

contact

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HIV AND AIDS TREATMENT - FBOs GETTING INVOLVED

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HIV AND AIDS TREATMENT - FBOs GETTING INVOLVED

When considering HIV and AIDS, treatment is an integral part of the HIV and AIDS prevention, care and support messages. Faith-based organizations (FBOs) specifically, are some of the institutions that can be most effective in not only relaying but also applying the practical lessons learnt from these messages. For this to happen effectively, these institutions need to be well equipped with knowledge and information about the opportunities that exist and how best they can utilize them to reach a wider audience and with the most impact.

Another important aspect of HIV and AIDS treatment is the control and treatment of opportunistic infections (OIs). People Living with HIV (PLWHIV) are at a high risk of acquiring OIs which cause progression of AIDS which, if not controlled, could eventually be fatal. To assist in the mitigating of OIs, and to assist the PLWHIV live productive and wholistic lives, Nate Smith and John Amollo explore the prevention, identification and management of OIs.

When dealing with HIV and AIDS, collaboration and partnerships, particularly with like-minded individuals and institutions is important. The Inter-religious Council of Uganda (IRCU) is a good example of how working with other religions, regardless of doctrine or beliefs, can assist in accessing or providing treatment and support for PLWHIV. Jowaad Keezala highlights the strides made and the challenges faced by IRCU in accessing HIV and AIDS treatment.

While working with different faiths and religions, it is important to equip the respective religious leaders with knowledge on HIV and AIDS. Jacinta Maingi from the Ecumenical HIV and AIDS Initiative in Africa (EHAIA) outlines how EHAIA equips Church leaders to adequately offer support to their communities.

One may ask: does spirituality have a direct link to a person's physical well-being? Are PLWHIV who are spiritual less likely to suffer from OIs and experience general well-being as opposed to those who are not spiritual? In the article "*Spirituality and HIV and AIDS*", Nate Smith explores the connections between spirituality and physical health.

The final four articles in this magazine are excerpts from research conducted on: "*The role of Churches and Church-*



FBOs can be effective in relaying the message and applying practical lessons on HIV and AIDS treatment

This issue of *Contact* has been published to give practical examples of how treatment can be made more accessible by FBOs and FBO health care institutions particularly in resource-limited settings.

Much has been accomplished in HIV and AIDS treatment, but more still needs to be done. In the scaling-up of HIV and AIDS treatment, FBOs have numerous opportunities and advantages but also face various challenges. The first article, by Peter Okalet, highlights these aspects from the perspectives of the FBOs.

based health institutions in accessing HIV and AIDS treatment." The research was conducted by two interns from the Netherlands; Aster den Bok, who is studying for a masters in theology and Willeke Neels, who is studying medicine. They conducted the study between February and July 2007 in collaboration with the Ecumenical Pharmaceutical Network (EPN).

Aster and Willeke visited Maua Methodist Hospital, Kijabe Mission Hospital, the Catholic Diocese of Kitui and Nazareth Hospital in Kenya. From the research they discovered that each area has its unique strengths and challenges. They also noted that the importance of supporting PLWHIV and the need to continue fighting stigma is cross-cutting in all centres.

The study on the Nazareth Hospital was the pilot project for development of the research. Though not conducted at the same level of intensity as the others, Nazareth highlighted some unique aspects within its HIV and AIDS department.

The Maua Methodist Hospital in the Maua area of Meru district highlighted how the hospital has partnered with the church and the community to ensure that PLWHIV live productive and dignified lives. Though with challenges, the innovative ways that the PLWHIV, with assistance from the church and hospital, have taken responsibility of their well-being is inspiring.

The African Inland Church (A.I.C) Kijabe Hospital is another institution which has taken HIV and AIDS treatment to the people. Working within its catchment areas, the hospital has empowered not just the PLWHIV but the community through training of health workers, adherence coaches and Church leaders to ensure that the message of treatment is conveyed.

Nutrition is important in relation to HIV and AIDS treatment. The final case-study which focuses on the semi-arid Kitui area of Eastern province emphasizes the importance of nutrition and the challenges faced in the light of lack of proper nutrition. Also highlighted are some of the main causes of lack of good nutrition and how best these challenges can be mitigated.

Though conducted only in Kenya, the lessons learnt and the recommendations made from the research conducted in these areas can stimulate adaptation and application in other countries and institutions.

We hope that you enjoy reading this issue of *Contact* magazine and that the lessons highlighted herein will be put to practical use.

Jacqueline Nyagah is the Communications officer for the Ecumenical Pharmaceutical Network.

Ecumenical Pharmaceutical Network's activities in HIV and AIDS treatment

EPN, a former programme of the World Council of Churches (WCC), is an independent non-profit Christian organization that works to increase access to medicines and health services through facilitating the development of compassionate, just and sustainable quality pharmaceutical care in and through the church health care system.

EPN's ultimate beneficiaries are in line with the Health for All ideal; however there is a specific emphasis on the poor and marginalized. The Network's intermediate beneficiaries are its members -church-related health services and their representatives.

The Network has three programmes: *development of an active network with increased impact; maximizing access to essential medicines for church health services and their clients and; increasing the capacity of church leaders and church-related health services to respond to the massive challenge of HIV and AIDS treatment.*

In its HIV and AIDS programme, the Network seeks to maximize the strength inherent in churches and church-related health services to address HIV and AIDS treatment issues. Through context-sensitive activities which are informed by research, the Network conducts HIV and AIDS treatment literacy workshops geared specifically at Church leaders. By educating these strategically placed opinion leaders of society on HIV and AIDS management and treatment EPN empowers the Church leaders to assist those in need to access HIV and AIDS treatment, care and support. Through the treatment literacy work, the Church and its institutions can become centres of support for People Living with HIV (PLWHIV).

EPN is also instrumental in advocacy issues concerning access to antiretroviral therapy (ART) at national and international levels.

SCALING UP TREATMENT FOR HIV AND AIDS

The roles, challenges and opportunities for Churches and faith-based health institutions

Faith-based organizations (FBO) have made significant contributions in providing and promoting treatment for HIV and AIDS. This article looks at these contributions as well as the challenges faced and the steps that need to be taken to ensure further scale-up of treatment.

Humanity is faced with trying to cope with the ravages caused by one of the world's most challenging crises, namely, HIV and AIDS. The scientific community, along with Governments, United Nations (UN) Agencies, development partners, Civil Society Organizations (CSO), non-governmental organizations (NGO) and faith-based organizations (FBO) are not yet equal to the task of managing the impact caused by HIV and AIDS. In 2005 this crisis was estimated to kill more than 5,000 people in the developing world each day¹.

We are dealing with a virus that is always 'ahead' of us. It leaves many devastated, disease-laden and even dead. Yet our collective response, is sluggish, uncoordinated, and erratic – to say the least! Perhaps the most sobering thing is that, beyond the current burden, the incidence of HIV infection continues to rise, with about 5 million new cases per year. No wonder, therefore, that, for every new person put on ARV treatment, six others get newly infected.² In Kenya, for example, as of mid 2007, only 240,000 persons were on Antiretroviral Therapy (ART), as opposed to the 430,000 people who needed to be put on ART treatment.³

CHALLENGES EXPERIENCED

High incidences

Typically, individuals infected with HIV are in the prime of their lives, shouldering significant responsibilities for their families, relatives and societies. In addition, thousands of infants are born each year to infected mothers and are at risk of contracting HIV infection and/or becoming orphans as their parents succumb to AIDS.

Global Progress up to late 2006, on Universal Access to ART

- ART coverage is 28% for adults and 15% for children
- 2.1 million (28%) of the 7.1 million in need are on treatment (1.3 million in Africa. This is also 28% of the requirement
- PMTCT coverage is only at 11%
- In Africa, 12 % of men, and 10% of women go for HIV testing and counselling.
- Ratio of men to women on ART is broadly in line with regional HIV prevalence rates for men and women.

Source: UNAIDS, December 2006, www.unaids.org

The high incidence of AIDS in some countries is threatening social, political, economic, educational, and military institutions, thus posing a threat to national, regional and global security. In African countries, where HIV prevalence rates are in excess of twenty percent, key societal institutions are at widespread risk of collapse. The potential consequences of this disintegration for local and international peace, prosperity, and freedom are massive.

Initial lack of information and technological knowledge

The global community today has the resources and much of the scientific know-how to begin to stem the devastating effects of the virus. However the earliest global responses were slow in coming and were not always well informed by either science or the lessons learnt from earlier efforts. Furthermore they were not sustained long enough to cause significant impact.

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Coordination of global efforts

Members of the international community who lead in the fight against AIDS in the developing world need to coordinate and harmonize their efforts.¹

Complex treatment regimens demanding for adherence

Even in sophisticated medical environments with the best of resources, Antiretroviral Therapy (ART) is a highly demanding form of treatment. The complex multi-drug regimens must be followed with scrupulous attention to adherence to prevent treatment failure and slow down the emergence of drug resistance. Drug resistance and treatment failure, common consequences of imperfect adherence, loom particularly large in resource-poor settings.

Lack of equipment in resource-poor settings

In resource constrained countries it is a challenge to monitor resistance and toxicity due to limited access to laboratories with the relevant capacity. To meet this challenge, well-designed logistical, clinical, and patient support systems are critical¹.

PROGRESS MADE

Fixed-dose combination

Fixed-dose combinations offer significant promise for improving adherence by simplifying treatment regimens. At the same time, this form of compounding presents clinical and pharmacological quality assurance issues that should not be under-appreciated.

Funding

Through the development of funding programmes such as the Global Fund, funds are offered to make ARV treatment more readily available.

Political goodwill

The international medical community has at its disposal the political goodwill, the know-how, and the resources to begin to meet the challenge of HIV prevention and care of those infected by HIV in the developing world. This calls for not abandoning those who start on therapy, nor ignoring the pleas of the millions more who will subsequently make claim on our humanity. Action is needed now, and we must act well.¹

Better understanding of HIV and AIDS

The better understanding of HIV and AIDS has increased the knowledge base of treatment.

ANTIRETROVIRAL TREATMENT

Antiretroviral treatment (ART) is one of the main sources of hope in the management and treatment of HIV and AIDS. Billions of dollars have been mobilized to initiate and enhance ART in resource-constrained settings. This has been done by groups and bodies including the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), the President's Emergency Plan For AIDS Relief (PEPFAR), the World Bank Multi-Country AIDS Programme, The Clinton Foundation, The Bill and Melinda Gates Foundation, the Department for International Development (DFID) and the United States Agency for International Development (USAID).

Challenges of ART

Those involved in scaling-up of ART need to be cognizant with the factors that affect virological response to therapy.

Key among these factors is resistance.⁴ Resistance to antiretroviral drugs refers to the virus' ability to withstand the effects of ART. This usually leads one to take second-line drugs which are more potent and more expensive.

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Challenges of ART

- Treatment should be life-long
- Accessibility and affordability of ARVs
- Resistance
- Adherence to treatment
- Toxicity and side effects
- Sustainability:
 - First line treatment
 - Second/higher line treatment
- Complacency
- Unregulated use and 'road-side' selling of ARVs.

Failure to receive the required drug potency or interaction with other drugs that a patient may be on could lead to resistance or a failure of drugs to have the desired effect

Another challenge of scaling up ART is the logistical support needed to provide uninterrupted drug supply. Failure to provide a consistent supply of medication, also known as lack of adherence, could result in lapses in treatment which could lead to resistance.

Medical factors may sometimes also offer challenges in the scale up of ART. Failure to receive the required drug potency, or interaction with other drugs that a patient may be on could lead to resistance.

The physiology of patients also contributes some challenges in the use of ART. These include altered drug metabolism, poor drug absorption, advanced HIV progression (low pre-treatment CD4 count or high pre-treatment viral load), anatomic compartmentalization of virus replication leading to limited drug exposure ("reservoir"). Other factors include host genetic variability in HIV susceptibility, incomplete adherence to regimen due to either bad side effects, high pill burden or inability to meet requirement for co-administration with food and/or water.

HIV also presents some factors which challenge the scale up of treatment. These include HIV virulence and pre-existing drug resistance. Health care providers may also offer incomplete counselling on issues such as medication effects, schedules and importance of adherence. Some health care providers may also prescribe a combination of ineffective drugs or offer inadequate clinical follow-up.

Stigma and discrimination also offer challenges in accessing ART. Through excluding stigma from church doctrine, working towards replacing ignorance with knowledge and replacing fear with hope, the Church and FBO institutions can help in overcoming these challenges.

The shortage of qualified personnel to deliver and monitor care in a manner that will produce the long-term outcomes sought is also a significant challenge. Many of the healthcare systems in these settings are under-staffed and the human resources required to meet the projected need is not present. A range of

mechanisms, both traditional and innovative, will need to be employed to insert the needed expertise¹.

What is needed to Scale-Up ART?

In order to scale up ART efforts, it is important to coordinate and sustain the global response to HIV and AIDS.

Scale-Up around the World: Lessons learnt from the Haitian Experience:

- Early government response and private-public partnership are important
- The provision of free care and ARVs is an essential element of programme success
- Strengthening the primary care infrastructure is critical
- It is important to develop local, field-tested solutions to monitor adherence
- An un-interrupted drug supply and coordination among multiple donors are essential

This can be done through the development and management of treatment strategies that cover the programme design, the integration of prevention and treatment strategies, adherence and quality assurance and the initiating and monitoring of treatment.

Building a comprehensive infrastructure for scale up of HIV and AIDS treatment is also an important measure to scale-up ART and ensure equitable care for all. This will involve mobilizing a workforce, including FBO and Church volunteers and securing the delivery of effective drugs.

Monitoring and evaluation (M&E) of the activities implemented in the scale up of treatment ensures that there is effectiveness and sustainability of provision of ART and that there is an improvement of future outcomes. M&E also ensures that there is room for formulating a research agenda, to conduct research as well as to apply lessons learnt from clinical and behavioural research.

Efforts of Faith-based organizations

At a global level, networks that speak for and on behalf of churches and FBOs include the Ecumenical Advocacy Alliance (EAA) and the Ecumenical Pharmaceutical Network (EPN).

EAA is a broad international network of churches and Christian organizations – currently numbering over 100 – cooperating in advocacy on HIV and AIDS.

One of the goals of the EAA for its HIV and AIDS campaign is to increase the universal access to treatment for PLWHIV. The specific objectives for this campaign include strengthening and expanding existing health services, infrastructure, human capacity and treatment literacy to make possible the appropriate and effective utilization of available therapies. It also works to influence governments and pharmaceutical companies to implement policies that recognize the right to universal access to life-prolonging therapies including the treatment of opportunistic infections and provision of antiretroviral (ARVs) drugs. Other objectives include increasing availability of health services for women, providing access to effective means for prevention of mother-to-child transmission of HIV and ensuring widespread access to comprehensive care and treatment.

In regard to these specific objectives EAA's HIV and AIDS programme has been involved in the following activities:

- i. Widely supporting the “3x5” campaign of the World Health Organization (WHO);
- ii. Linking with the wider EAA's Global Trade Strategy for joint efforts addressing patents and access to drugs;
- iii. Distributing and promoting existing HIV and AIDS guidelines and conducting HIV and AIDS treatment literacy activities;
- iv. Promoting the “Staying Alive with HIV” Campaign.

The Ecumenical Pharmaceutical Network (EPN), which started as a programme within the Christian Medical Commission of the World Council of Churches, is supported by and works with all Christian denominations and has over 100 members in over 30 countries worldwide. The mainly institutional members include Christian Health Associations (CHA) and Drug Supply Organizations (DSO). The members' work in HIV and AIDS treatment includes increasing response by churches

and church health services to context-sensitive treatment literacy activities and providing information on factors affecting access to antiretrovirals for Church Health Services.

EPN has conducted several HIV and AIDS treatment literacy workshops for Church leaders' in several African countries. The primary purpose of the workshops is to equip the leaders to handle issues of HIV and AIDS treatment within their congregations. During the workshops the church leaders receive training on various topics including the physiology of the body, the physiology of the virus, the effects of the virus on the body and antiretroviral therapy.

Contributions made by Church-based Drug Supply Organizations

In addition to EAA and EPN, there are faith and church-based drug supply institutions that are involved in the scale up of ART. These include Mission for Essential Drugs and Supplies (MEDS), Joint Medical Store (JMS), ChanMediPharm and Churches Health Association of Zambia (CHAZ) based in Kenya, Uganda, Nigeria and Zambia respectively. These institutions focus primarily on the distribution and supply of good quality, affordable drug supplies. They have also partnered with the public sector in distribution of antiretroviral drugs.

Conclusion

There is no question that the pandemic can be defeated. No matter how terrible the scourge of AIDS, no matter how limited the capacity to respond, no matter how devastating the human toll, it is absolutely certain that the pandemic can be turned around with joint Herculean effort between the African countries themselves and the international community!⁵

Peter Okalet is the Senior Director for Health, HIV and AIDS Policy at MAP International

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The primary purpose of the workshops is to equip the leaders to handle issues of HIV and AIDS treatment within their congregations

MANAGING OPPORTUNISTIC INFECTIONS IN RESOURCE-LIMITED SETTINGS

Opportunistic infection management is the core in HIV care. Early recognition through careful evaluation and selective diagnostic testing leading to appropriate treatment of OIs, even in resource-limited settings, can significantly improve the lives of people living with HIV infection.

An opportunistic infection (OI) is an infection which happens to persons with a weakened immune system. Normally the immune system is very effective in fighting off infections. However, in cases where an individual is infected with HIV, the immune system is weakened primarily because immune cells called "CD4 cells" have been destroyed. This decreases the ability of the immune system to protect the body against infections.

Identifying Opportunistic Infections

Recognizing OIs in a patient with HIV infection requires careful attention to the patient's symptoms and the findings of a physical examination. Since some OIs are much more likely if the CD4 count is very low, having the results of a recent CD4 count can be very helpful. In advanced facilities, complex diagnostic equipment and laboratory services are available thus making definitive diagnosis of OI's feasible. In addition, these facilities may enjoy ready access to drugs for management of various conditions. They may also have highly qualified personnel. In contrast, health facilities in resource-poor settings are ill-equipped and the number of staff limited.

When formulating a diagnosis, a clinician carefully considers all the clues, and gives a list of the most likely diagnoses that fit with the clinical findings. Laboratory tests or X-rays can then be used selectively in a cost-effective way to confirm or exclude possible diagnoses. In some cases, a "therapeutic trial" which involves a course of treatment for a possible diagnosis can be administered to see if the patient's condition improves.

MANAGEMENT OF OI:

Diarrhoea

Diarrhoea is a common OI in People living with HIV and AIDS (PLWHIV). It could be acute or chronic with the possible causes including viruses, protozoa, bacteria or parasitic infestations. Where the causative agent has been identified it is important to give specific treatment.

To manage diarrhoea it is important to give supportive treatment which can include correction of fluid-electrolyte imbalance and provision of nutritional support.

Drugs like metronidazole, ciprofloxacin, albendazole and aminosidine are quite useful in management of diarrhoea in HIV infection.

Bacterial Pneumonia

This occurs quite often in people with impaired immunity. Its frequency might be the first sign that the immune system is not functioning well. Depending on the severity, it should be treated with antibiotics.

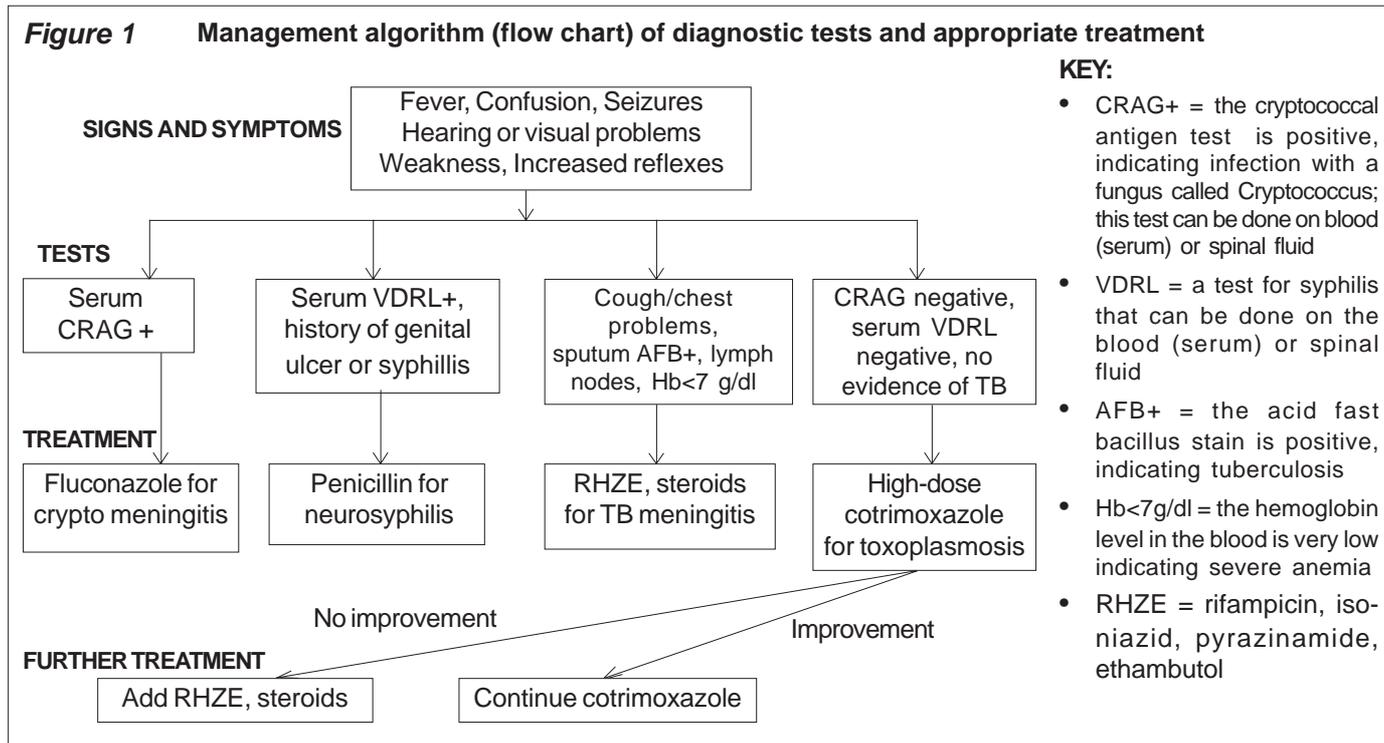
Headache

In evaluating a patient with HIV infection and headache, key elements in the medical history should include duration of symptoms and the presence of other findings such as seizures or convulsions, hearing or vision loss, or chest complaints which could be suggestive of TB.

Attention should also be given to the vital signs (pulse rate, respiratory rate, blood pressure, and temperature), and the patient should be examined carefully for evidence of focal neurologic findings such as eye muscle paralysis, blindness, paralysis or weakness of the arms or legs and enlarged lymph nodes especially in the neck or in the armpits.

If the headache is severe and has been present for only a few hours to days, then malaria or bacterial meningitis are

Since some OIs are much more likely if the CD4 count is very low, having the results of a recent CD4 count can be very helpful



possibilities, especially if the patient also has fever or confusion. Useful tests would include microscopic examination of a blood smear to look for malaria parasites and a lumbar puncture (spinal tap) to look for evidence of bacterial meningitis in the cerebrospinal fluid (CSF).

If the headache has been present for several days, weeks, or even months, other diagnoses are more likely, including cryptococcal meningitis, toxoplasmosis, TB meningitis and neurosyphilis (syphilis involving the brain or the lining around the brain). If a recent CD4 count is more than 200 cells/mm³, then the first two diagnoses (cryptococcal meningitis and toxoplasmosis) are less likely, since these usually occur when the CD4 count is very low. If the patient has been taking Cotrimoxazole for at least a month, then toxoplasmosis is less likely, since Cotrimoxazole helps to prevent this OI.

Useful diagnostic tests include serum cryptococcal antigen (CRAG), serum VDRL (serologic test for syphilis), sputum AFB (acid fast bacilli) stain to look for TB, and haemoglobin (Hb) or haematocrit (Hct) to look for anaemia. A lumbar puncture, a procedure to remove spinal fluid for laboratory investigations using a needle, may also be helpful to make a diagnosis. However this should be avoided

if the patient is paralyzed on one side of the body or has swelling of the optic disc known as papilledema. Papilledema can be detected by looking in the back of the eye using an instrument known as an ophthalmoscope. These signs may indicate the presence of a mass lesion pressing the brain. Figure 1 shows a simplified management algorithm which can help lead to a timely diagnosis and appropriate treatment.

Tuberculosis (TB)

TB is a common OI among HIV positive persons. Depressed immunity leads to reactivation of latent TB, and TB disease accelerates HIV disease progression. TB treatment is standardized, based on 5 core drugs, namely *Rifampicin*, *Isoniazid*, *Ethambutol*, *Pyrazinamide* & *Streptomycin*. Since these drugs are provided free in most healthcare facilities, health care workers should use national treatment guidelines. As in all OIs case detection, appropriate treatment and contact tracing are important. The treatment outcome should be the same as in HIV negative patients.

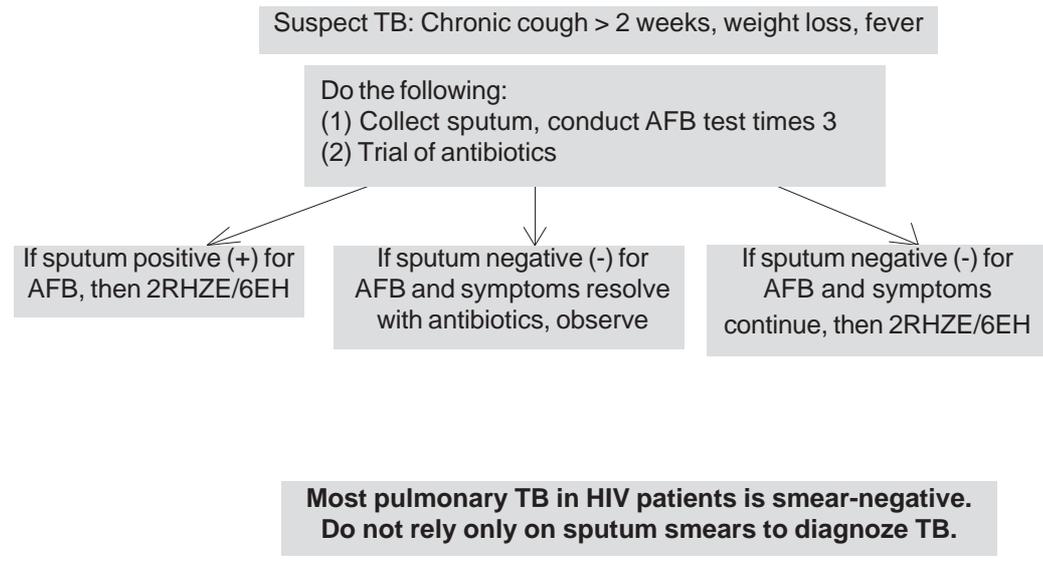
The biggest challenge in TB treatment is the emergence of drug resistant strains which need special treatment. It is therefore important to refer severe cases of TB to a well equipped medical facility.

The biggest challenge in TB treatment is the emergence of drug resistant strains which need special treatment

An algorithm (flow chart) to make a probable diagnosis of TB in a patient with HIV infection

Figure 2

Pulmonary TB: WHO Protocol



KEY:

- AFB is acid fast bacilli, the germs that cause tuberculosis
- 2RHZE/6EH is the abbreviation for a standard course of anti-TB medications; “R” is rifampicin, “H” is isoniazid, “Z” is pyrazinamide, and “E” is ethambutol
- 2RHZE indicates 2 months of the 4-drug RHZE combination, followed by 6EH, indicating 6 months of the 2-drug EH combination

HIV testing should be offered for all TB patients

HIV testing should be offered for all TB patients. Those who test positive for HIV should be registered for comprehensive care. Care should be taken as to the choice of drugs to be administered to avoid drug interactions, for example, protease inhibitors or nevirapine should not be administered to a patient on rifampicin.

Figure 2 is an algorithm which can assist in making a probable diagnosis of TB in a patient with HIV infection. However this test may only be available in urban health facilities.

Dealing with OI

Some OIs can be prevented through good nutrition, multivitamins, and proper hygiene. Many OIs can be prevented by taking the antibiotic Cotrimoxazole on a daily basis. Cotrimoxazole is particularly effective in patients with low CD4 count (of less than 350 cells/mm³), or a history of previous OIs such as TB or pneumocystis pneumonia (PCP). Preventive treatment (prophylaxis) with the use of Cotrimoxazole can help prevent malaria, salmonella infection, PCP, toxoplasmosis, and some cases of diarrhoea and pneumonia. Cotrimoxazole prophylaxis can decrease the risk of death by 40- 50% and reduce the chance of hospitalization by about thirty percent¹.

Conclusion

Rural health facilities carry a big burden in caring for patients infected with HIV. To cope with the challenges of dealing with OIs, these facilities should:

- Identify the conditions commonly seen at the facility;
- Form an active Drugs and Therapeutic Committee (DTC);
- Come up with selected essential drugs by drawing up an institutional Essential Medicines List (EML). This should be based on the Ministry of Health guidelines;
- Design institutional simple treatment protocols, which should also be based on the Ministry of Health recommendations;
- The DTC should revise the EML and the treatment protocols from time to time, to be in pace with the dynamic field of HIV and AIDS care;
- There should be a clear referral system in place, to cater for conditions that cannot be managed adequately at the facilities.

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John Omondi Amollo is the M.O. in-charge at the Mutomo Hospital in Mutomo, Kenya

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FAITH-BASED LED INTERVENTIONS

INTER RELIGIOUS COUNCIL OF UGANDA

The Inter-religious Council of Uganda (IRCU) is an illustration of how faith-led interventions can assist in accessing antiretroviral therapy. Despite differences in faith affiliation, belief and doctrine, members of IRCU work collaboratively in ensuring access to HIV and AIDS treatment.

The Inter Religious Council of Uganda (IRCU) is a national, inter-faith, non-governmental organization that brings together different religious groups to work along areas of common concern through the sharing of knowledge and resources. The Council was established in 2001 with a mission to promote peace, moral and spiritual integrity, social-economic welfare and collaborative action among communities.

Currently, there are five religious coordinating bodies (RCBs) that comprise the IRCU: the Catholic Church in Uganda, the Uganda Muslim Supreme Council (UMSC), the Church of Uganda (COU), the Uganda Orthodox Church, and the Seventh Day Adventist Uganda Union. IRCU also collaborates with the Uganda Christian AIDS Network (UCAN). UCAN coordinates more than 100 faith-based and community organizations that provide HIV and AIDS prevention, care, treatment, and support.

IRCU operates in three programme areas:

- Health (particularly HIV and AIDS and its impact on individuals, families and communities);
- Peace and Reconciliation;
- Education.

HIV and AIDS Programme

The main activities carried out under the HIV and AIDS programme are:

- Expansion of access to and utilization of quality palliative care services for persons affected and infected with HIV and AIDS and their families;
- Scaling up access to appropriate support services for orphans and vulnerable children (OVC) as well as their caretakers;
- Expanding access to and utilization of Antiretroviral Therapy (ART) services for eligible people living with HIV (PLWHIV).

IRCU's role in providing treatment

In Uganda, over 80,000 people are on the life saving ART. Despite the national scale up of the ART programme in Uganda, there are still many HIV infected people in need of ART who cannot

access the services. To cater for this need the RCBs have extensive networks of institutions and infrastructure throughout the country through which IRCU operates to reach the grassroots. In collaboration with the RCBs, and through a network of 22 faith-based health facilities, IRCU has provided both financial and in-kind (ARV, transport, and laboratory equipment) support to the facilities to provide ART. Through 13 faith-based health facilities, IRCU has provided training to 56 health workers in basic ART management, with 31 of the 56 trained in specialised ART management. From the efforts of the trained staff, at least 900 PLWHA put on ART and approximately 1,500 public health institutions have been supported with ART and laboratory testing. Over 400 clients have been enrolled in TB treatment.

Challenges

Although IRCU is an umbrella organization that attempts to unite all faith groups in Uganda, there is need to strengthen coordination among the FBOs. There is also a need to disseminate and replicate examples of good practices across the faith communities. Some conflict exists between some religious groups' HIV and AIDS policies and health or scientific practice, especially regarding condoms.

Conclusion

Since the pandemic is a social scourge, it is crucial that far reaching faith-based HIV and AIDS networks are supported to enhance the environment for debate, research, and service delivery in HIV and AIDS. In-depth research is needed to strengthen the knowledge base on which FBOs plan, monitor, and evaluate their HIV and AIDS programmes. Furthermore, to effectively offer care, support and treatment, there is need to take advantage of the diverse networks of religious institutions and their structures which penetrate from national levels to the remotest grassroots.

Jowad Kezaala is the Secretary General of the Inter Religious Council of Uganda (IRCU)

EQUIPPING CHURCH LEADERS IN HIV AND AIDS TREATMENT

THE ECUMENICAL HIV AND AIDS INITIATIVE IN AFRICA (EHAIA)

As the war to stop the spread of HIV and its impact continues, there is a need to address other interventions that will contribute in mitigating the effects of the virus to those infected and affected by HIV and AIDS. In view of the strategic role played by Church leaders who are represented at international, national and community levels, it is deemed necessary to include them and give sufficient knowledge to them on HIV and AIDS treatment.

If through HIV and AIDS treatment literacy we can postpone death and prolong a life in the event of HIV infection, we have gone several steps in defeating HIV and AIDS and the Church should be at the forefront.

More than twenty years after the first proven clinical case of Acquired Immune Deficiency Syndrome (AIDS) was reported, the pandemic has devastated humankind. The number of deaths caused by the pandemic is worse than any natural disaster or war that Africa has faced in the last century. HIV and AIDS affects all people irrespective of their religion, race, creed, colour, social class, age or gender. It constitutes a global emergency and is one of the most formidable challenges to human life and dignity. It is not only a health issue but also causes serious set backs in socio-economic spheres. The average life expectancy in many countries in sub-Saharan Africa is reported to be less than 40 years due to HIV and AIDS. This has enormous implications for the future sustainability of the nations, communities and family institutions.

HIV and AIDS treatment literacy for Church leaders

Church leaders command an impressive crowd at least on a weekly basis. Since they are usually respected at all levels and are mostly effective in communicating to their ever-ready audience, they can be an excellent resource in teaching about HIV and AIDS and its treatment. In many situations, their word seems to be more convincing to their audience than that of other professionals thus they are strategically positioned to communicate in a less costly environment through their churches. Some have also realized that they can contribute in making people live longer by encouraging them to access treatment on time.



Church leaders can be excellent resources in teaching about HIV and AIDS

Why the Church and Church leaders should be involved in HIV and AIDS treatment literacy

One of the issues that would be greatly overcome by involving Church leaders in HIV and AIDS treatment literacy is the stigma and discrimination associated with HIV and AIDS. Through giving positive messages in the Church, more people would avail themselves for voluntary counselling and testing knowing that, should the need arise, there will be treatment and support from the Church and through health care institutions.

It is highly commendable how health providing institutions that are faith-based have been involved in providing HIV and AIDS treatment to those who seek services. However the impact is limited when members of the churches (which own the health facilities) are not aware of the availability of treatment. Religious leaders need to know what is available and how their congregants can access these services.

Faith-based organizations role in HIV and AIDS treatment literacy

One of the ways in which HIV and AIDS treatment literacy can be transferred to Church leaders is through the work of faith-based organizations (FBOs). The Ecumenical HIV and AIDS Initiative in Africa (EHAIA) is one such organization. Working in collaboration with the Ecumenical Pharmaceutical Network (EPN), Bread for the World and the Pan-African Treatment Access Movement (PATAM), EHAIA encourages churches to analyse their potential and local resources to respond positively to HIV and AIDS issues. Through this analysis, the Church is in a position to evaluate its position on HIV and AIDS and identify the areas in need of intervention or more knowledge.

One such area has been the need to place treatment in the continuum of HIV and AIDS care. To address this, the organizations have trained Church leaders on issues such as the biology

CHAK



of the virus, treatment and, the resources at the churches' disposal to mitigate the spread of HIV and AIDS and support treatment .

Conclusion

Church leaders as key opinion and strategic leaders in community can communicate issues on HIV and AIDS treatment to their congregations and peers. More collaborative efforts are therefore needed at all levels in equipping Churches to address all aspects of HIV and AIDS.

Participants at an Anglican conference on HIV and AIDS.

Jacinta Maingi is the Regional Coordinator (Eastern Africa) of the Ecumenical HIV and AIDS Initiative in Africa (EHAIA).

SPIRITUALITY AND HIV AND AIDS

A health crisis is a time when people may turn to God. Do spiritual beliefs have an impact on physical health? If so, is the effect positive or negative? If positive, is this a direct effect or is it mediated through other variables such as healthy lifestyle, social support or psychological effects? What is the relationship between spirituality and the physical well-being of a Person Living with HIV (PLWHIV)?

Religion is defined as belief in and reverence for a supernatural power or powers regarded as creator and governor of the universe; and spirituality can be defined as matters relating to religion.

Spirituality and health

There are three possible impacts of spirituality on physical health. Spirituality can have:

- a negative impact on physical health
- a positive impact on physical health
- no significance on physical health

The Bible has quite a bit to say about physical health. These perspectives may help PLWHIV better understand the illness in the larger context of life and spirituality. Some of these teachings include:

- Health as a blessing from the Lord;
- Physical effects of sinful lifestyles;
- Healing effects of encouraging words;
- Healing in response to prayer;
- Illness as part of God's plan.

Most studies on religion or spirituality and health have been conducted in healthy people (most often the elderly). Religious people tend to have healthier behaviours¹ and healthy people who regularly attend church services have been found to have a twenty-five to thirty percent reduction in mortality when unwell.²

Spirituality and HIV infection

Spirituality can have negative effects on a patient's ability to cope with a chronic illness, especially an HIV infection. These negative effects include:

- Denial: "I can't be infected because I'm a Christian."
- Shame: "I cannot tell anyone what I have done."

- Condemnation: "People like that deserve what they get."
- Magical thinking: "God healed me, so I don't need to take medications."

However, spirituality can also have profoundly positive effects on a patient's health and lifestyle. These include:

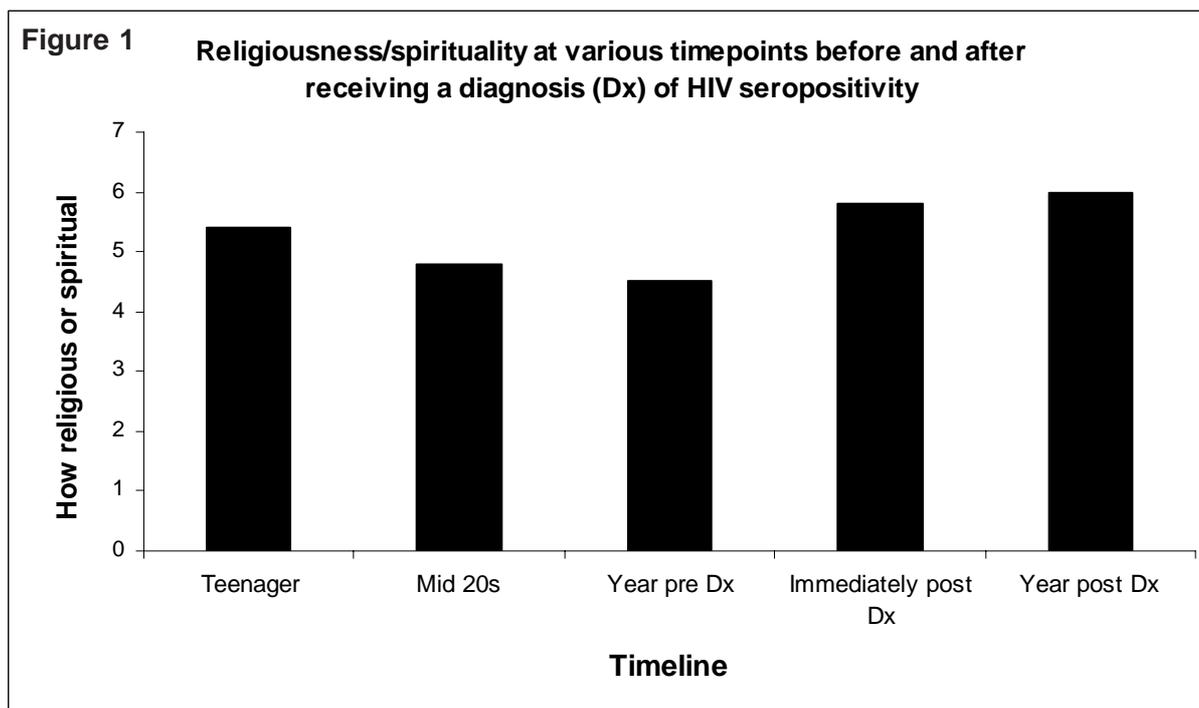
- Healthier lifestyles
 - Adherence to medication
 - Avoiding risky sexual behaviour
 - Avoiding alcohol and illicit drugs
- Social support
 - Regular church attendance
 - Close family relationships
- Psychological effects
 - Optimism
 - Coping skills
 - Having a will to live

Divine intervention

Studies on attitudes among PLWHIV have produced some surprising results. Forty-nine percent of PLWHIV feel that their spirituality has improved from before being diagnosed with HIV infection.³ Fifty percent of PLWHIV believe that their religiousness or spirituality helped them live longer.⁴

Does an increase in spirituality occur around a health crisis point such as receiving a positive diagnosis of HIV? If so, are changes in spirituality related to HIV disease progression? Figure 1 shows the results of a recent study conducted by Ironson and colleagues attempting to answer these questions.⁵ Of 100 HIV-positive people sampled, forty-five percent reported an increase in spirituality in response to finding out that they were HIV positive. Only thirteen percent became less spiritual after their positive diagnosis.

Religious people tend to have healthier behaviours



These changes in spirituality or religiousness after an HIV positive diagnosis had profound effects on the progression of the HIV infection. Those who became less spiritual after HIV diagnosis lost CD4 cells 4.5 times faster than those who became more spiritual after diagnosis. Those who became less spiritual had an increase in HIV viral load of 1.18, whereas those who became more spiritual had a 0.03 decrease in viral load.

Even after using controlling indicators such as church attendance, healthy behaviour (such as adherence to HIV medication, avoiding risky sexual behaviour, and not using alcohol and cocaine), affect (optimism, depression, hopelessness), coping skills (avoidance vs. proactive), and social support, increased spirituality remained a significant predictor of slower disease progression indicated by CD4 and viral load changes.

In summary, an increase in spirituality or religiousness was common after an HIV diagnosis. This increase predicted slower disease progression (as measured by CD4 and viral load changes), and the effect was independent of other psychosocial

variables. Therefore, medical personnel should be aware of the potential importance of spirituality on the physical health of their HIV-infected patients.

The role of healthcare providers in addressing spirituality and HIV and AIDS

Although empiric data in this area is still emerging it is important for health care workers to enquire from their patients:

- How they are coping with the diagnosis of HIV;
- If they have religious or spiritual beliefs that are helping them cope with the diagnosis and status.

During the clinical encounter, it is important to take time to encourage the spiritual development of patients by asking patients about their spiritual or emotional concerns and listening to what they have to say. Praying with patients on every visit is important. During prayers their spiritual or emotional concerns as well as their medical issues should be discussed. Encouraging the patients to join with other believers on a regular basis is also important.

Those who became less spiritual after HIV diagnosis lost CD4 cells 4.5 times faster than those who became more spiritual after diagnosis



One of the aspects of spirituality is social support

Many of our well-accepted cornerstones of adherence, support and HIV care have strong spiritual equivalents. Some of these spiritual equivalents include:

- Adherence = discipline, self-control, faithfulness, submission to authority
- Disclosure = truth-telling
- Support groups = fellowship
- Community involvement = carrying each other's burdens
- Addressing stigma = speaking the truth in love

Addressing these areas from a spiritual or religious perspective may help to strengthen patients' adherence and improve clinical outcomes.

Conclusion

Both clinical and Biblical evidence point to the strong connection between spirituality and physical health. For PLWHIV, the effect of spirituality on clinical outcomes is particularly profound. Addressing spiritual issues and encouraging spiritual growth are essential parts of comprehensive HIV care and are likely to lead to significantly better outcomes – both medically and spiritually.

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DIGNITY FOR PERSONS LIVING WITH HIV

MAUA METHODIST HOSPITAL

Maua Methodist Hospital which is situated in Maua, Kenya, was built in 1928 by the Methodist Church of Kenya (MCK). It started its palliative unit in 1988. Through its Community Health Department (CHD) and in collaboration with the Church and community, the hospital not only offers treatment and care for Persons Living with HIV (PLWHIV) but also empowers them to live wholistic lives.

In Maua, there are many challenges experienced in relation to HIV and AIDS. These include poor nutrition, poverty, increasing population of orphans and vulnerable children, lack of access to care and treatment, poor adherence to treatment, stigma and lack of appropriate HIV and AIDS education. The Maua Methodist Hospital and the churches around it are trying to address some of these challenges.

Churches and church leaders' involvement

The palliative unit of the hospital works closely with the Methodist Church in the area to address HIV and AIDS issues.

In 2000/2001, the hospital started a community mobilization activity to raise awareness on HIV and AIDS issues among church leaders. Of the six churches identified, three indicated a willingness to be involved in the activity. One of the churches has raised money for training and mobilized PLWHIV to seek treatment, while another has organized and hosted support groups for both children and adults who are HIV positive.

The Methodist Church has also developed a policy that guides the response to HIV in the church. The policy encourages talking about HIV and AIDS when preaching. Often the church has an HIV and AIDS information session after church announcements where a member of staff from the hospital is invited to give a talk about HIV and AIDS to the congregation.

The palliative unit offers training to Church leaders and members of the congregations. The trainings mainly focus on Home Based Care (HBC), medical facts and the spiritual aspects

of HIV and AIDS. These trainings, of which refresher courses are given once a year, have proved effective in creating awareness among Church leaders and congregations. Through the knowledge they have acquired, the Church leaders offer church facilities for the set up of clinics and often refer patients to the palliative unit. Once a week the palliative unit sets up clinics in various churches where staff from the hospital conduct medical check-ups where necessary provide medicines. This is especially helpful for those who cannot afford or are too weak to travel to Maua Hospital.

PLWHIV involvement

Through encouragement from the CHD, PLWHIV have started support groups which they use as the basis to urge others to go for HIV Voluntary Counselling and Testing (VCT). To discourage the dependency syndrome, the CHD has a hands-off policy in the running of the PLWHIV support groups. The PLWHIV are therefore responsible for the organization and management of activities within the groups.

With advice from the medical personnel, the members of the support groups have successfully grown kitchen gardens to supplement the diets of the PLWHIV.

This empowers the PLWHIV, volunteers and health committees to address the issue of nutrition which is essential for successful HIV and AIDS treatment. Support group members are trained how to plant and grow vegetables and how to purify waste water using sand for watering the gardens. Occasionally the hospital offers its support by sponsoring competitions for the best kept garden. The PLWHA are enthusiastic about the competition

The Methodist church has also written a policy that guides work on HIV in the church. The policy encourages talking about HIV and AIDS when preaching

which offers them the motivation to take care of the gardens and by extension themselves.

Members of the support groups are also responsible for the financial issues of the groups. These include establishment of a joining fee and a system for allowing payment of the fee in instalments. A particularly successful financial decision of the support groups was urging its members to join a Savings and Credit Society (SACCO). This has greatly benefited its members. The SACCO was an initiative of the staff members of Maua Methodist Hospital. It was started as a small welfare association to cater for any financial eventualities or needs of the hospital staff. It has now grown to a large micro-financing organisation which caters for the Maua Methodist Hospital, the church and the residents of Maua area.

To appreciate the value of the services offered to them, the PLWHIV are required to pay a small amount of money towards their medication and treatment when they visit the palliative unit. In this way, they value the products and services that are offered and are also motivated to freely contribute ideas and

suggestions on how best the unit can be run. PLWHIV in this system feel it is their responsibility to make the treatment successful and are willing and empowered to work on their situation.

The support groups receive support from the palliative unit by provision of medical check ups and nutritional advice and training supported by Samaritan's Purse.

THE CHALLENGES

Even with these successes, Maua Hospital and church members face challenges in their work.

Stigma

One of the main challenges is stigma. Both the PLWHIV and to some extent the staff working in the palliative care unit experience stigma. The main causes of stigma include the fear of gossip that surrounds one being termed HIV positive and the term "palliative unit" which implies a unit of dying people.

Use of miraa (khat)

Miraa (Khat) is a stimulating herb which is widely used in the Meru area. The leaves of the herb are chewed to produce juices which when ingested cause various effects. The effects

Community involvement is crucial in the removal of stigma



CHAK

Members of the Methodist Church Palliative Unit

include insomnia and a lack of appetite which may cause one to skip meals. In the presence of poor knowledge about proper nutrition and the need for a balanced diet for the successful use of antiretroviral therapy (ART), the use of this herb presents great challenges. It is difficult to dissuade miraa chewing as the habit is widespread, even among some of the hospital staff.

Cultural and religious issues

In Maua, cultural and religious beliefs greatly influence people's perception on HIV and AIDS. Some of these include:

- belief that an HIV infection is a punishment from God;
- faith and miracle healing of HIV infection through prayer;
- belief that HIV and AIDS is caused by witchcraft or that witchcraft cures HIV and AIDS;
- belief that the HIV infection is caused by angry ancestors.

In addition to the health information given at the palliative care unit, the church leaders try to deal with these cultural issues through educating the community and offering Biblical-based guidance.

Lack of implementation of policies

Although several opportunities exist within the Church to talk about HIV, these are not properly utilized. Due to its connection with sex, there is shyness in addressing HIV and AIDS in church. There is a lack of understanding that church leaders, due to their vast reach and influence in the community, are instrumental to improve knowledge and understanding of HIV and AIDS. Some opportunities to increase access to HIV and AIDS care and treatment are thus lost. More effort therefore needs to be put to ensure Church leaders' support.

Dormant support groups

As a result of the hands-off management policy by the hospital, some of the support groups have become docile. The docile groups are only used for the collection of drugs while some that are registered as Community-Based Organizations (CBO) are inactive as members do not attend meetings.

Others which started off with many members have dwindled to small numbers and projects which were started with enthusiasm have been neglected or left with a few members to run. There seems to be need for some guidance on sustainability of the groups.

Conclusion

The experience of Maua Hospital and the Methodist Church shows that there is room for sustainable cooperation between the two bodies. Both offer unique and relevant resources and strengths which when combined can achieve a lot. Due to its wide reach the church has better ways to reach the people while the hospital has the correct information about the virus and related issues of its control and treatment. The church has facilities and resources in the community while the hospital has audience in great need of prayers and support in the wards. The church gives spiritual healing and the hospital offers physical healing. In working collaboratively they provide more holistic care.

This excerpt is from a report following a research on *The role of Churches and Church-based health institutions in accessing HIV and AIDS treatment (2007)* conducted by Aster den Bok and Willeke Neelis.

It is a challenge to dissuade miraa chewing as the habit is widespread, even among some of the hospital staff

INVOLVING THE COMMUNITY IN RESPONDING TO HIV AND AIDS

FOCUS ON A. I. C. KIJABE HOSPITAL

The Africa Inland Church (A.I.C) Kijabe Hospital is situated on the eastern escarpment of the Rift Valley, 60 kilometers northwest of Nairobi. The hospital was built by the African Inland Missionaries (AIM) and is owned by the African Inland Church. The hospital sees over 100,000 patients per year of which a sizeable number are HIV positive. HIV and AIDS has taken a heavy toll in the community around Kijabe Hospital and it is with this in mind that the hospital started its HIV and AIDS activities. The initial activities, which started in 1999, were primarily targeted at the Prevention of Mother to Child Transmission (PMTCT).

Church leaders get information how to deal with HIV and AIDS in a spiritual way, how to give support and how to counsel PLWHIV

Involving the Church is crucial in HIV and AIDS treatment

In August 2004 the Kijabe Hospital became part of AIDS Relief. This project provides free antiretroviral therapy (ART) to eligible members of local communities. The project currently takes care of over 3,700 HIV positive patients of which 2,550 are on ART.

Training

The project runs various activities for its staff as well as the community to ensure that they are all well equipped in catering for the needs of the community they serve. Continuous education in HIV and AIDS treatment is conducted regularly particularly for the Community Health Workers (CHW) before they are sent out to the field to carry out home-visits. Besides this training, CHW are mentored by community nurses during supportive visits. Adherence officers and treatment coaches also train the CHW.

To enhance the activities of the project, the hospital hosts training on HIV and AIDS for clinical officers and nurses for AIDS Relief Kenya. It is hoped that this would be expanded to other mission hospitals in Kenya.

The AIDS Relief program in Kijabe also hosts trainings of staff from other AIDS Relief centres in the East African region.

In addition to the training offered to healthcare workers, the AIDS Relief project also offers training specifically targeted to Church leaders in HIV and AIDS issues. Reasons for involving Church leaders in this are:

1. Church leaders reach far more people than the hospital;
2. Church leaders have an influence in the community;
3. A large portion of the Kenyan population is Christian and attends a church service regularly.

The training provided to the pastors involves giving them medical facts and also tackling myths and misconceptions which Church leaders may have about HIV and AIDS. In addition church leaders get information on how to deal with HIV and AIDS from a spiritual perspective, how to give support and how to counsel People Living with HIV (PLWHIV). This offers a wholistic approach to HIV care.

Spiritual Support

In addition to the AIDS Relief project, the hospital has a chaplaincy department which deals with the spiritual growth of patients, staff and students. Their daily activities include daily department



devotions, prayer meetings, fellowships and seminars for staff members of the hospital. For the patients, the chaplains undertake bedside evangelism, outpatient devotions and pastoral counselling. On Sundays, they organize a chapel service for patients at the hospital. This department is crucial in offering support to the AIDS Relief project.

Church and Church leaders' roles in HIV and AIDS treatment

Support groups

Some pastors have offered their church facilities as meeting places for support groups. Sometimes pastors join the PLWHIV during support group meetings to offer guidance, counselling as well as spiritual support. Furthermore, the pastors often link biblical teachings to HIV and AIDS in their sermons.

Nutrition

The church in Kijabe is trying to respond to the nutrition needs of the PLWHIV. Some churches have introduced a system where each Sunday they invite members of the congregation to donate food items to assist in feeding those in need. Though this system is fairly simple, the response has not been positive as on most occasions few or no collections are made.

Orphans and Vulnerable Children (OVC)

In Kijabe and the surrounding areas, it is unfortunate that not much has been done to support OVC. However one church leader has started a project supported by Compassion International which caters for over 300 children.

In addition to the above, local churches have collaborated with the AIDS Relief in offering clothes and food for PLWHIV and facilities for conducting training.

CHALLENGES

Stigma

Stigma is a major challenge for both staff and PLWHIV. To help mitigate this, Kijabe Hospital has collaborated with the Church to train over 500 church leaders from the hospital's catchment area. This initiative and partnership has created more openness and awareness about HIV and AIDS particularly in the Church thus

reducing the levels of stigma. Several Church leaders have put to practice what they learn by talking about HIV and AIDS in their sermons and inviting the AIDS Relief team to talk about HIV and AIDS in their churches. From the training the Deliverance Church in Limuru has developed an HIV and AIDS policy.

A separate department

The AIDS Relief clinic is run as any other clinic within the hospital and also has its own space within the hospital. However this has in some way increased stigma as anyone known to frequent the clinic whether staff or patient is associated with HIV and AIDS. However when a patient requires admission, the patient is admitted in the hospital wards just like any other patient.

Medical, cultural and religious beliefs and practices

Cultural, medical and religious beliefs and practices sometimes hinder the access to ART. The Church and Church leaders can assist in dealing with some of these practices through educating the community on facts of HIV and AIDS and incorporating HIV and AIDS in their sermons.

Conclusion

One of the strengths of AIDS Relief Kijabe is the good relationship and cooperation with local churches and Church leaders in the catchments area. Through this relationship, AIDS Relief is in a position to reach more people and create more awareness.

A.I.C. Kijabe Hospital and the AIDS Relief project is a good example of how a mission hospital can address the challenges of HIV and AIDS in cooperation with churches.

Cultural, medical and religious beliefs and practices sometimes hinder the access to ART

This excerpt is from a report following a research on *The role of Churches and Church-based health institutions in accessing HIV and AIDS treatment* (2007) conducted by Aster den Bok and Willeke Neels.

WORKING IN PARTNERSHIP

THE CHURCH AND HOSPITAL ADDRESS HIV AND AIDS

Nazareth Hospital is situated in Riara Ridge, in the Limuru division of Kiambu District in Kenya's Central province. It is a non-profit missionary hospital under the Catholic Archdiocese of Nairobi. The hospital was founded in 1964 by the Consolata Sisters, who were in charge of the hospital up to 1999. The hospital is now managed by the Catholic Church's Franciscan Sisters of the Immaculate Heart of Mary.

The hospital runs an HIV and AIDS department called the Holy Family Centre (HFC). The hospital's mission is to provide accessible, affordable and quality health care to the marginalized and needy. The centre runs specific activities geared towards improving the situation of HIV and AIDS including offering clinical care, Antiretroviral (ARV) therapy, Voluntary Counselling and Testing (VCT), mobile clinics and technical support to health workers.

Capacity building and education

The HFC runs an education programme which trains volunteers from the community who in turn train others on HIV and AIDS issues. The training sessions have proved useful in educating members of the community as most are well informed on HIV and AIDS.

In addition to giving education and information on HIV and AIDS, the volunteers also inform the community

on the support they can receive from the HFC. When faced with a situation that is beyond their ability, the volunteers call on the doctors from the Nazareth Hospital for advice. These trainings assist the community to own the HIV and AIDS programme.

Orphans and Vulnerable Children

The HFC gives special attention to orphans and vulnerable children (OVC). In addition to providing ART for children, each Wednesday the centre runs a special clinic for children where they are attended to by a children's counsellor. The centre also gives advice to parents with children below 12 years to avail the children for HIV testing and counselling and offers support to grandparents who are looking after HIV-orphaned children. The children who cannot live with their grandparents or other relatives are referred to children centres by a social worker.

The training sessions have proved useful in educating members of the community as most are well informed on HIV and AIDS



CHAK

The Church and hospital need to work together to address HIV and AIDS.

Nutrition and feeding

The Nazareth Hospital, in conjunction with the Nazareth Catholic Church and the First Presbyterian church, Norfolk USA, runs a nutrition and feeding programme which caters specifically for those in the community who cannot afford to adequately feed themselves or their families. Through the church outreach programme, home visits are conducted and those who need to be on the feeding programme are identified. The programme also assists in identifying those with a Body Mass Index (BMI) of less than 18 who receive a food package or food supplements from the programme.

The church and hospital also offer support in the form of dairy goats to families in need. These give products which help to substitute the families' nutrition intake.

Economic empowerment and poverty eradication

In the area surrounding the Nazareth Hospital and Church, poverty is one of the issues that accelerates most the spread of HIV and AIDS. To mitigate the poverty situation, the church and hospital empower the community by offering employment to those in need. Through cleaning the church or hospital compounds or tending neighbouring farms, the PLWHIV earn money to cater for their basic needs and also to pay the one hundred shillings (USD 1.5) registration fee which is charged to access the services offered at the centre. In some situations, where families earn less than one dollar a day, the hospital donates a dairy goat which serves as a source of milk for sale or for food.

CHAK



These counsellors not only have basic medical and counselling skills but also theological knowledge

Pastoral Counsellors

Nazareth Hospital has taken a unique step in that it has employed pastoral counsellors. These counsellors not only have basic medical and counselling skills but also theological knowledge. The counsellors, together with the doctors, make rounds in the wards and provide patients and PLWHIV with spiritual support and counselling. They do not have to be Catholic as not all the patients are Catholic.

Publications and materials

Since 2004, staff members of the Nazareth Hospital have published annual editions of a book on HIV and AIDS. The books, titled *Nanasi*, offer HIV and AIDS case studies on clinical or counselling care particularly for medical personnel, patients and social workers in resource-poor settings. The books which can be used on an individual or group level are widely used in clinics and health training institutions in Kenya.

CHALLENGES

Despite all the accomplishments of the HFC there are various challenges experienced.

Non-involvement of other churches

Although some churches in the area are actively involved in HIV and AIDS issues, most churches do not offer activities specifically for HIV and AIDS issues neither do they have HIV and AIDS policies. The Nazareth hospital and Catholic church need to spread their outreach programmes to involve more churches in HIV and AIDS issues.

Lack of knowledge on HIV and AIDS issues

Though the Nazareth Hospital and the Catholic Church are involved in the education and training within the community, there are members of the community who have no information on HIV and AIDS. The two institutions need to apply ways to inform the larger community on HIV and AIDS. One of the most effective ways to do this would be to include more churches in their programmes.

Stigma

Some members of the community associate HIV and AIDS with poverty. The perception in the community is that the well-off in society can take their family members to expensive hospitals and provide them with good quality treatment and care. This camouflages the nature of the illness. Stigma is further propagated by referring to home visits as "evangelistic visits." This makes it difficult to offer the much needed support.

Self stigma is another form of stigma. In some situations PLWHIV request for a drug regimen that they can take once a day. This ensures that they take their medicines in private where no questions can be asked in regards to their ailments.

Unfortunately stigma has also been noted in the trainings that take place within the community. The facilitators, some of whom are HIV positive, do not disclose their status within the community or to those they train. Some

trainings also have two categories of trainees: treatment assistants and adherence counsellors. In most cases adherence counsellors are PLWHIV while treatment assistants are not. This situation makes it difficult for the PLWHIV to openly discuss some of the personal challenges they encounter as they feel that those who are not infected may not fully comprehend or empathize with their situation.

Conclusion

Through the Nazareth Hospital, the HFC is working well with the churches in the area to provide HIV and AIDS treatment and support. The Centre offers a good example of how to run an HIV and AIDS programme and many churches and hospitals can learn from its example.

This excerpt is from a report following a research on *The role of Churches and Church-based health institutions in accessing HIV and AIDS treatment (2007)* conducted by Aster den Bok and Willeke Neels.

Self stigma is another form of stigma. In some situations PLWHIV request for a drug regimen that they can take once a day

FOOD SECURITY AND HIV AND AIDS

THE CHALLENGES OF CATHOLIC DIOCESE OF KITUI

Nutrition is a major factor to consider when dealing with HIV and AIDS treatment. A well-balanced diet and adequate amount of food intake is important for patients on ARVs. How is the Church handling this aspect of HIV and AIDS treatment and what challenges does it face?

The Catholic Diocese of Kitui is situated in the semi-arid districts of Kitui and Mwingi in Kenya's Eastern province. Started in 1984, the diocese developed a Home Based Care (HBC) programme to address HIV and AIDS within the community. An area of great need that the diocese has identified is nutrition. According to a study¹ conducted by EPN in 2004, the diocese had developed a successful feeding and nutrition programme particularly for People Living with HIV (PLWHIV).

Unfortunately, the feeding programme has ceased operations due to poverty caused primarily by insufficient rainfall. The general climate of the area is dry with little or no rainfall. This makes growing crops and rearing animals difficult.

Three hospitals (Muthale, Mwingi and Mutomo) and the diocese have developed various mechanisms to deal with the nutrition situation in the area.

NUTRITION

The role of the hospitals

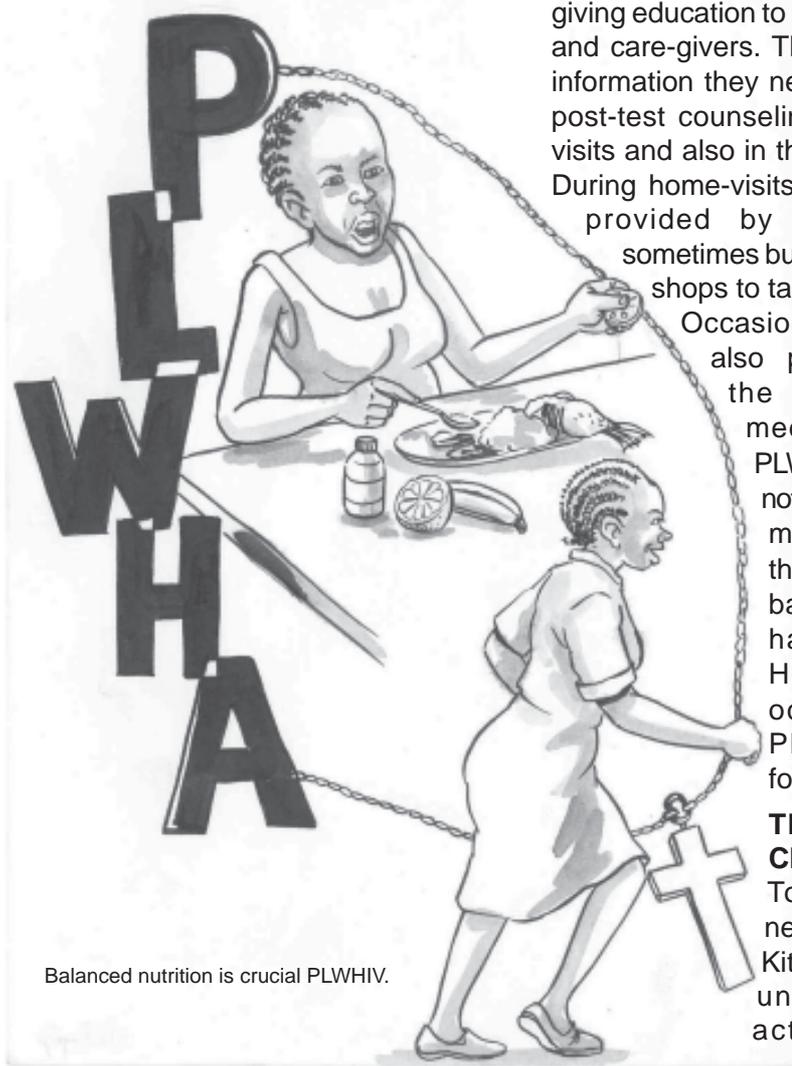
The hospitals address nutrition through giving education to PLWHIV, volunteers and care-givers. The PLWHIV get the information they need primarily during post-test counseling sessions, home visits and also in their support groups. During home-visits, nurses use funds provided by the diocese to sometimes buy food from the local shops to take to those in need.

Occasionally the hospitals also provide food during the support group meetings for the PLWHIV. This is however not adequate since for most of the PLWHIV, this may be the only balanced meal they have in a week. However on some occasions, the PLWHIV are given food to take home.

The role of the Church

To cater for the nutritional needs of PLWHIV in Kitui, the Church has undertaken various activities including

This is however not adequate since for most of the PLWHIV, this may be the only balanced meal they have in a week



Balanced nutrition is crucial PLWHIV.

The community has developed a dependency attitude towards donors and well wishers

collection and distribution of food to PLWHA, Orphans and Vulnerable Children (OVC).

During Sunday services, the church requests the congregation to donate food by placing it in two boxes provided at the back of the church. This however does not yield much returns as on most days the boxes are empty. Once in a year the Church dedicates a Sunday service to celebrate the harvest. The congregation is requested to bring part of their produce to the Church as an act of thanksgiving to God. The food is then given to the poor. However, as those in need of support are usually more than those giving, this does not work well.

The church in Muthale also provides a member of its clergy, a nun, to work in the kitchen of the hospital. She gives information on the preparation of food and the nutritional requirements particularly of PLWHIV .

To supplement the nutritional intake of those in need, the Church in some circumstances provides a goat or a sheep to needy families. The animals provide milk for the families' consumption or for sale to get some money to cater for their basic needs. Due to the semi-arid nature of the land, sheep and goats are ideal for this project as they do not require as much care in terms of food and water as cows.

POVERTY

The level of poverty in Kitui is high. Most homes are dilapidated, the land is difficult to till due to insufficient rainfall and employment hard to come by. This situation has aggravated the HIV and AIDS situation which poses some challenges particularly for the hospitals.

The main challenge for Muthale and indeed other hospitals in the Kitui area is charging a fee for the services and products they provide. PLWHIV are required to pay fifty Kenya Shillings (USD 0.7) at the hospital but most of them cannot afford this. Some PLWHIV go to the extent of declining admission in the hospital when they are unwell because they cannot afford the charges. In some of these cases the

hospital waives these charges. Most hospitals charge a fee to conduct laboratory tests. However due to the poverty in Muthale, the hospital does not charge to conduct any tests. The hospital does not have the necessary equipment to carry out CD4 count test and therefore transports blood samples to another hospital in the area. This is expensive for the hospital as it transports the blood samples at its own cost.

Another charge that the PLWHIV are expected to contribute is a minimal fee towards supporting themselves as a group. However more often than not they cannot afford this fee.

Conclusion

The situation in Kitui can only be alleviated if the communities take responsibility for their situation. Though the Church and the hospitals are assisting as much as they can, the members of the community have developed a dependency attitude towards donors and well wishers.

One of the ways the community members can assist themselves is by initiating income generating projects that do not necessarily involve tilling the land or animal husbandry.

Following the example of the convent at Muthale, the community can use an irrigation system to grow fruits and vegetables on a small scale. The produce can be used for food with the surplus if any sold to cater for basic needs. However due to the low amount of rainfall, particularly in Kitui, irrigation would be a challenge.

Reference:

1. Starting points survey for increasing access to HIV and AIDS treatment in Kenya, Ecumenical Pharmaceutical Network (EPN), 2004
2. The role of Churches and Church-based health institutions in accessing HIV and AIDS treatment, Aster den Bok and Willeke Neels, 2007

This excerpt is from a report following a research on *The role of Churches and Church-based health institutions in accessing HIV and AIDS treatment (2007)* conducted by Aster den Bok and Willeke Neels.

WITNESSES OF TRANSFIGURATION, EMISSARIES FOR TRANSFORMATION

Matthew 17:1-8

The following reflection has been prepared by **Manoj Kurian** of
World Council of Churches (WCC)



For the three disciples Peter, James and John, the vision of the transfigured Jesus in conversation with Moses and Elijah and the voice from heaven must have been deeply moving and awe inspiring. In the context of the laws of their faith and in accordance to what the prophets (represented by Moses and Elijah) had to say, the three disciples witnessed their master's messianic role being affirmed by the voice of God.

The only verbal response that Peter could manage during the transfiguration was an attempt at trying to capture the moment permanently by proposing to create tents for Jesus, Moses and Elijah. The shrines on the mountain top would supposedly keep the disciples in a constant state of spiritual exhilaration. But almost as a rebuttal to Peter's wish, the voice from the clouds affirms God's love for Jesus, by commanding the disciples to listen to Jesus. He further instructed them to internalize what they had experienced, to descend to the reality of daily life and to be emissaries dedicated to the transformation of the world.

We all experience amazing moments in our life. We meet people who inspire us, we participate in and experience revolutionary initiatives that make a significant impact on people's lives.

We know what has to be done to deal with the HIV epidemic. We know how to treat the disease effectively. We have encountered and contributed to dynamic programmes carried out in many centres that respond to the needs of People Living with HIV. However there is a tendency for us to remain within those moments. We idealize these experiences and crystallize them in our 'best practices'.

Questions for reflection

1. Have we internalized what we need to do to ensure effective HIV and AIDS treatment?
2. In regards to HIV and AIDS treatment, are we on our way to the valley of life, where we can be emissaries for the transformation of the world?

RESOURCES

Helpers for a healing community: a pastoral counselling manual for AIDS

This is a step-by-step manual used by the Church to provide counselling services to people who are infected and affected by HIV and AIDS. The book describes comprehensive steps the counsellor should take from the beginning to the end of a counselling session, and how to organize and manage follow-up activities for the client and family.

AIDS in Africa: the Church's opportunity

This book highlights the paths that the Church in Africa can take to address the challenges of HIV and AIDS. It highlights the roles that the Church can play in counselling, for individuals and families.

The above (and other resources) are available from MAP International's Kenya office. To contact MAP please visit: http://www.map.org/site/PageServer?pagename=contact_Our_Offices

Living well with HIV and AIDS: A manual on nutritional care and support for PLWHA

Meeting immediate food, nutrition and other basic needs is essential if HIV and AIDS-affected households are to live with dignity and security. Providing nutritional care and support for people living with HIV (PLWHIV) is an important part of caring at all stages of the disease. This manual provides home care agents and local service providers with practical recommendations for a healthy and well balanced diet for PLWHIV. It deals with common complications that PLWHIV experience at different stages of infection and helps provide local solutions that emphasize using local food resources and home-based care and support.

Available online at:

<http://www.fao.org/DOCREP/005/Y4168E/Y4168E00.HTM>

Springs of Life audio visual cassette

This video primarily features Ruth Kioko a Person Living with HIV (PLWHIV). In the video Ruth urges the Church to get involved in AIDS prevention and care. The tape, filmed just eight days before Ruth succumbed to AIDS, has a sobering effect on the importance of the Church's role in HIV and AIDS.

AIDS in your community

This manual centres on how best to develop a community-based education programme on HIV and AIDS. It also highlights the resources available in a community to respond to the spread of the virus.

Scaling up effective partnerships: A guide to working with faith-based organizations in the response to HIV and AIDS

This guide seeks to counter the lack of information and misinformation which inhibits the scaling up of existing faith-based projects and the development of joint initiatives to tackle HIV and AIDS issues. The guide contains case-studies as well as information to counteract myths on HIV and AIDS, current responses, potential obstacles and current terminologies which are all intended to give practical advice for initiating or expanding collaboration at national and international levels. It is available in English, French and Spanish.

Authors: Steven Lux and Kristine Greenaway

Available for online at:

http://www.e-alliance.ch/hiv_faith_guide.jsp

Exploring solutions: How to talk about HIV prevention in the Church

Many people today know how to prevent HIV transmission and yet the disease continues to spread. Why is this? HIV and AIDS touches on many issues that the Church finds difficult to openly and realistically discuss such as sex and injecting drug use. This leads to perpetuating myths and untruths about how HIV is spread, who gets infected and how it can be treated. If HIV and AIDS cannot be discussed openly, then its root causes cannot be changed.

This guide, which is available in English, French, Portuguese, and Spanish, aims to support Church members and leaders to talk openly, accurately and compassionately about why HIV spreads and what can be done on an individual and community level to help stop the infection.

Available online at: http://www.e-alliance.ch/hiv aids_exploringsolutions.jsp

Contact deals with various aspects of the churches' and community's involvement in health, and seeks to report topical innovative and courageous approaches to the promotion of health and healing.

This issue of **Contact**, which focuses on HIV and AIDS treatment and the involvement of faith-based institutions, was published by the Ecumenical Pharmaceutical Network (EPN).

Contact is available on the World Council of Churches' Website: <http://wcc-coe.org/wcc/news/contact.html>

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