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Title: **Religious Leaders Infected And Affected By HIV As Agents Of Change"**

INERELA+

RELIGIOUS LEADERS INFECTED AND AFFECTED BY HIV AND AIDS AS AGENTS OF CHANGE"

Quote: *"The church through her structures and networks has the ability and credibility to effectively respond to the pandemic of HIV and AIDS and its related conditions if it maximizes her existing opportunities and roles within and outside the church effectively"* (Council of Anglican Provinces of Africa, 2007).

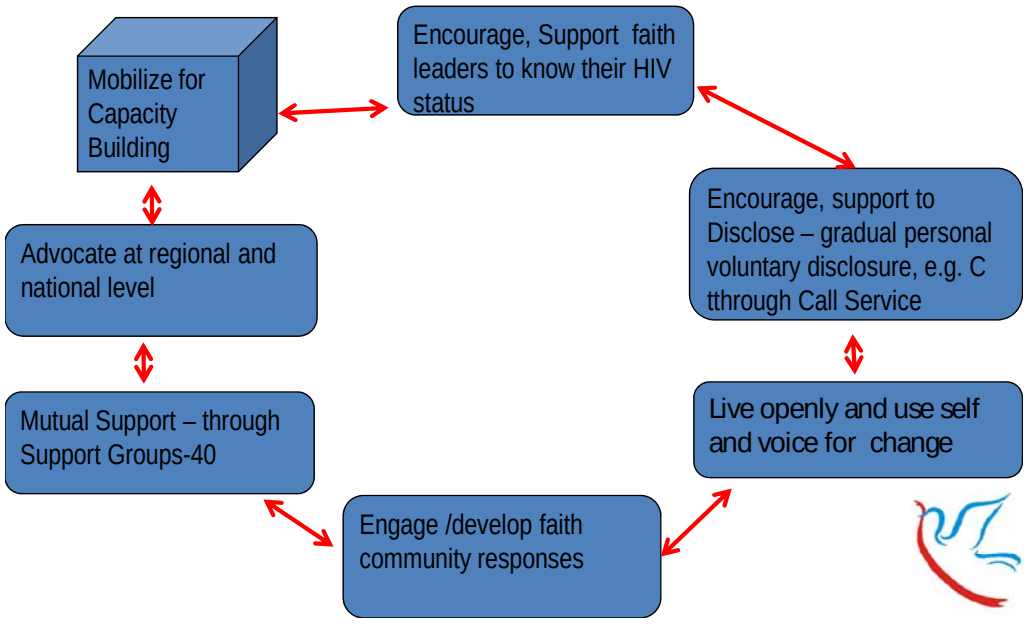
INTRODUCING INERELA+

INERELA+ is an international, interfaith network of religious leaders, both lay and ordained, women and men, who are living with, and/or, personally affected by HIV. It is recognized that religious leaders have a unique authority that enables them to play a central role in providing moral and ethical guidance within their communities. Indeed, their public opinions can influence entire nations. INERELA+ looks to empower its members to use their positions of respect within their faith communities in a way that breaks silence, challenges stigma and provides delivery of evidence-based prevention, care and treatment services.

INERELA+ works towards having a nation where **S**tigma, **S**hame, **D**enial, **D**iscrimination, **I**n action and **M**is-action (SSDDIM) are non-existent, as well as shifting from the Abstinence, Being Faithful and Condom use (ABC), messaging only, to a more comprehensive approach called 'S.A.V.E'. The SAVE model advocates for:

1. **S**afer practices: A+B+C+PMTCT+ safe blood, safe injections, safe circumcision, safe microbicides, and vaccine research.
2. **A**ccess to treatment: for opportunistic infections, PEP, STDS and ARVs and to nutrition.
3. **V**oluntary, routine and stigma-free HIV counseling and testing.
4. **E**mpowerment of children, youth, women, men, families, communities, and nations livings with or vulnerable to HIV & AIDS (economically, socially, spiritually, educationally, culturally, technologically, physically and politically).

THE PROCESS OF MAKING AN INFORMED LEADER



- In order to address Stigma, Shame, Discrimination, Denial, Inaction and Mis-action (SSDDIM) INERELA+ Kenya equips, empowers and engages its members to live positively and openly as agents of hope and change in their faith communities, through a cycle:

1) Faith Leaders are mobilised for capacity building where information and skills are transferred

2) Uptake of VCT, where religious leaders become role models for their congregations

3) Disclosure of HIV status through Call Service counselling. Disclosure is at different levels: to the Counsellor, to family and to the Public at large. The process of disclosure is gradual, personal and voluntary

4) Encourage living openly as Agents of Change through giving and sharing testimonies

5) Encourage Action: Congregational responses which target Women, Men, Youth and Children.

6) Formation of support groups for mutual support (40 such groups now exist in Kenya).

7) Advocacy where Faith leaders get involved in influencing Policy making process and Service delivery, while at the same time mobilising faith communities to do the same.

8) The cycle continues whereby Faith Leaders continue to build the capacities of their congregants – thus creating a ripple effect in their communities.

THE ROLE OF AN INFORMED RELIGIOUS LEADER

In World history, faith communities, leaders and their associated organizations and agencies have acted and advocated for and brought about better living conditions, policies and practices. They have contributed to efforts for realizing a safer, healthier and fairer world to all its citizens irrespective of their gender, age or geographical location. Many Faith leaders were behind much of the campaign that brought about the end and abolition of slave trade, end of apartheid in South Africa, increased medication to prevent mother to child transmission (MTCT) of HIV – to name but a few. Such is the potential of an informed religious leader's influence.

By contrast negative, reactionary, non-informed and mis-informed opinions, views and responses from some religious leaders and faithfuls have undermined national HIV/AIDS prevention polices and frustrated more accurate, more adequate and more comprehensive public health responses to save lives. This mostly happens when religious leaders and the faithfuls have mistakenly confused behaviors and practices that are culturally or religiously considered right with behaviors and practices that are safe in the HIV/AIDS context.

Many leaders are used to the idea of leadership as "prescribing", "providing" and "directing". However, the challenge of both HIV and AIDS are showing us that there is another model of leadership: "mutual learning, capacity development, facilitation and participation". The 'expert' verses 'recipient', and/or, top-down model of leadership has brought more of stigma, shame denial, discrimination, in-action and mis-action and short-term change when it comes to HIV &

AIDS prevention, care, treatment and impact mitigation. To handle HIV & AIDS, religious leaders and professionals need to perfect the skills of listening, empowering, facilitating, sharing and team building rather than merely giving prescriptions from above. It is only when religious leaders learn to handle HIV/AIDS effectively that they can be able to help the congregations to:

a) Break down barriers of prejudice, fear and stigma which have often frustrated comprehensive, inclusive and impactful action against HIV & AIDS and other preventable and controllable diseases.

b) Acquire more spiritual strength and resolve towards realising a safer, healthier and fairer environment for all irrespective of age, gender and geographical location.

c) Recognise, celebrate, remember, pray and thank God for the persons, families, communities, nations, leaders, agencies, healthcare service providers, researchers, educators, counsellors and donors who have the zeal and the commitment to SAVE families, communities and nations from HIV & AIDS.

BEST PRACTICES THAT ARE BEEING CARRIED OUT BY RELIGIOUS LEADERS IN THEIR AREAS OF INFLUENCE:

1. Deliberately teaching on upholding and enhancing Christian cultural values of virginity, monogamy, and faithfulness in marriage.

2. Setting up and facilitating youth-friendly sexual education programmes to raise awareness of the youth on HIV and AIDS and other related issues on reproductive health through debates, conferences, dramas, poems, and songs. Involving adults in these activities to reduce misconceptions.

3. Training church leaders - both lay and ordained - on HIV & AIDS, and on sexual reproductive health rights and sexuality.

4. Co-ordinating the integration of VCT and PMTCT and family counselling for HIV&AIDS prevention.

5. Empowering people living with HIV with information and skills for positive ling and positive prevention.

6. Establishing support groups and training home based care givers.

7. Establishing functional referral services for accessing ARVs from existing hospitals and clinics.

CHALLENGES FACED BY RELIGIOUS LEADERS

1. Stigma and Discrimination: These remain high at family, congregational and community level for people living with HIV.

2. Resources: the task is heavy with increased demand for interventions and the resources to intervene are limited.

3. Negative cultural beliefs: cultural beliefs that re-enforce stigma, shame and discrimination are a great barrier to success.

4. Leadership: Church leadership is yet to prioritize issues of health and HIV &AIDS.

5. Information and skills gap: inadequate information, knowledge and skills to help people make informed decisions.

6. Insufficient strategies and approaches of addressing structural challenges: There is a need for the church to address the social-cultural, economic and political challenges of the community to successfully contribute to the wholeness of life in the midst of the pain and despair brought about and made worse by HIV &AIDS.

7. Role modelling of safe behaviours: this is a big challenge in light of globalisation and negative media influences.

8. Parallel programming: there is need to integrate the programming of all health and sexual reproductive issues together and not deal with them separately. For example, messages need to be integrated on TB, Malaria, Diabetes, Family planning and HIV &AIDS.

9. Poverty: poverty contributes to poor nutrition and poor living condition. This is a great challenge especially for the people living with HIV. And HIV leads to depletion of resources, thereby worsening the poverty status.

CONCLUSION:

If the religious leaders individually and collectively advocate for anti-SSDDIM and promote SAVE messages, work with stakeholders in the medical practice, government and international community towards the same, then we will be living in a world which is ‘at Zero’: Zero new infections, zero discrimination, and zero AIDS-related deaths.

Quote: “W*ill the men and women who have been entrusted with leadership gifts take their gifts seriously, develop them fully, and deploy them courageously, so that the willing and gifted believers in their churches can work together to make a difference in the world*”? (Bill Hybels, Senior Pastor, Willow Creek Community Church, Chicago, USA, 2002)