickness of the immoral. Such communities are scarred spiritually.
- Members of the faith communities infected and affected by HIV have also been spiritually scarred, having to deal with the stigma and rejection of their communities. Some even neglected their faith as they journeyed with the virus and sickness. Orphans and elderly parents who deserted the faith community because of the stigma are equally scarred spiritually.

Looking at all these effects, we can see that HIV and AIDS have affected people biologically, psychologically, socially, economically, and spiritually. This means that those infected and affected by HIV may suffer in all these ways; they also need healing from all these elements.

Exercise 1

Exercise objective: By the end of this exercise, participants will have understood the various ways in which HIV and AIDS have affected their communities.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 20 minutes

The facilitator will divide participants into groups of no more than six participants. In these groups, the participants will choose a moderator and secretary,

who will write down agreed points and also present the group findings to the plenary. The following questions and points will help the groups in their deliberations:

1. Share your experiences of how HIV and AIDS affected your community before and after the greater availability of ART (focus on which age group was most infected, which age group saw the most deaths, how this affected the population, and the main problems your community has had to deal with).
2. What was your faith community's message about HIV and AIDS and those infected and affected by it? What is your faith community's message now to people living with and affected by HIV and AIDS?

Exercise 2

Exercise objective: By the end of this exercise, participants will be able to identify the different effects of HIV and AIDS in their community.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will divide participants into groups of not more than six participants. In these groups, the participants will choose a moderator and secretary, who will write down agreed points and also present the group findings to the plenary. The questions and points below will help the groups in their deliberations. As suggested in the points above, HIV and AIDS affect people biologically, psychologically, socially, economically, and spiritually. In this exercise, we must explain and clarify these effects.

1. List examples of biological effects of HIV and AIDS on people infected and affected by the virus.
2. List examples of psychological effects of HIV and AIDS on people infected and affected.
3. List examples of social effects of HIV and AIDS on people and communities affected by the pandemic.
4. List examples of economic effects of HIV and AIDS on individuals, families, and communities affected by the pandemic.
5. List examples of spirituality effects of HIV and AIDS on individuals, families, and faith communities affected by the pandemic.

Holistic Healing: An Approach to Addressing the Effects of HIV and AIDS

- We normally think of healing when we hear of sickness because healing has always referred to the process of removing sickness from one's body. In this case, healing is the medical correction of a biological affliction of the human body. However, in previous units and in the preceding section, this manual has challenged this understanding of healing as being too narrow and neglecting other forms of healing that we all want to achieve.
- Holistic healing is an attempt to eliminate all forms of affliction that human beings experience in their lives that cause them to be, not only sick, but also unwell. Holistic healing can only be achieved if we all come together to address all the different things that affect people.
- In the preceding section, we observed that HIV and AIDS have caused sickness, poverty; disruption of social relationships; and psychological, spiritual, and economic torment. This means, therefore, that if holistic healing is to be achieved, we must address all these aspects.
- Through deliberations in Kampala in 2017, participants hailed the importance of a holistic approach to healing – the bio-psycho-socio-spiritual approach – as the best strategy to achieve sustainable holistic healing for persons living with HIV and all the people and communities affected by HIV and AIDS.
- This approach discourages exclusive faith-healing claims from faith leaders and it also discourages a blanket dismissal of faith healing by non-faith practitioners. Instead, it invites all practitioners to come together to achieve holistic healing.
- What is a bio-psycho-socio-spiritual approach to healing? In short, this approach calls for the collaboration of various sectors in combating HIV in order to achieve healing.

    1. **Bio** represents biological. This refers to the need for biological and medical input toward holistic healing. Medical professionals such as doctors, nurses, and pharmacists have an important role to play, as they focus on the medical problems faced by people infected by the virus. All other people have an obligation to support the work of medical professionals in this regard. The most important role that all others can play is to encourage people undergoing medical treatment to adhere to it. ART belongs here!
    2. **Psycho** represents psychological. This refers to the need for psychologists' input toward holistic healing. The mental strain caused by knowing you are living with a virus that can never leave your system is great and must be dealt with to achieve healing. The mental strain caused by seeing a loved one struggle with the fact they are living with the virus or succumbing to

the virus and AIDS-related sicknesses leaves psychological scars on the individual and or communities. Psychologists, therefore, are an integral part of the search for holistic healing in the context of HIV and AIDS.

3. **Socio** represents social, but it has a broader meaning in this usage. Socio covers social and economic elements in our lives. HIV and AIDS has caused many problems, including disruption of relationships as people are rejected, excluded, and discriminated against by families and communities. It has also caused disruption of economic activities – people have lost jobs because they are too sick to work and companies have lost production as the workforce is decimated. Because of HIV and AIDS, families have been exposed to poverty. The number of orphans and child-headed families has increased. Holistic healing must address these social and economic challenges because they cause human beings to be unwell. Professionals in these areas, along with everyone else, must find ways to strengthen family and community bonds and fight against poverty.
4. **Spiritual** represents human spirituality and faith, which have not escaped the effects of HIV and AIDS. Many people, both infected and affected, have been led to question their spirituality and faith when faced by the reality of HIV and AIDS. Many people, infected and affected, have turned to spirituality and faith when faced by the reality of HIV and AIDS. In times of great pain, many people have sought the spiritual assurance that God is with them. Chaplains and ordained ministers of religion and faith communities in general must also take up their positions in the quest to achieve holistic healing. For some people, ART cannot be successful unless religious leaders assure them that ART has been inspired by God or lays their hands on them in prayer.

- Holistic healing can only be achieved if all people in all these different areas come together and work together to address the various ailments that human beings are suffering from in this context of HIV and AIDS.

Exercise 1

Exercise objective: By the end of this exercise, participants will have learned and understood the proposed strategy for holistic healing in the context of HIV and AIDS.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will divide participants into groups of no more than six participants. In these groups, the participants will choose a moderator and secretary, who will write down agreed points and also present the group findings to

the plenary. The following questions and points will help the groups in their deliberations:

1. According to this manual, what strategy is proposed for achieving holistic healing in the context of HIV and AIDS?
2. Why is it important to work together to achieve holistic healing for people living with HIV and people affected by HIV and AIDS?

Exercise 2

Exercise objective: By the end of this exercise, participants will be able to draw up a possible action plan on how they will participate in this bio-psycho-socio-spiritual approach to holistic healing.

Method: small groups; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will divide participants into groups of not more than six participants. In these groups, the participants will choose a moderator and secretary, who will write down agreed points and also present the group findings to the plenary. The following questions and points will help the groups in their deliberations:

1. In which category or categories of the strategy do you belong? (It is possible for one to belong to more than one category.)
2. List the things that you can do in your category to contribute to the healing of individuals and communities, with and without outside help.
3. List the things that you can do to help others in different categories make their own contributions to healing individuals or communities.
4. Why do you think holistic healing is important?

SECTION 3

Strategies for Achieving Holistic Healing in the Context of HIV and AIDS

UNIT 12

Appreciating Partnerships and Collaborations

"For where two or three are gathered in my name, I am there among them."
(Matt. 18:20)

Unit Objective

At the end of this unit, participants will understand the importance of partnerships and collaborations.

Background

To have a greater impact in the societies in which we work, it is always important to pull resources, including our minds and ideas, together. We stand a better chance of doing more if we combine resources than if we work separately. Traditionally, our societies had "get togethers" for the purpose of helping each other in the fields. Since HIV and AIDS affect communities, not simply individuals, they are best responded to through working together in partnerships with others in related fields. Holistic healing means addressing all factors that worsen the situation of communities affected by HIV and AIDS, such as food production, medication procurement, spirituality, and relationships. Since no single group can do all the things necessary to provide healing, it is important to come together and work together to achieve holistic healing for individuals and communities.

- World figures spell out the stark reality of the AIDS epidemic for African nations and developing nations in other continents. The impact of HIV and AIDS currently being experienced in Africa will be present for years to come.

- Some of the wider dimensions of the HIV and AIDS crisis in Africa are now well recognized, as is the need to mount an extraordinary response. HIV and AIDS present unique challenges requiring unparalleled action through partnerships and collaborations with all stakeholders in societies and communities.
- The HIV and AIDS epidemic threatens human health and development and destabilizes society, and is amplified and fuelled by wars, civil strife, and movements of people. Moreover, the fight against HIV and AIDS is being affected by the drying up of resources, making every penny and dollar extremely important and to be used in the wisest of ways.
- HIV and AIDS differs from most other lethal epidemics in that it claims the lives of people when they are at their most productive and when they are likely to be parents of dependent children. In particular, HIV and AIDS have reversed four decades of development in Africa and threaten future development and populations.
- It is, therefore, critical that those who are playing a role in responding to this epidemic avoid duplicating and unnecessarily overlapping activities to avoid double spending the meagre resources available for this work.

What Is Partnership?

- Partnership refers to an arrangement (formal but sometimes informal) where parties, known as partners, agree to cooperate to advance their mutual interests. These may at times involve relationships between organizations that may not be automatically recognized as likeminded.
- For example, partnerships may involve a health care service provider, a faith-based organization, an agricultural assistance organization and a funding organization. These seemingly different organizations can bring their different expertise to work towards the same goal.
- Partnerships thrive when clear roles and responsibilities are outlined for each of the partners and accountability mechanisms are put in place.
- In a partnership, partners are accountable to each other to develop and strengthen trust between them.

What Is Collaboration?

- Collaboration is closely related to partnership, but it is also different. While partnerships in general result in some of collaboration, not all collaborations are partnerships.
- Collaboration is a joint effort of multiple individuals or work groups to accomplish a task or project. Most collaboration occurs among like-minded organizations, where they pool their resources to achieve a common target.

- Collaboration, therefore, is closer to cooperation than partnership.
- For example, WCC-EHAIA-promotes HIV competence among churches and works with theological institutions to integrate and mainstream HIV into theological curricula, as well as addressing the root causes of the pandemic. ARASA is a regional partnership of non-governmental organizations working together to promote a human rights approach to HIV, AIDS and TB in southern Africa through capacity building and advocacy. It is constituted in the form of a trust, and all partner organizations are members of the trust. Steering committees – comprising trust members – act as advisory boards for the two ARASA programme areas: (i) training and awareness raising and (ii) advocacy and lobbying. And INERELA+ is an international, interfaith network of religious leaders – both lay and ordained, women and men – who are living with or personally affected by HIV. It looks to empower its members to use their positions within their faith communities in a way that breaks silence, challenges stigma, and provides delivery of evidenced-based prevention, care, and treatment services. They can pool resources to produce a manual on faith healing and treatment adherence. While their individual resources may not be sufficient to produce their own manuals, if they pool their resources, they can produce the manual and share it.
- Collaborations are cost effective in a context of limited resources, and, therefore, are very important.

Fundamental Characteristics and Principles of Partnerships and Collaborations

- **Shared visions and goals** (good practices): Partnerships that are built on shared visions and goals will help promote mutual support and solidarity beyond the implementation of specific programmes and projects. Partnering with a different sector helps to open new opportunities and increase the reach of public engagement initiatives.
- **A spirit of inclusion** (good practices): Partnerships and collaborations that are formed in a spirit of inclusion can better respect and promote the value of diversity. Working with others allows for a diversity of organizations to be part of the conversation, helping to ensure that public engagement initiatives reflect diverse voices, actors, and opinions.
- **Respect, honesty, transparency, and accountability** (good practices): The best partnerships are dynamic relationships founded on respect and honesty, in which partners strive for better understanding and appreciation of one another. They ensure all partners have a clearly defined understanding of how finances for the activity/project will be handled. They build in processes that encourage and ensure transparency and accountability. It is important to respect the value and contributions of each partner in the partnership or collaboration.

- **Respect for autonomy** (good practices): Each partner or collaborator is an autonomous organization. This brings with it responsibilities and obligations related to structure, governance, accountability, etc. that may differ between organizations. It is important to discuss and understand partners' obligations and constraints up front and take them into account when making decisions.
- **Facilitation of the sharing of knowledge** (good practices): While collaborations operate much more fluidly, an effective communications plan with specific timelines for communications among partners is critical to ensure knowledge is shared.
- **Negotiation of objectives, expectations, roles, and responsibilities** (good practices): Each partner or collaborator will use checklists or survey tools to identify their own organization's objectives, expectations, roles, and responsibilities within the partnership, as well as those of their potential partners. They will make certain all partners understand these fully to avoid misunderstandings. Written documentation of the discussions related to the above is critical.

Advantages/Benefits of Partnerships and Collaborations

Partnership-based approaches to dealing with challenges have become increasingly popular among policy makers. The following are advantages/benefits of partnerships:

- **Facilitating innovation and evaluation**: Partnerships/Collaborations arguably have greater scope to test new and innovative approaches, as partners/stakeholders coming together from a range of different backgrounds can produce greater dynamism through sharing ideas, expertise, and practice, and risks can be contained.
- **Sharing knowledge, expertise, and resources**: A defining feature of any inter-organizational partnership/collaboration is the manner in which skills, knowledge and expertise are shared in order to maximize the appropriateness, quality, and efficiency of problem-solving capacities.
- **Pooling resources, synergy**: At the most basic level, partnership-based approaches can increase the total level of resources brought to bear on social, economic, political, and health challenges. Synergies may also be achieved through this coming together.
- **Improving efficiency and accountability**: One of the key benefits associated with effective inter-organizational collaboration/co-operation and partnership is that it can lead to more efficient policy delivery by eliminating the duplication of effort and improving communications.

- **Building capacity**: Partnerships and collaborations that incorporate local stakeholders can build community capacity and engender a sense of community ownership.
- **Gaining legitimation and "buy-in"**: The tapping up of "local knowledge" through the involvement of community-level partners/stakeholders can contribute to developing approaches that can effectively address localized problems. Engaging community-level partners/stakeholders can also result in the legitimation of, and mobilization of local support for, new policy goals.

Disadvantages/Problems/Limitations of Partnerships

Like all other forms of coming together of different players, partnerships and collaborations do face some challenges that affect their effectiveness:

- **Conflict over goals and objectives**: A lack of clear specific aims or goals is often cited as a major cause of the failure of partnerships. Many partnerships have agreed broad aims, but their detailed goals may be unclear, or the partners may have differing understandings of what the goals mean. This may be accentuated if some partners have undeclared or "hidden" agendas. At the strategic level, conflicting priorities and "turf wars," where different agencies fight over control of an issue or service, can undermine attempts at developing collaborative approaches.
- **Costs of resources**: There are considerable resources costs, for instance in terms of partners' employees' time in meetings and discussions and in delays to decisions due to consultation with other partners. It may also be difficult to close an inefficient or unsuccessful partnership, or even one whose objective has been achieved, if all partners do not agree, as this may "sour" relations elsewhere.
- **Accountability**: There can also be problems of accountability because no single partner feels fully accountable for the actions of the partnership due to the split between responsibility and control (e.g., no single body takes full responsibility for problems or for ensuring that overall the policy is effective and efficient). It may not be clear "who is in charge."
- **Organizational difficulties**: Some of the critical barriers to effective partnership or collaboration include organizational (these include differing missions, professional orientations, structures, and agency processes); legal/technical (statutes or regulations set down by higher authority; technological capacity and practice of the organization); and political (the external political environment but also internal bureaucratic politics).
- **Differences in philosophy among partners**: There are a variety of related factors that have affected the development and implementation of partnerships, such as differing value and ethical systems between the different partners.

- **Power relations**: The handling of differences in the relative power of the bodies or individuals in a partnership is important to its success. There will be different balances of power between actors at different stages of a partnership. This needs to be carefully managed, because it has the potential to destroy partnerships and collaborations.
- **Community participation**: In regeneration partnerships, a lack of "community capacity" consistently undermines the ability of local partners/stakeholders to engage in partnerships. Further, the increasing involvement of the voluntary sector as a delivery partner "risks subverting the legitimate role" of community organizations.

Exercise

Method: small groups; plenary
Aids: flipchart, markers
Duration: 40 minutes

The facilitator will divide participants into groups of not more than six participants and allow the groups to reflect on partnerships and collaborations, how partnerships and collaborations work, and why it is fundamental to cultivate and maintain partnerships and collaborations in general as well as in the context of HIV and AIDS. Further, participants should critically reflect on the characteristics of partnerships and collaborations, key principles and advantages/benefits as well as disadvantages/problems/limitations of partnerships and collaborations, while discussing the following questions and points:

1. What is partnership and collaboration? Highlight their differences and similarities.
2. To what extent do partnerships/collaborations contribute to the broader goals in your community in the context of HIV and AIDS?
3. How do partnerships and collaborations work?
4. Considering partners who are working in your community, are there times when you think it is better not to allow partners or collaborators? What are the advantages and disadvantages of collaborations? What are the advantages and disadvantages of partnerships?
5. Think about a collaboration or partnership that did not achieve the expected goals and list the factors that contributed to this result. Examine how these could have been prevented?
6. What partnerships/collaborations would be needed to address faith-healing issues?

UNIT 13

Advocacy and Communication

"Is not this the fast that I choose: to loose the bonds of injustice, to undo the thongs of the yoke, to let the oppressed go free, and to break every yoke? . . . If you offer your food to the hungry and satisfy the needs of the afflicted, then your light shall rise in the darkness and your gloom be like the noonday." (Is. 58:6-10)

Unit Objectives

At the end of this unit, participants will understand:

- The meaning of advocacy in the context of ART and faith healing
- The importance of communication in the context of ART and faith healing
- The important role of religious leaders in treatment adherence advocacy and communication.

It is critical for religious leaders to be actively involved in promoting treatment adherence in the context of HIV and AIDS. In doing so, they need to be guided by insights from advocacy and communication.

What Is Advocacy and Communication?

Although there are many (and contested) definitions of advocacy and communication, in this unit we are going to adopt simplified definitions of these concepts. **Advocacy** for religious leaders means "standing for and standing with" individuals, families, and communities who have specific needs that must be met. Previously, there was an idea that advocates would "speak for those who had no voice." Activists often say to religious leaders, "We are not voiceless. You refuse to hear us."

Therefore, advocacy is now understood as:

- Being willing to learn from those who have first-hand experience of the issue under discussion
- Giving space to those with first-hand experience of the issue to articulate the issue themselves
- Supporting those with first-hand experience of the issue
- Guarding against policies and practices that exploit and oppress
- Partnering with marginalized communities for long-term social transformation.

And communication is understood as:

- Imparting or exchanging information by speaking, writing, or using some other medium

Communication and advocacy are closely related. In order for advocacy to be effective, there is need for effective communication. In terms of addressing treatment adherence in the context of HIV and AIDS, religious leaders need to communicate effectively.

Effective Advocacy and Communication for Religious Leaders to Promote Treatment Adherence

Religious leaders are strategically placed to play an effective role in advocacy and communication in order to promote treatment adherence in the context of HIV and AIDS. The following factors are key in order for religious leaders to challenge harmful theologies that lead some individuals to stop taking their medication in favour of spiritual healing only:

- Be aware of sacred texts that support advocacy and the urgency of addressing issues that endanger the health and wellbeing of the people of God, such as treatment adherence in the context of HIV and AIDS
- Acquire adequate knowledge and information regarding ART (effectiveness, side effects, etc.)
- Utilize the pulpit and sacred time to communicate positive messages promoting ART as God's intervention in the wake of HIV and AIDS
- Be willing to be informed by the experiences of people living with HIV, according them respect and space to guide congregations on the importance of treatment adherence
- Promote the uptake of ART by people living with HIV
- Proclaim clear and consistent messages that encourage people living with HIV to embrace ART
- Use different communication strategies to promote treatment adherence in the context of HIV and AIDS
- Invite medical specialists and other experts to address believers on ART
- Utilize multiple communication strategies (for example, SMS messages) to convey positive messages on ART.

Religious Leaders and the Challenge of Addressing Exclusive Faith-Healing Claims

There is need for religious leaders to undertake effective advocacy in order to ensure that all those who must benefit from life-saving medication do so. It is scandalous that lives are being lost at a time when God has availed medication

that prolongs life. Canon Gideon Byamugisha, one of the most articulate and consistent activists from within the faith-based community, has consistently argued that some deaths are "avoidable and postponable." This refers to deaths that occur due to human wrongdoing. Clearly, death due to failure to adhere to ART falls into this category of deaths. Therefore, religious leaders must be more actively involved in the quest to address exclusive claims of faith healing in the context of HIV and AIDS. Byamugisha, alongside other religious leaders such as Phumzile Mabizela and Rahab Kariuki, has been consistent in challenging religious leaders to preach life-giving messages in the face of HIV and AIDS.

In order for religious leaders to effectively address exclusive faith-healing claims in the context of HIV and AIDS, they need to invest in partnership and collaboration. They must join forces with other critical players so that they can achieve the best possible results. One of the biggest challenges of the faith community has been the tendency to operate in isolated ways. It is through building on the strengths of different players that we can deal with the challenge of exclusive claims of faith healing of HIV and AIDS.

Exercise

Exercise objective: By the end of this exercise, participants will have reflected on the different stakeholders that they can work with in order to address the challenge of exclusive faith-healing claims in the context of HIV and AIDS in an effective way.

Method: small group discussion; plenary

Aids: flipchart, markers

Duration: 30 minutes

Facilitators must be alert regarding strategic collaborations with the media, relevant government departments (health, home affairs, security, etc.), civil society organizations (lawyers), and medical and pharmaceutical companies. They must highlight contemporary communication strategies, such as the use of mobile phones, to enhance treatment adherence.

The facilitator will divide participants into groups of no more than six participants and allow the groups to reflect on the importance of collaborating in addressing the exclusive claims of faith healing of HIV and AIDS while discussing the following questions and points:

1. What are the challenges that individuals, families, and communities have experienced from the exclusive claims of faith healing of HIV and AIDS?
2. Who are the other relevant stakeholders interested in addressing the issue of the exclusive claims of faith healing of HIV and AIDS? What are they doing about the exclusive claims of faith healing of HIV and AIDS?
3. How can we (faith leaders) partner with the other stakeholders in order to address the exclusive claims of faith healing only of HIV and AIDS?

4. How can we build stronger interfaith partnerships and approaches to addressing the issue of faith healing only of HIV and AIDS?
5. Identify the potential challenges and opportunities in collaborating with others in addressing the exclusive claims of faith healing of HIV and AIDS.

UNIT 14

Transformed Leadership for Holistic Healing: Practising Advocacy

"Thus says the Lord: For three transgressions of Israel, and for four, I will not revoke the punishment; because they sell the righteous for silver, and the needy for a pair of sandals – they who trample the head of the poor into the dust of the earth, and push the afflicted out of the way; father and son go in to the same girl, so that my holy name is profaned." (Amos 2:6-7)

Unit Objective

By the end of this unit, participants will be able to identify and implement leadership skills in order to address the challenge of exclusive claims to faith healing in the context of HIV and AIDS.

Background

- Leadership implies creativity and providing urgent and effective solutions to challenges threatening the health and wellbeing of individuals, families, communities, and nations.
- Effective leadership requires the capacity to listen and collaborate with others in the search for solutions.
- Leadership means standing with and for individuals, families, communities, and nations living with and affected by HIV and AIDS.
- Individuals such as Nkosi Johnson, the young activist for treatment in the face of HIV, as well as organizations such as INERELA+ have provided leadership in the overall response to HIV and AIDS. They have mobilized communities to utilize their resources to respond to the epidemic creativity and sustainably.

What Is Transformed Leadership?

The concept of leadership has generated many definitions. However, the dominant meaning of transformed leadership (also expressed as transformative or transformational) is that which involves personal commitment and concrete action. In the specific context of addressing the challenge of exclusive claims of healing HIV and AIDS through faith, transformed leadership means that

religious leaders make it their responsibility to be at the forefront in addressing this challenge.

Transformed leadership is:

- Inclusive
- Proactive

Inclusive leadership implies that leaders do not adopt a "lone ranger" strategy in which only they are central to the quest for solutions. Inclusive leadership in addressing the challenge of exclusive claims of faith healing of HIV and AIDS means that the leader initiates and strengthens partnership and collaboration with other relevant stakeholders. The religious leader does not regard other players as competitors or enemies, but as "co-workers in God's vineyard."

Being inclusive means working with people from diverse backgrounds and having different perspectives on issues. Being inclusive means accepting everyone without blaming or being judgmental about the "other." In the specific case of addressing the challenge brought about by those who dismiss ART and insist on faith healing only, religious leaders must be willing to engage those who propound such a theology. Engaging them does not mean sharing their perspective. However, there can be no lasting solution to this challenge without creating platforms for dialogues. It is reassuring to note that, in some contexts, religious leaders who once proclaimed the message of faith healing only have changed their messaging and encouraged their members to embrace ART.

Being proactive means not waiting for someone else to come in and address a challenge. Further, being proactive means initiating the solution before the challenge gets out of control. Regarding the issue under discussion, being proactive means embarking on potential solutions to the issue of exclusive claims of faith healing of HIV and AIDS right away and unapologetically.

Leadership can be further defined as the capacity to inspire others to act. Leadership in this sense is critical for the development of individuals, organizations, and societies. Transformational leadership is a way of leading in which the leader is a learner, a mentor, and a teacher. She/he is a trailblazer and mapmaker. She/he is concerned not only with improving conditions within existing frameworks and mindsets, but with going one step further to design and lead processes that shift the frameworks and mindsets themselves.[5]

5. UNDP, *Leadership Development Strategy Program: The Answer Lies Within* (New York: UNDP, nd), 7. Bold in original.

Transformed Leadership, Holistic Healing, and Advocacy in Addressing Faith Healing and Treatment Adherence

Religious leaders can practise advocacy and bring holistic healing in the context of HIV and AIDS. Previous units have highlighted the meaning of advocacy, which essentially means "standing for and with" the disadvantaged. Holistic healing means that people living with HIV enjoy meaningful and fulfilling/fulfilled lives, free from stigma and discrimination. They are also not subjected to grand claims about the miraculous healing of HIV and AIDS or being forced to abandon their medication. Practising advocacy and promoting holistic healing in the face of exclusive claims of faith healing of HIV and AIDS implies:

- Adopting a human rights framework, in which the rights of people living with HIV are respected and protected (this means establishing partnerships and collaboration with civil society actors in the legal sector)
- Encouraging adolescents (both boys and girls) living with HIV within religious communities to take up leadership in addressing exclusive claims of faith healing of HIV and AIDS
- According space to women's leadership in addressing the challenge of some religious leaders causing people to abandon their medication in the context of HIV and AIDS
- Acting as change agents by engaging in an ongoing dialogue with fellow religious leaders who insist on faith-healing approaches only and encouraging them to embrace medical treatment of HIV and AIDS
- Establishing effective links with networks of people living with HIV and being willing to be led, informed, and taught by their experiences and expectations
- Developing and distributing resource materials (various media) that provide information on the significance of ART.

Exercise

Exercise objective: By the end of this exercise, participants will be able to identify how they can be transformed leaders who are effective in promoting ART adherence.

Method: small group discussion; plenary

Aids: flipchart, markers

Duration: 30 minutes

The facilitator will divide participants into groups of no more than six participants and allow the groups to reflect on the importance of promoting ART adherence while discussing the following questions and points:

1. In your local language, how is leadership defined? How is transformed leadership defined?
2. What would you regard as the key leadership qualities that are required in addressing the challenge of some religious leaders who discourage some people living with HIV from either initiating or continuing with ART?
3. What are you going to do, personally, to address the challenge of some religious leaders who are barriers to the uptake of ART?
4. Identify the steps you are going to take to ensure that your leadership/response is sustainable?

Appendices

Annex 1

Stakeholder and Partner Mapping for Holistic Healing in the Context of Exclusive Claims to Faith Healing

"John said to him, 'Teacher, we saw someone casting out demons in your name, and we tried to stop him, because he was not following us.' But Jesus said, 'Do not stop him; for no one who does a deed of power in my name will be able soon afterward to speak evil of me. Whoever is not against us is for us.'" (Mark 9:38-40)

Stakeholder and partner mapping is an important step to understanding who your key stakeholders and partners are in responding to HIV and AIDS, and what they are looking for and already doing in relationship to your work in mitigating the effects of HIV and AIDS. To be most effective, this process should be driven by an engagement strategy.

What Is Stakeholder and Partner Mapping?

Stakeholder mapping is a collaborative process of research, dialogue, and discussion that draws from multiple perspectives to determine a key list of stakeholders and potential partners across the entire stakeholder spectrum. Mapping can be broken down into four phases:

1. **Identifying**: listing relevant groups, organizations, and people involved in HIV and AIDS work directly or indirectly
2. **Analyzing**: understanding stakeholder perspectives and interests in combating HIV and AIDS
3. **Mapping**: visualizing relationships to objectives and other stakeholders
4. **Prioritizing**: ranking stakeholder relevance and identifying issues.

The process of stakeholder mapping is as important as the result, and the quality of the process depends heavily on the knowledge of the people participating. Since the adopted approach is a holistic bio-psycho-socio-spiritual

model, we should look for partners across the various elements. We want to have partners from:

- The **medical** and **pharmaceutical** field to help in the area of treatment
- The **psychological** field to help with professional counselling for those infected and affected
- **Social** and **economic** backgrounds to help with identifying and meeting the social and material needs of those affected and infected
- A **spiritual** background to help with the faith needs of those infected and affected.

Depending on your objectives, the relevant stakeholders or partners you need to engage with may not play the usual sustainability roles but may instead serve other functions relevant to your work.

- **Be diverse**: Make sure to include a rich diversity of stakeholder expertise, geography, and tactics from across the spectrum. This is an opportunity to reach out and mix the old with the new, including individuals from each of the following stakeholder categories: influencers, collaborators, advocators, and implementation partners.
- **Be social**: Social media provides an unparalleled opportunity to identify and reach lesser-known stakeholder groups. Canvas blogs, forums, networking, reviews, and news sites to discover stakeholders relevant to your business and to learn about their interest in your activities.
- **Be aware**: People have a tendency to focus on formal authorities in the mapping process, but the loudest voices or heaviest campaigners are not necessarily your key stakeholders. Step back and add silent members to your list because they may have a hidden wealth of expertise.

Analyzing the Potential Partners

Once you have identified a list of stakeholders, it is useful to do further analysis to better understand their relevance and the perspective they offer, to understand their relationship to treatment adherence and holistic healing in the context of HIV and AIDS, and to prioritize based on their relative usefulness for this engagement.

The following list of criteria can help you analyze each identified stakeholder:

- **Contribution** (value): Does the stakeholder have information, counsel, or expertise on HIV and AIDS that could be helpful to the religious leaders?
- **Legitimacy**: How legitimate is the stakeholder's claim for engagement?
- **Willingness to engage**: How willing is the stakeholder to engage?

- **Influence**: How much influence does the stakeholder have? (You will need to clarify "who" they influence, e.g., other companies, NGOs, consumers, donors, etc.)
- **Necessity of involvement**: Is this someone who could derail or delegitimize the process if they were not included in the engagement?

Action: Use these five criteria to create and populate a chart with short descriptions of how stakeholders fulfil them. Assign values (low, medium, or high) to these stakeholders. This first data set will help you decide which stakeholders to engage.

Prioritizing Potential Partners

Prioritization of stakeholders is a critical exercise that should help you minimize the risk of approaching stakeholders with the least potential of success while letting those most likely to want to partner with you to be approached by other organizations. Once stakeholders have been identified, analyzed and mapped, you must now proceed to rank the stakeholders depending on the issues they prioritize and the issues you prioritize. This exercise will give you an idea of who to approach first, and sometimes who not to approach at all.

Action: Rank the stakeholders working in the same community you are, with one being best option for partnership and five being the worst option for partnership. The following points may be used for this ranking exercise:

1. Who is working on SGBV (sexual gender-based violence) in this community? (Some suggest that some women become victims and survivors of SGBV because they are on ART and hence may be persuaded by faith healers to abandon ART and opt for exclusive faith healing.)
2. Who is working on women empowerment projects in this community? (Many women have been infected by HIV because they had no means to sustain themselves and ended up in relationships skewed against them, where they could not negotiate for safer sex.)
3. Who is working on development projects in this community? (Poverty makes many people – men and women – more vulnerable, and development-focused groups can become critical partners in improving the livelihoods of persons and their ability to combat HIV and AIDS).
4. Who is working on treatment adherence for people living with HIV?
5. Who is working on social and economic justice? (Social and economic justice are critical components if holistic healing is to be achieved in any community, so such players are key potential partners.)

Using these focus questions, you can identify and prioritize the stakeholders in the order indicating the best potential partners for your own organization or group.

Activity: Mapping Your Own Context

Activity objective: By the end of this activity, participants will have attempted a mapping exercise for their own context.

Method: brainstorming; small groups; plenary

Aids: flipchart, markers

Duration: 45 minutes

The facilitator will divide participants into groups paying attention to their areas of work, so that participants from the same area are grouped together. These groups will then attempt a mapping exercise for their group, "Working on GBV from a Christian Perspective." The groups must creatively attempt to work through the different exercises of mapping as indicated above.

Annex 2

What Is a Theology of Accompaniment?[6] Some Reflections

Jesus said in a parable, "Truly I tell you, just as you did it to one of the least of these who are members of my family, you did it to me" (Matt. 25:40). This verse is powerful and can be a good entry point to understanding the theology of accompaniment. To begin with, it says that the people who are poor, who are dispossessed and forgotten, and who are living at society's margins are members of Jesus' family. It goes further to suggest that how I treat members of Jesus' family is a measure of how Jesus judges how I have treated him. This verse also reinforces for me how the entire family of human beings is Jesus' family and that I am obliged by my baptism into Christ's body to love and serve all the people of God's creation. Serving the people of God can take various forms, including, perhaps most importantly, through accompaniment. Doing this brings us into contact with our God, our Father, who walks hand-in-hand with us through life. God walks with us always, and as Christians, we are called to walk with those who may need our company.

Walking With

"Walking with" is an iconic statement of equality and belovedness, and an affirmation of the Episcopal Church's baptismal covenant. It requires each of us to "seek and serve Christ in all persons, loving your neighbour as yourself" and to "strive for justice and peace among all people, and respect the dignity of every human being" (*Book of Common Prayer*, p. 305). The idea that a stern God the Father chooses to walk hand-in-hand with an unsophisticated child who has not yet formed mature concepts of being in community strikes me as important in the theology of accompaniment. That is, we must choose to "walk with" people who perhaps haven't quite figured out the importance of following Jesus' command to love our neighbours as ourselves. Sometimes, people think they need to be alone when, in actual fact, they think no one wants to be with them anyway. When we choose to walk with such people, we bring joy and contentment to their lives. "Walking with" such persons makes them

6. Adapted from Lelanda Lee, *The Theology of Accompaniment and Asset Based Community Development*, available online at http://faith.episcopal.co/wp-content/uploads/2016/02/Theology-of-Accompaniment-and-ABCD-Essay.pdf (accessed 11 July 2018).

appreciate and acknowledge that they belong. We do not "walk for" them; rather, accompaniment means "walking with" them.

"Walking with" means that we treat each other as we want to be treated, because Christ expects no less. In religions worldwide, this philosophy is known as the Golden Rule: "Do unto others as you would have them do unto you." "Walking with" begins with being in each other's company, spending time together, sharing experiences of the community in common, and relating to each other's stories. Being in each other's presence leads to conversations in which we tell our hopes and dreams to one another, share our troubles and worries, and listen to and take in what our sisters and brothers have to say. In a sense, one could assert that "walking with" points to a theology of hospitality that views the stranger or guest – the "other" – as like the occupants of the house or space. They are us, and we are them. There is no difference between us and them; we are equally beloved in the sight of the Creator. "Walking with" has the essential elements of journeying with, through thick and thin, in joyful and celebratory moments, and in heartache and grief. What's important is the sticking together and holding each other up, because those with whom you walk also love the same community and its people and their interests and concerns.

This understanding of theology of accompaniment shows that throughout biblical history, this was a critical component of the religion and life of Israel, as well as that of the early church. God accompanies Abraham as he journeys to the promised land. Even though Moses was comfortable in the palace, he chose to "walk with the Israelite slaves" in their journey of independence. The prophets Elijah, Elisha, Amos, Micah, Hosea, and Isaiah and many others accompanied the poor and oppressed people of Israel. The Jesus movement as epitomized by Jesus himself was a movement of accompaniment. Jesus "walks with" those who were victims of the Roman system. Paul walks with Gentiles as he planted church after church. The strength of the church emanates from its position as a movement and institution that walks with the people. The church accompanies persons from birth until they are interred in their graves. A theology of accompaniment has been bequeathed to us by our biblical forebears and God makes us appreciate the importance of accompaniment. Accompaniment makes us members of a community; and when no one accompanies us, we feel like outcasts. People living with HIV and those affected by HIV and AIDS have for some time been made to live without accompaniment, making them feel like they did not belong to the family of God. Having no one accompany you can also cause stress and depression in those not being accommodated.

Presence and Avoiding Toxic Charity

The theology of accompaniment – of "walking with" – also encompasses the ministry of presence, where we simply are in the company of another person or in the company of a community, being present, listening, paying attention, and not "doing anything." That is a tough practice for most individuals, who

think of themselves as helpful and helping. And it is a very tough practice for a human services agency that is founded on the principle of being a "helping organization." Even when we "do something" for another, it is important to avoid "toxic charity," that is, doing things for another that takes away the acknowledgement of their gifts and their ability to do things for themselves. This is particularly true of people living with HIV or those affected by it. Their health condition does not necessarily mean they cannot do things for themselves. Their situation may mean they lack friends: people who are willing just to be there for them, people who are willing to listen to them. As faith leaders, we are strategically positioned to be such persons who minister by simply being present, by being there.

As someone with a background in economics and banking, I appreciate the difference between God's economy and our human economy. In God's economy, there is always sufficiency; what we have been given is always enough. That is contrasted with the human economy, in which we frequently go from one episode of perceiving scarcity, feeling like we don't have everything we need, to another episode of feeling anxious and victimized by what we believe we lack. From the study of scripture, our eyes are opened to seeing the abundance that God has created and gifted to human beings, and we are invited into an ethos of gratitude and sharing that abundance with others. God invites us into an economy where gratitude is the place of initiation and thanksgiving is the currency that frees us from fear. In a similar way, Asset Based Community Development (ABCD) invites us to be thankful for the assets in our community and to lift up and share those assets with others for the benefit of the entire community. Gratitude is where we begin – acknowledging with our fellow community members that we have what is needed to strengthen us as a community.

Robert D. Lupton wrote in his book *Toxic Charity* (HarperOne, 2011) of the importance of partnerships and acknowledging the capacity of people and communities to learn to do their own work to improve their communities. This is opposed to helping organizations coming in to give help and resources without acknowledging the existing resources and giftedness within those communities. In the fifth chapter of John's gospel, Jesus models the opposite of toxic charity by healing one man who had been ill for 38 years and commanding him to "stand up, take your mat and walk." Also note how Jesus began the interaction by asking the man, "Do you want to be made well?" Jesus engages in holy listening and takes nothing for granted about the man's desires. The man answers Jesus, "Sir, I have no one to put me into the pool when the water is stirred up; and while I am making my way, someone else steps down ahead of me." ABCD suggests to us the importance of attending to what the community desires. Being present and willing to accompany another on the journey to self-discovery of their gifts and those of their community is a gracious invitation to claiming self-actualization of those gifts and self-empowerment. In the context of HIV and AIDS, accompaniment entails appreciating that living with HIV does not alter the fact that all persons are created in the image of God

and that we are called to always be there for all persons, especially those who suffer from stigma and discrimination. What most of these individuals desire the most is to continue to belong and to have a community and friends that can be with them in their journey.

Stories Connect Us

Just as Jesus told parables to teach the disciples and other people who came to hear him, sharing our personal and familial stories with one another – storytelling – is fundamental to our Christian identity and to the principles of ABCD. Our Judeo-Christian tradition is full of storytelling as a means of teaching the community, from the examples of Jesus' parables to the Jewish Seder's recounting of the Passover to the Christian eucharist's recitation of the last supper. ABCD also uses storytelling in the form of individual community members being invited to tell their stories through one-on-one conversations (interviews). These stories – our stories – connect us to each other's humanity and show us how much we have in common and how many gifts each of us has to offer to our neighbours. The ABCD process further shows us how to connect ourselves and our gifts to one another for our mutual thriving. As faith leaders, we will do a lot of good by availing a listening ear to those whose lives have been affected by HIV and AIDS, and we can in the process of accompaniment share our own stories of how we once desired accompaniment as we felt deserted and rejected. Sharing similar experiences and how we were accompanied by some people can go a long way in making those we are accompanying feel that they are treading on a well-trodden path.

From the youngest to the oldest, from the least educated to the most educated, whether in one language or another, telling stories is something that everyone has the innate ability to do to. They can share who they are, where they come from, who has shaped them, and what they hope and dream for themselves and their community. Storytelling is an everyday way of living into the African Bantu philosophy of *ubuntu*, which is often explained as "I in you, and you in me," or "I am, because you are." Our stories tell who we are and lay out points of connection that we can grab hold of and build mutuality and understanding. We become part of another's story when we hear their story and can see ourselves in their story because of our shared humanity – we are moved by what we hear, empathize with the person telling the story and the people in the story, and desire to do something to help the storyteller and people like the storyteller. The more stories we hear and share, the more we recognize that we are all part of one story created by God the Creator, God the companion, and God the reconciler.

Annex 3

Fact Sheet on Discordant Couples[7]

What Is a "Mixed-Status Couple"?

When one partner is HIV-negative and one partner is HIV-positive. Also known as a serodiscordant couple.

Couples HIV Testing and Counselling

Testing for HIV together and receiving counselling with your partner can:

- Make it easier to disclose your HIV test results to one-another
- Help you to cope if one or both of you receive a positive result
- Make planning for the future a shared responsibility.

Safer Sex Tips

Mixed-status couples are able to have safe sexual relationships by following this advice:

- Talk about HIV prevention and family planning together as a couple, and with a health-care professional.
- Use condoms every time you have sex.
- Consider your HIV treatment options.

HIV Treatment for the HIV+ Partner

- Antiretroviral drugs lower the amount of HIV in your body.
- Antiretroviral drugs can reduce the virus to very low levels (undetectable), making you less likely to pass on HIV.
- You should start taking HIV treatment straight away after your diagnosis.
- Treatment will lower the virus in your body to prevent transmission to your partner. Seek advice from a health-care provider about starting treatment.

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7. AVERT, *HIV and Mixed-Status Couples*, Brochure, available online at www.avert.org/learn-share/hiv-fact-sheets/serodiscordant-couples (accessed 11 July 2018).

HIV Treatment for the HIV- Partner

- Treatment taken by HIV-negative partners is called pre-exposure prophylaxis (PrEP). This is recommended for mixed-status couples.
- It prevents exposure to HIV from becoming an infection.
- Access to PrEP is limited so it may not be available to you.

Family Planning

- It is important to plan your pregnancy to protect your partner and baby from HIV.
- Your health-care professional can direct you to family planning services.

Conception Options

Having an HIV-negative baby is possible with careful planning. Your conception options will vary depending on which partner is HIV-positive.

Artificial insemination

- Artificial insemination protects the male partner from HIV-infected bodily fluids. His sperm is inserted into the woman's vagina using a syringe. You can do this at home, but with medical advice.
- Artificial insemination is most effective when a woman is ovulating (releasing an egg). Ovulation occurs about 14 days after a woman's period starts.
- Ovulation varies between women; seek advice from your doctor.

Sperm washing

"Semen" is the fluid that comes from a man's penis when he ejaculates ("comes"). This fluid contains sperm and seminal fluid.

- HIV-infected semen cannot infect your baby but can infect your partner.
- Sperm washing is a procedure that separates HIV-free sperm from the HIV-infected seminal fluid.
- HIV-free sperm can be inserted into the woman's vagina by artificial insemination, eliminating HIV risk.
- Washed sperm can also be used to fertilize the woman's egg by in vitro fertilization (IVF).
- HIV-negative donor sperm is another option that eliminates HIV risk.
- Access to sperm washing and IVF can be limited in some settings.

Alternatively, timed unprotected sex is unlikely to pass HIV to the female partner, if the male partner has:

- Undetectable viral load for six months
- Good adherence to their treatment
- No sexually transmitted infections (STIs).

Seek professional advice first.

HIV Treatment and Timed, Unprotected Sex

Both types of serodiscordant couples could take HIV treatment and conceive naturally.

- The HIV-positive partner can take HIV treatment to lower their viral load.
- The HIV-negative partner can take PrEP prior to unprotected sex in some cases (the risk of HIV infection still exists).
- Both partners should be tested and treated for STIs to reduce the risk of HIV transmission.
- Couples should monitor their viral load closely if having unprotected sex.
- Couples should only have unprotected sex whilst the female partner is ovulating.
- Unprotected sex still risks passing HIV to the negative partner.

Know Your Rights

You have the right to:

- Request or refuse an HIV test
- Refuse HIV treatment
- Choose if, how, and when to conceive.

Annex 4

Fact Sheet on TB and HIV

World Health Organization

Stop TB Partnership

2009 update TUBERCULOSIS FACTS

- TB is contagious and **spreads through the air**. If not treated, each person with active TB infects on average 10 to 15 people every year
- More than **2 billion people**, equal to one-third of the world's population, are infected with TB bacilli, the microbes that cause TB. 1 in 10 people infected with TB bacilli will become sick with active TB in their lifetime
- TB is a **disease of poverty** affecting mostly young adults in their most productive years. The vast majority of TB deaths are in the developing world, and more than half of all deaths occur in Asia
- There were **9.4 million new TB cases** in 2008 (3.6 million of whom are women) including 1.4 million cases among people living with HIV
- **1.8 million** people died from TB in 2008, including 500 000 people with HIV - equal to 4500 deaths a day
- The estimated global incidence rate fell to **139 cases per 100 000 population** in 2008 after peaking in 2004 at 143 cases per 100 000. Rates are **falling very slowly** in 5 WHO regions (the rate is stabilizing in Europe). The total number of deaths and cases is still rising due to population growth
- There were **5.7 million TB case notifications** in 2008. **36 million people were cured** in DOTS programmes (between 1995-2008), with as many as **8 million deaths averted** through DOTS
- The **87% global treatment success rate** exceeded the 85% target for the first time since the target was set in 1991. 53 countries exceeded this 85% patient treatment target
- **TB is a leading killer of people with HIV**. People who are HIV-positive and infected with TB are 20 to 40 times more likely to develop active TB than people not infected with HIV living in the same country
- Critical to saving lives is the urgent implementation of the **Three Is** (**I**ntensified case-finding, **I**soniazid prevention therapy, and **I**nfection control) - measures which reduce the burden of TB in people living with HIV
- **Multidrug-resistant TB** (MDR-TB) is a form of TB that is difficult and expensive to treat and fails to respond to standard first-line drugs. **Extensively drug-resistant TB** (XDR-TB) occurs when resistance to second-line drugs develops on top of MDR-TB
- **5% of all TB cases have MDR-TB**, based on data from more than 100 countries collected during the last decade
- There were an estimated **500 000 new MDR-TB cases** in 2007. Just over 1% of cases were receiving treatment in 2008 known to be based on WHO's recommended standards
- In 2008, WHO reported that the **highest rates of MDR-TB ever recorded**, with peaks of up to 22% of new TB cases, were in some settings of the former Soviet Union. In the same region, 1 in 10 cases of MDR-TB is XDR-TB
- **27 countries account for 85% of all MDR-TB cases**. The top five countries with the largest number of cases are India, China, the Russian Federation, South Africa and Bangladesh. XDR-TB has been found in **57 countries** to date
- In 2009, a **World Health Assembly MDR-TB and XDR-TB resolution** was endorsed by 192 WHO Member States and included recommended priority actions to combat drug-resistant TB

THE TB TARGETS FOR 2015

UN Millennium Development Goals:
to have halted and begun to reverse incidence

Current assessment
On target in all WHO regions
though incidence is falling slowly

The Stop TB Partnership targets:
halving prevalence and deaths by 2015
in comparison with 1990

Current assessment
WHO Africa region not on target

If the Global Plan to Stop TB 2006-2015 is fully funded and implemented 14 million lives will be saved and 50 million people treated

The **WHO Stop TB Department** together with WHO regional and country offices: develops policies, strategies and standards; supports the efforts of WHO Member States; measures progress towards TB targets and assesses national programme performance, financing and impact; promotes research; and facilitates partnerships, advocacy and communication

The **Stop TB Partnership** (with its secretariat housed by WHO) is a network of more than 1 000 stakeholders; it has a Coordinating Board and 7 working groups: DOTS Expansion; Global Laboratory Initiative; MDR-TB; TB/HIV; New Drugs; New Diagnostics; New Vaccines

Annex 5

Antiretroviral Therapy (ART)

What Is ART?

ART are medications that treat HIV. The drugs do not kill or cure the virus. However, when taken in combination, they can prevent the growth of the virus. When the virus is slowed down, so is HIV disease. Antiretroviral drugs are referred to as ARV. Combination ARV therapy (ART) is referred to as highly active ART (HAART).

What Is the HIV Life Cycle?

1. Free virus circulates in the blood-stream.
2. HIV attaches to a cell.
3. HIV empties its contents into the cell.
4. The HIV genetic material (RNA) is used by the reverse transcriptase enzyme to build HIV DNA.
5. The HIV DNA is inserted into the cell's chromosome by the HIV integrase enzyme. This establishes the HIV infection in the cell.
6. When the infected cell reproduces, it activates the HIV DNA, which makes the raw material for new HIV viruses.
7. Packets of material for a new virus come together.
8. The immature virus pushes out of the infected cell in a process called "budding."
9. The immature virus breaks free of the infected cell.
10. The new virus matures: raw materials are cut by the protease enzyme and assembled into a functioning virus.

What Are the Approved Drugs?

Each type, or "class," of ARV drugs attacks HIV in a different way. The first class of anti-HIV drugs was the nucleoside reverse transcriptase inhibitors (also called NRTIs or "nukes"). These drugs block Step 4 of the life cycle, where the HIV genetic material is used to create DNA from RNA. Non-nucleoside reverse transcriptase inhibitors, also called non-nukes or NNRTIs, also block Step 4 but in a different way. Protease inhibitors, or PIs, block Step 10, where the raw material for new HIV virus is cut into specific pieces. Entry inhibitors prevent HIV from entering a cell by blocking Step 2. HIV integrase inhibitors prevent HIV from inserting its genetic code into the human cell's code in Step 5.

How Are the Drugs Used?

Antiretroviral drugs are usually used in combinations of three or more drugs from more than one class. This is called "combination therapy." Combination therapy helps prevent drug resistance. Manufacturers of ARVs keep trying to make their drugs easier to take, and have combined some of them into a single tablet regimen.

What Is Drug Resistance?

When HIV multiplies, many of the new copies have mutations that are slightly different from the original virus. Some mutant viruses keep multiplying even when you are taking ARV drugs. When this happens, the virus can develop resistance to the drug and ART may stop working. See fact Sheet 126 for more information.
If only one or two ARV drugs are used, it is easy for the virus to develop resistance. For this reason, using just one or two drugs is not recommended. But if three drugs are used, a successful mutant would have to "get around" all of the drugs at the same time. Using combination therapy means that it takes much longer for resistance to develop. Adherence to ARVs is very important for treatment to work. The viral load test is used to see if the ARV drugs are working

What's Next?

New drugs are being studied in all of the existing classes. Researchers are also trying to develop new types of drugs, such as those that will block other steps in the HIV life cycle and drugs that will strengthen the body's immune defenses.

Annex 6

Proposed Programme for Training of Trainers

Time	Day One	Day Two	Day Three	Day Four
0800-0830	Morning devotion	Morning devotion	Morning devotion	Morning devotion
0830 - 1030	Arrival and registration	Narratives and testimonies: two narratives (Unit 5)	A theology of accompaniment (Unit 8)	Partnerships and collaboration for holistic healing (Unit 12)
1030-1100	Arrival and registration	HEALTH BREAK	HEALTH BREAK	HEALTH BREAK
1100-1300	Arrival and registration	Narratives and testimonies: two narratives (Unit 5)	Children, adolescents, and young people, and faith healing in the HIV context (Unit 9)	Advocacy and communication for holistic healing (Unit 13)
1300-1400	LUNCH BREAK	LUNCH BREAK	LUNCH BREAK	LUNCH BREAK
1400-1530	Purpose of and background to the manual (Units 1 & 2)	What is faith healing and faith treatment/curing? (Unit 6)	Re-defining faith healing for transformative faith communities (Unit 10)	Transformed leadership for holistic healing (Unit 14)
1530-1600	HEALTH BREAK	HEALTH BREAK	HEALTH BREAK	HEALTH BREAK
1600-1800	How to use the manual and getting started (Units 3 & 4)	ART is God's miracle (Unit 7)	Strategies for holistic healing (Unit 11)	General plenary and house keeping
1800	REST AND SUPPER	REST AND SUPPER	REST AND SUPPER	REST AND SUPPER

NOTE: In the event that survivors of the effects of exclusive faith-healing claims are within the group and they are willing to share their own testimonies, these can be used in place of the narratives in Unit 5.

Annex 7

Proposed Programme for Training of Religious Leaders

Time	Day One	Day Two	Day Three
0800-0830	MORNING DEVOTION	MORNING DEVOTION	MORNING DEVOTION
0830-1030	Narratives and testimonies: two narratives (Unit 5)	A theology of accompaniment (Unit 8)	Partnerships and collaboration for holistic healing (Unit 12)
1030-1100	HEALTH BREAK	HEALTH BREAK	HEALTH BREAK
1100-1300	Narratives and testimonies: two narratives (Unit 5)	Children, adolescents and young people, and faith healing in the HIV context (Unit 9)	Advocacy and communication for holistic healing (Unit 13)
1300-1400	LUNCH BREAK	LUNCH BREAK	LUNCH BREAK
1400-1530	What is faith healing and faith treatment/curing? (Unit 6)	Re-defining faith healing for transformative faith communities (Unit 10)	Transformed leadership for holistic healing (Unit 14)
1530-1600	HEALTH BREAK	HEALTH BREAK	HEALTH BREAK
1600-1800	ART is God's miracle (Unit 7)	Strategies for holistic healing (Unit 11)	General plenary and house keeping
1800	REST AND SUPPER	REST AND SUPPER	REST AND SUPPER

NOTE: In the event that survivors of the effects of exclusive faith-healing claims are within the group and they are willing to share their own testimonies, these can be used in place of narratives in Unit 5.

Annex 8

Pre-Training Evaluation and Post-Training Evaluation Forms

Pre-Training Evaluation Form

1. Gender _____ Age Range ☐ 15–24 ☐ 25–34 ☐ 35–49 ☐ 50–65 ☐ 65+

2. What do you understand by faith and healing? _____

_____

_____

_____

_____

_____

3. Can someone living with HIV and who has AIDS be healed? Explain briefly.

_____

_____

_____

_____

_____

4. What are your expectations coming to this training? _____

_____

_____

_____

_____

_____

5. What are your fears about this training? _____

_____

_____

_____

_____

_____

Post-Training Evaluation Form

1. Gender _____ Age Range ☐ 15–24 ☐ 25–34 ☐ 35–49 ☐ 50–65 ☐ 65+

2. Rate the following aspects of the training
(5 = Excellent, 4 = Very Good, 3 = Good, 2 = Poor, 1 = Very Poor)

Facilitation
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Logistics (Transport, Accommodation, Meals)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Programming (Time, Activities)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

3. Write down three things that challenged you in this training regarding faith healing and antiretroviral therapy

_____

_____

_____

_____

_____

This training has challenged me positively (5 = I strongly agree, 1 = I strongly disagree)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

This training has given me a basis to be an advocate for holistic healing in my community
(5 = I strongly agree, 1 = I strongly disagree)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

I will recommend my fellow leaders to undergo this training
(5 = I strongly agree, 1 = I strongly disagree)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Write down any other comments you may have on the training _____

_____

_____

_____

_____

_____

This manual helps us to equip ourselves with life skills that will help our communities become healthy and inclusive for all. – Rev. Dr Olav Fykse Tveit, WCC general secretary

Exclusive claims of faith healing in the context of HIV and AIDS in sub-Saharan Africa are deterring people living with HIV from taking medication as prescribed by their doctor. This manual responds to that challenge by providing tools to help equip religious leaders in all areas of the church to encourage compliance. Its practical, user-friendly units have been field-tested and are adaptable to many contexts.

This is one of four manuals on HIV and AIDS produced by the World Council of Churches' Ecumenical HIV and AIDS Initiatives and Advocacy (WCC-EHAIA) with the support of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the American President's Emergency Plan for AIDS Relief (PEPFAR).

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