Faith Leaders and HIV Stigma Reduction in Africa: Good Practices Collection

WACC
communication for all

hfa
hope for HIV/AIDS International

UKaid
from the British people

Compiled by

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DIAGRAMS

Foreword

We are at a historic crossroads in the global response to HIV. After thirty years, we finally have the technical tools and know-how to reach universal access to HIV prevention, treatment, care and support services. The challenge facing us now is to translate this opportunity into a reality for all.

Despite astounding medical progress over the past decades, many people are still excluded from the benefits of this progress as a result of who they are or where they live. Indeed, of the 34 million people estimated to be living with HIV today, some 16 million people need but do not have access to HIV treatment.

If we are to overcome AIDS, technical and medical solutions alone will not suffice. We must do more to tackle inequalities, injustice and societal attitudes that fuel vulnerability to HIV and limit many people's access to comprehensive prevention, treatment, care and support.

As rightly reflected in the new UNAIDS vision of "zero new infections, zero AIDS-related deaths and zero discrimination", eliminating stigma and discrimination against people both living with and vulnerable to HIV must be a core priority. And as faith communities we have a crucial role to play.

Our leaders and institutions wield tremendous influence at the ground level and have at the core of their ethos the mandate to tackle injustice and demonstrate compassion.

But we must not shy away from the fact that some faith communities and religious leaders have fostered, and continue to foster, HIV-related stigma and discrimination.

We must ask ourselves the hard questions about why stigma and discrimination persist to-date in so many societies and at so many levels today. We must be clearer and more visible in our efforts to disseminate evidence-based information about HIV and AIDS, to foster dialogue to tackle the "difficult" issues and to harness the positive power of faith communities to include and support people living with HIV.

The Ecumenical Advocacy Alliance, an international network of over 80 churches and Christian organizations advocating together on issues of common concern, has campaigned on HIV and AIDS since 2001, with overcoming HIV-related stigma and discrimination a key focus of our efforts. The World Association for Christian Communication, an EAA member, has been a leader in addressing stigma and discrimination through communication and advocacy, upholding the rights of people living with HIV (PLHIV) and empowering communities to speak out in support of all those affected. WACC's partnership with Hope for HIV/AIDS International in this project to empower faith leaders in Lagos, Nigeria to become advocates for PLHIV is a model of the kind of efforts needed in "Getting to Zero".

This collection of case studies of good practice, which was included as an aspect of this project in Nigeria, is a helpful contribution in identifying practices and organizations that can more systematically and effectively help to reduce stigma and discrimination.

Several of the key findings from this report should be highlighted for all future efforts, such as:

- Faith leaders are "community-based resources, role models and change makers", hence their importance in stigma reduction efforts.

- Including people living with HIV in the leadership of programs is vital so that the programs truly address their needs. But what is also required is a safe space where they feel they can share and be heard with respect and confidentiality if needed.
- Learning facts is important, but perhaps just, if not more important, is hearing real life stories and testimonies. The learning then is not just abstract, and can be transformative.

You - as I have been - will be inspired by the vision of caring faith communities, prophetic ministry and inclusion of all people reflected in the case studies in this report. But you will also be aware that this work is not easy – funding is increasingly difficult, real change requires long-term efforts, and many of the issues that need to be addressed are engrained in cultures and traditions. What's more, political will for responding to HIV seems to be waning, as indicated by the disappointing lack of a stronger target to eliminate the AIDS epidemic in proposals for post-2015 targets so far.

But we will not stop now. The fact that people are still dying as a result of HIV-related stigma today is a scandal, and we are committed to working hard to ensure that faith communities are increasingly part of the solution rather than the problem, and are further empowered to address – with lasting success - stigma and discrimination against people both living with and vulnerable to HIV.

Ruth Foley
HIV Campaign Coordinator
Ecumenical Advocacy Alliance
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Introduction

The term stigma originates from the Greek word which describes the physical marking – branding, marking, blotting, blemishing, or tattooing - of specific groups of people. Originally the branding was done to visibly identify specific people or groups, such as slaves or sailors. The treatment of specific groups of branded people was influenced by the social, cultural, and even status beliefs of the time. Usually, branded individuals were avoided or shunned, particularly in public places.

Individuals were often not branded for something they did or chose to do – they did not, for example, choose to become a slave – but rather they became stigmatized by what others did to them.

In recent times stigma has become a much more commonplace process of branding people simply for being different in some way. Individuals are no longer physically marked, but the process of stigmatization seems to have become even more prevalent. Examples of groups being stigmatized range from behavioral to genetic or religious differences and include aspects such as gender, perceived wealth, social status, intelligence and even health.

HIV infection and AIDS have in many ways been one of the most stigmatized conditions in modern times. Much has been written about the reasons for this stigma, the ways in which it manifests and the effect that this has on the epidemic and on addressing the challenges of the epidemic. An in-depth review of this literature is beyond the scope of this document. It is, however, clear that stigma has a profound effect on the lives of people living with HIV and on the success of programs addressing the challenges of the epidemic. In the context of HIV, stigma poses a serious barrier to an effective response to the pandemic because the fear of infection and social judgment are two key actionable drivers of the pandemic. The presence of stigma and discrimination, can, for instance, discourage individuals from:

- Being tested for HIV.
- Accessing health care, including adhering to treatment.
- Learning about and using effective means of prevention, such as condoms.
- Disclosing their HIV status to intimate partners, raising the risk of transmission of HIV.
- Talking or living openly with their status to enable support.

Stigma and discrimination also can cause individuals living with HIV to be alienated from their families and friends, threatens their livelihood and thus their ability to provide for themselves and their families, and adds psychological and spiritual stress in addition to medical concerns.

Faith communities have often been judged for the role some have played in creating and entrenching stigma due to moral judgments, but faith communities have also been leaders in providing care and support – and in addressing the pervasive stigma present within religious communities and in the wider society.

If we are honest, we have to admit that to a greater or lesser degree we all stigmatize.

Before we start addressing stigma, we might therefore find it beneficial to review our own individual and collective actions of stigma and stigmatizing our brothers and sisters.

Project and Scope

The Christian AIDS Bureau for Southern Africa (CABSA) was tasked by the World Association for Christian Communication (WACC) and Hope for HIV/AIDS International (Lagos, Nigeria) to do a survey on Faith-based **Best Practices on HIV Related Stigma in Africa** as part of a UKaid (DFID)-sponsored project on empowering faith-leaders to reduce HIV-related stigma and discrimination in Lagos State.

The purpose of the project was to document best practices of faith-based communities in Africa in addressing stigma related to HIV in their communities so that it can be shared with other organizations, and thereby assist in enhancing program design and impact. Because this is a small study of self-reported "best" practice, the terms "good" or "replicable" practice are used rather than imply an objective assessment that these cases are the "best".

Methodology

A multi-pronged approach was followed.

1. An electronic survey was compiled based on WACC guidelines and placed on a user friendly generally accessible website (www.surveymonkey.com) for organizations with access to the internet.
    a. The survey was marketed through:
        i. The CABSA Facebook page.
        ii. Two CABSA Newsletters, each sent out to almost 1000 recipients.
        iii. E-mail.
        iv. Tweets.
        v. Redistribution through various organizational networks and newsfeeds, including the WACC list-serve.
        vi. Marketed on the CABSA website, that receives more than 300 visitors per day, for two weeks.
    b. Personal email requests for completion were also sent to organizations known to be active in the field.
    c. Responses were monitored and reminders sent out.
2. Compilation of the questionnaire in Microsoft Word format for emailing to people without internet facilities but with email. This option was also offered in emails and newsletters.
3. Finally programs and processes were sourced on the Internet. All project related documents sourced in this way were scrutinized for inclusion. One such usable document was found.
4. A final stage assessed the responses received and identified key players who had been approached but who did not respond. These were then approached again via email and personal phone calls, resulting in several additional case studies.
5. The draft report was then sent to the respondents for their review and approval.

Response

A total of 23 responses were obtained, of which two were duplicates, giving an overall response of 22 organizations. A total of ten requests for MS Word versions of the survey were requested and of these, five organizations completed MS Word versions.

Of the responses received, three of the responses were from outside Africa and therefore outside the scope of this study. Further, 8 questionnaires were incomplete or supplied insufficient information for inclusion (Table below). However, the results obtained from incomplete questionnaires were used where possible and incorporated in the overview report.

A further three responses did not supply sufficiently relevant information on addressing stigma for inclusion in this report.

Table 1: Response patterns

	Q1 – Biographic	Q2 – Contact	Q3 - Overview	Q4 – Countries	Q5 – Why Faith ?	Q6 – Progr Summary	Q7 – Successes	Q8 – Measures	Q9 - Lessons	Q10 – Feedback?
Responses	22	22	22	13	13	13	13	12	12	15

From the results it can be noted that the respondents had sufficient information on "who and what" - their organization is (vision and mission) - but as soon as detailed information on stigma projects and programs was required, either the information was lacking or there was an unwillingness to share. As indicated, two sets of duplicate responses were received. One of the respondents indicated that the person completing the questionnaire stopped completing it, went to obtain further information and re-completed the survey. One of the good practices set out here is from this organization.

In a number of cases email requests were sent requesting further information, with no result.

After reviewing the responses obtained, a further number of responses unfortunately had to be eliminated for various reasons. The net result was that eight complete good practice examples have been listed. It is believed that this overview, which includes and combines all responses from all respondents, could in itself be used as a basis for discussing and compiling a program to address stigma.

A number of potential reasons for the relatively poor response to the request for information in this study can be assumed:

- Faith-based organizations might be reluctant to publically proclaim their materials or processes as being a "Best Practice".
- Many reputable faith-based organizations responding to HIV are experiencing cutbacks in funding, and thus also increasing strain on their financial and human resources.
- Many organizations contacted about the study find it difficult to identify specific activities focused on stigma alone, although much of their work may touch on different aspects related to stigma.

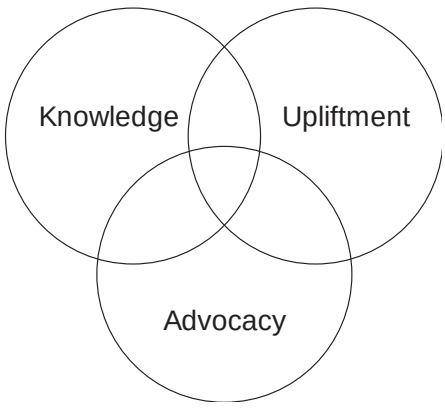
Faith Groupings

Good practice overviews were received from seven Christian, one Muslim and one interfaith organizations. The information from the Muslim organization was very complete regarding HIV related programs, but unfortunately supplied insufficient information regarding addressing stigma for inclusion here. The majority of the Christian organizations indicated that they follow an interdenominational approach.

Processes

One aspect that can be identified from the responses, whether they were fully completed or not, is that addressing stigma is not a problem that can be solved by adopting a single process or intervention strategy.

Diagram 1: Categories for addressing stigma



From this study there seem to be three key components or processes used by the organizations for addressing stigma (see diagram 1): knowledge sharing, uplifting and supporting individuals, and advocating for and on behalf of stigmatized groups.

For the purposes of this report, the following definitions are used:

- **Knowledge sharing** is considered to include all forms of education, from one-on-one discussions to formal classroom presentations. One of the key reasons for using this approach to address stigma is that stigma is often based in fear and lack of knowledge. Where training is done, duration varies from one-day awareness workshops to seven-day residential "facilitator" training. Workshops also include modules on the need for advocacy.
- "**Upliftment**" is seen as all processes of physical and mental care or support given to individuals or groups. (The terms 'development' or 'care and support' are deliberately not used, as they have specific definitions and criteria that might not be fully reflected in the activities of the reporting organization). This ranges from clothing and food to employment, hospices and care centers, to organizations supplying psycho-social support. There are two main reasons for this approach. Firstly the upliftment of individuals (recognition as worthy person) leads to increased self-worth and reduction of self-stigma. Secondly, although not specifically stated as such, seems to be "modeling" behavior of a faith-based organization towards a person living with HIV, showing others that their fears and the stigma are unfounded.
- **Advocacy** approaches can range from lobbying governments and large organizations, to presenting workshops on stigma, printing and distributing posters, or arranging group gatherings or marches addressing a specific issue. Advocacy is used for two basic reasons. Firstly, to build a groundswell against stigma or unfair practices with a view to corrective action and social change, and secondly, to make people living with HIV and experiencing stigma aware that stigmatizing behavior is not acceptable, and there are organizations working against it that they can approach for support.

The respondent organizations adopt one or possibly two of these approaches. The majority of the processes listed are educational, followed by upliftment, supporting or aiding affected groups. Although difficult to dissect from information supplied, it is clear that some of the faith-based organizations surveyed have also adopted aspects of advocacy.

Based on the information available, no organization seems to have fully embraced all three of these components.

Summary of key approaches use:

- Knowledge sharing
  - Training and awareness workshops
  - Sessions and talks involving personal sharing
  - Developing theological understanding and preaching
  - Developing and making available support materials and information sources such as
    - Websites
    - Booklets
    - Posters
    - Bible messages
    - Pamphlets
    - Resource centers and resource packs
- Upliftment processes include
  - School fees and uniforms
  - Food parcels
  - Helping create markets for products
  - Liaising with educational centers for further training and education

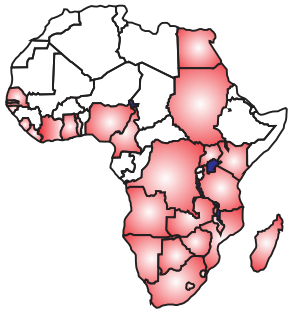
  - Economic development, e.g. Small business and financial advice
  - Home based care / health care center
  - Life skills training
  - Peer support programs
  - Donation drives
  - Counseling and testing
- Advocacy
  - Actively seeking opportunities to speak about key issues for and on behalf of people
  - Posters
  - Functions and meetings

Countries represented in the responses

Even though only a few good practices are set out here, the impact of their processes and interventions are spread widely throughout Africa.

The countries where the organizations operate to a greater or lesser degree are highlighted in the map of Africa included here.

Diagram 2: Countries where respondent organisations work



Target Groups

As earlier indicated, different target markets are the focus of different program types and approaches to address stigma.

No indicators of discrimination on the basis of religion were found in upliftment processes, rather organizations seem focused on helping where the need exists. The same was found regarding advocacy.

Regarding knowledge sharing, education and training, there seems to be a split between a focus on the community and a focus on religious leaders within specific religious groups.

In terms of talks, awareness sessions and discussions, the approach again becomes community driven.

Reasons given why organizations focus their programs on faith leaders is that they are community-based resources, role models and change makers. It is noted that their efforts and contributions make a difference within organization and the community through prayers, preaching and educating.

Motivation

As would be expected, or hoped, with a survey among faith-based organizations, the majority of respondents indicate their reason for involvement in the fields of HIV and Stigma as being directly or indirectly linked to their faith.

Indicators

In broad terms, the measures and indicators of success utilized include:

- Numbers trained
- Anecdotal evidence
- Questionnaires
- Pre- and post- workshop assessments
- Surveys
- Numbers assisted and supported
- Use of support material

There are only two cases in which formal – albeit small – research projects have been undertaken to determine success.

Summary: Key Learning and Replicable Practices

Each case study identified issues and practices as key learnings from their HIV and anti-stigma efforts, which are grouped here into "themes" which should be included in any project.

Key Learning	Replicable Practice
- People still die because of stigma. - Mobilization and transformation training plays a major role for any subsequent positive action. - Involve all critical stakeholders especially people living with HIV and people living with disabilities. - Promote safe spaces for dialogue and engagement. - Unpack difficult issues and promote constructive dialogue and action planning. - There are still myths around HIV, AIDS and TB. - People living with HIV are integral to the success of the program. - Livelihood vulnerability is a major impediment to project implementation.	Follow multiple approaches and techniques.
- Proactive actions by faith leaders can significantly reduce stigma within their congregations. - It is challenging to motivate local faith leaders to take proactive steps. - Start with leadership as door openers.	Must be pro-active.
- Impact of programs and workshops deteriorate over time. (People fall back) - People self-stigmatize. - Addressing stigma cannot be short term and must be pursued over long periods of time - more than just a few days, weeks or months. - The support of faith-based leaders cannot be a one off and there is a need for a long term reinforcing. - A single contact may not be enough and often multiple exposures and multiple methodologies are required for the message to be internalized. - Form action teams as these tend to define the agenda of the Church on HIV and AIDS.	Practice must be on-going.

Key Learning	Replicable Practice
- Practical exercises highlighting personal behaviors are more effective than pure theoretical training. - HIV positive role models and, more importantly, mentors are needed to help young people make the journey to living positively with HIV. - Sermons, personal testimonies, and public testing of faith leaders seem especially effective.	Develop / create and include role models.
- The project or program must be focused around specific groups or objectives - Stigma is an indicator of other larger issues that need addressing.	There is no one approach – Best practice is often the one that is best for a specific situation.
- People sometimes stigmatize other without realizing it. - Share experiences. - Stigmatizing behavior is most often identified when linked to practical situations, discussions, personal stories and introspection.	Make it personal.
- Faith leaders at times fear controversy, and at times have a perception that other issues may be more important. - A sound theological understanding is essential in addressing stigma - People often stigmatize around HIV due to a lack of understanding and fear. - Even religious leaders stigmatize HIV positive people. - Sharing of good practices adds value to helping faith communities understand issues. - Attitudes changed must be followed with the right skills to get things right.	Help people understand the total situation and reality.
- Passion for other people is the key to removing stigma and discrimination. - Most important things cost nothing, yet they bring impact to the lives of the people. - Sometimes you must listen to the stories and not just look at hard facts - A single visit or touch can make a difference. - Acknowledge their strengths.	Include cognitive and affective components.

Key Learning	Replicable Practice
- Changing attitudes does not happen overnight. - It is hard to monitor and measure behavior and change of attitude.	Perseverance is key.
- People are still uninformed about HIV in communities, thus the slow progress to mitigate stigma. - Seek inner transformation on issues of stigma and discrimination. - Ensure information provided is accurate, up to date and relevant.	Best practices must remain relevant.

Limitations of this study

It is important to realize that this is a small study of self-reported 'best practice'. Generalizations should therefore be avoided. The term "good" or "replicable" practice is therefore preferred

Regarding the good practices listed here, three additional factors should be kept in mind.

1. As this is a self-report study, the respondent may have focused on what they believed to be important.
2. This was a desk review and reports were analyzed without the possibility of verifying information through visits or in-depth follow-up.
3. It is possible that specific practices were not highlighted here as result of miscommunication or misinterpretation of responses.

Conclusions

Communal aspects of all the cases studies included here, and some that were collected but not included, are that they all approach the issue of addressing stigma from an appreciation of the worth of individuals.

Stigma is seen as something that reduces the worth of the individual in both their own eyes and the eyes of the community and thus needs to be addressed to redeem the inherent value of the individual.

Stigma is not seen as a one-sided concept but as an issue that requires interventions and processes that help both the stigmatizing and stigmatized. The interventions are all based on appreciative and positive perspectives and approaches.

In line with appreciative approach, all the case studies approach stigma primarily from a perspective of changing individual behavior rather than attempting to address the issue through lobbying or rules and regulations.

Finally all the approaches and programs arise from a basis of faith in that (even if fellow human beings do not enact it), each person is appreciated, worthy, and loved according to the doctrines of each specific faith

One key shortcoming in addressing stigma that can be identified among most of these organizations is the absence of formal research or measures indicating the impact of organizational interventions.

Case Study: AIDSLink International

Purpose and Vision:

To see hope restored in individuals and communities as we together overcome the challenges of HIV and AIDS.

Location:

Pretoria, South Africa

Countries / Areas where working:

- Southern Africa and
- Zambia
- Internationally – Asia, Europe, Latin America

Target groups:

- Faith-based Leaders
- Community leaders
- People involved with the pandemic at grassroots level
- Intravenous Drug Users
- People living with HIV and AIDS
- Children and young adults
- Vulnerable people

Motivation for program:

"We do this because there are so many inappropriate attitudes, and faith leaders are at the heart of communities in Africa and elsewhere and need to be part of the solution!"

Program Description:

Ultimate goal:

Equipping local people to respond through training and educating
Mobilizing: making people aware of the need and how they can help
Networking: getting alongside those involved
Supporting and strengthening local responses
Prevention
Caring for the hurting
Helping children affected by HIV and AIDS
Reaching out to those who are vulnerable.

Primary approach:

- AIDSLink utilizes a multipronged approach.
  1. The primary approach comprises conducting Channels of Hope facilitators training and workshops*. This involves training facilitators and equipping them to conduct sessions, taking the knowledge back and identifying approaches and opportunities in their own communities.
  2. Ministry
  3. Challenging inappropriate attitudes whenever and wherever we come across them.

(*Materials from the CABSA Churches Channels of Hope workshop is used with formal CABSA approval and permission.)

Duration:

7 days residential training of facilitators.

Contents

The purpose of the training is to equip participants with the appropriate attitudes, knowledge, and skills to be channels of hope, and being able to assist faith communities in their journeys towards HIV competence.

The successful participants are:
- Equipped with thorough knowledge on HIV and AIDS related topics and issues;
- Enriched and challenged to explore a Christian response to the challenges of HIV and AIDS;
- Empowered with facilitation skills and guidelines;
- Motivated to be a channel of hope.

Conducting Channels of Hope workshops involves a wide variety of learning methods based on the principles of experiential learning and includes:

- Group participation,
- Group debates and discussions,
- Mini lectures,
- Hypothetical scenarios and role plays,
- Demonstrations,
- Individual and personal activities and reflection,
- Group activities,
- Games,
- Pictures,
- DVDs,
- Storytelling and
- Sharing experiences.

Program History:

AIDSLink started in 2004.

Measures and indicators of success:

Personal follow up with participants.

Example of success: When we first met Angel* in Zambia in August of 2012, she told us she had “that thing”. We told her about our upcoming AIDSLink Channels of Hope (COH) facilitators’ training and were delighted when she found out that she could attend. The first few days of the seven-day COH training, young Angel was silent. Several people in the course told the group that they were HIV positive and shared how that has affected their life. But Angel kept her secret to herself. Then, in front of 35 people, Angel shared publicly for the first time in her life, “I am HIV positive.” From that point on, Angel transformed from meekness to boldness. Her whole countenance changed. For the first time in years, she could be herself. Angel went back to her home in Zambia and a month after the course

updated our AIDSLink team. She said, "I thank you for supporting me physically and spiritually. Really, you have changed my life. Before coming to the course, my weight used to be 43kg, but now, it has changed to 50kg. For me, it is so wonderful!"... "After the course, I decided to break my silence. I started by sharing my status at my school. My passion now is to share my knowledge of HIV and AIDS in several churches in my city before I start my HIV and AIDS practical in January." "On November 2nd, I had a dream where I received a note with the heading, 'The fall of Jericho and all destroyed'." Angel's walls of self-stigma have fallen down. She is HIV positive. In that, there is no shame.
*Name changed

Key learning points:

- There is also a need for freedom from self-stigma.
- Stigma can impact on personal health (to the extent that people don't take treatment).
- Not all indicators of success are quantifiable and often we need to sit down and hear the stories.

Support Materials Developed:

Various publications

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Case Study: Christian Aids Bureau for Southern Africa (CABSA)

Purpose and Vision:

CABSA dreams of Caring Christian communities ministering reconciliation and hope in a world with HIV. They achieve this by helping churches to understand the epidemic and its drivers, to hear God's voice, and respond comprehensively and competently. CABSA's main activities are training and mobilizing faith leaders, knowledge management and sharing, sensitizing, advocacy and networking.

Location:

Randburg and Wellington, South Africa

Countries / Areas where working:

Training takes place predominantly in Southern Africa, but CABSA has trained facilitator representatives in 40 countries, of which 26 are in the Africa

Training program used by licensed partners (World Vision International and AIDSLink) world-wide.

Target groups:

- Religious and faith-based leaders.
- Churches and members working in the field.
- Individuals with a calling to become involved.

Motivation for program:

"CABSA believes churches are ideally positioned to be change agents if they are HIV competent and become caring Christian communities, ministering reconciliation and hope in a world with HIV."

Program Description:

Ultimate goal:

Faith communities who understand their calling, and respond appropriately and comprehensively to the challenges of HIV in their own communities.

Primary approach:

CABSA adopts a multi-pronged approach to stigma and utilizes multiple, indivisible methodologies. A few core activities include:

1. A key focus of CABSA is the Churches Channels of Hope program. In this program CABSA trains individual faith leaders on all levels as facilitators. The purpose of this is to equip participants with the appropriate attitudes, knowledge, and skills to be channels of hope and assist faith communities in their journeys towards HIV competence.

The successful participants are:

- Equipped with thorough knowledge on HIV and AIDS related topics and issues;

- Enriched and challenged to explore a Christian response to the challenges of HIV and AIDS;
- Empowered with facilitation skills and guidelines;
- Motivated to be a channel of hope.

Conducting Channels of Hope workshops involves a wide variety of learning methods based on the principle of experiential learning and includes:

- Group participation,
- Group debates and discussions,
- Mini lectures,
- Hypothetical scenarios and role plays,
- Demonstrations,
- Individual and personal activities and reflection,
- Group activities,
- Games,
- Pictures,
- DVDs,
- Storytelling and
- Sharing experiences.

Other approaches include:

- Presentations and exhibits,
- Talks and radio interviews,
- E-mails,
- Newsletters,
- Posters and flyers,
- Weekly Bible message,
- Comprehensive website often addresses issue of stigma.

Duration:

The training program stretches over seven days with long hours, homework and preparation.

All other processes are on-going.

Content:

The training program is built around 5 themes

Theme 1: HIV and AIDS and Me (addressing attitudes extensively)
Theme 2: HIV and AIDS - Information that empowers
Theme 3: Living with HIV
Theme 4: Christian Response
Theme 5: Towards HIV competent faith communities.

Program History:

The first training was done in 2003. Since then CABSA trained more than 680 facilitators, and the licensed partners have trained many more.

Other processes developed over time from the training, based on needs identified and listening to facilitator needs.

Measures and indicators of success:

Pre and post training assessments.

Formal and informal feedback on all programs and approaches: Multiple letters of appreciation and personal stories of changes in life.

Numbers trained: At the end of 2012 there were 687 trained Channels of Hope Facilitators.

Surveys on post training impact: Facilitators supplying voluntary feedback in 2011 indicated that facilitators had contact with more than 60,000 people in the year.

In 2012 CABSA staff played a role in more than 200 events attended by more than 6500 people.

Website averages 10,000 visits per month.

Impact analysis undertaken with Prof. Christina Landman of Research Institute for Theology and Religion, University of South Africa (not yet complete).

Weekly Bible Message sent to more than 700 subscribers.

Newsletter with information and resources to inform a competent response to HIV sent to more than 900 subscribers.

Personal follow up with participants.

Key learning points:

- Stigma cannot be approached as a single concept - it is part of a total system involving individual and group understanding, behavior and perceptions.
- Stigma is an indicator of other larger issues that need addressing.
- People sometimes stigmatize others without realizing it.
- A sound Biblical and theological understanding, especially of aspects such as sin, punishment and health, is essential in addressing stigma.
- A single contact may not be enough and often multiple exposures and multiple methodologies are required for the message to be internalized.
- Stigmatizing behavior is most often identified when linked to practical situations, discussions, personal stories and introspection.
- People often stigmatize around HIV due to a lack of understanding, incorrect knowledge and fear.

Support Materials Developed:

Presentation packs to qualified facilitators:

- A comprehensive manual that includes all the information covered during the training and more.
- Master copies of the slides, posters and hand-outs,
- A set of laminated discussion cards,
- A CD-ROM with additional reading, tools and power-point presentation
- Additional booklets that complement the content of training.

Refresher workshops
Website
Newsletters (2 different newsletters)

Weekly Bible Messages
Resource centers
Sourcing of material and distribution of mini-resource centers
Contributed to many publications e.g. the "Positive in Church" Toolkit with a focused section on stigma (available online at http://www.positiveinchurch.org/)

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Case Study: Empact Africa

Purpose and Vision:

EMPACT Africa is a non-profit faith-based organization in Austin, Texas, USA. We are dedicated to working with local pastors in southern Africa to help them fight the stigma associated with HIV and AIDS.

Location:

Austin, Texas, USA

Countries / Areas where working:

Southern Africa:

- Lesotho
- South Africa
- Zambia
- Presbyterian Church in Africa

Target groups:

Christian faith-based leaders

Motivation for program:

"We believe that local faith leaders are uniquely positioned to fight stigma because of their role in shaping people's attitudes and beliefs and because of their leverage not only within their faith communities, but also with the wider community in which they live. In fact, we believe that without proactive steps by local faith leaders, it will be impossible to eliminate the stigma of HIV and AIDS."

Program Description:

Ultimate goal:

The reduction in stigma within congregations by helping local pastors understand the implications and effects of stigma, and thereby allowing them to take proactive steps to address the problems of stigma.

Primary approach:

A training workshop for faith leaders

Duration:

Four days

Contents

The workshop incorporates materials from CABSA Churches Channels of Hope training* and some materials developed by EMPACT Africa.

- Basic facts around HIV and AIDS.
- Concept, effects and impact of stigma,

- Theological response,
- Action planning and tracking.

(*Materials from the CABSA Churches Channels of Hope workshop is used with formal CABSA approval and permission.)

Program History:

The program has been running for 5 years with around 800 church leaders trained to date.

Measures and indicators of success:

- Numbers trained
- Anecdotal evidence: Information on effect of actions such as church based support groups and testing campaigns.
- Development and administration of questionnaires for both workshop participants and members of congregations.
- Pre and post workshop assessments (3 and 6 month intervals)
- Administering stigma surveys to congregational leaders as a way of stimulating them to action.
- Recent small scale study (with Stellenbosch University - Unit for Religion and Development Research) to measure the change in stigma within congregations shows
  - Changes in attitudes of workshop participants
  - Significant reduction in stigma within congregations

Key learning points:

a. Practical exercises highlighting personal behaviors and attitude are more effective than purely theoretical training.
b. Proactive actions by faith leaders can significantly reduce stigma within their congregations.
c. Sermons, personal testimonies, and public testing of faith leaders seem especially effective.
d. Impact of programs and workshops deteriorate over time.
e. Addressing stigma cannot be short term and must be pursued over long periods of time - more than just a few weeks or months.
f. The support of faith-based leaders cannot be a once off and there is a need for a long term reinforcing.
g. The project or program must be focused on specific groups or objectives.
h. It is challenging to motivate local faith leaders to take proactive steps.
i. Faith leaders at times fear controversy and at times have a perception that other issues may be more important.

Support Materials Developed:

Stigma-Free Faith Communities: *A Faith Leader's Guide to Ending the Stigma of HIV and AIDS*

The booklet has three parts:

- Characteristics of a stigma-free faith community
- Best practices for ending stigma
- A framework for incremental transformation

The first two provide the foundation; the third describes the steps to take for successful transformation into a stigma-free faith community.

- A5 saddle stitched,
- 28 pages

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Case Study: International Network of Religious Leaders Living with, or Personally Affected, by HIV (INERELA+)

Purpose:

To equip, empower, and engage religious leaders living with and personally affected by HIV to live positively and openly as agents of hope and change in and beyond their faith communities.

Location:

INERELA+ is an international network of religious leaders – lay and ordained, women and men – living with, or personally affected, by HIV.

The Head Office is located in Randburg, Gauteng, South Africa.

Countries / Areas where working:

Worldwide but regarding the specific program set out here:
- Mozambique
- South Africa
- Zambia
- Zimbabwe

Target groups:

The target groups for this program were religious leaders working with children between the ages of 12 and 18.

Due to their authority within communities as well as their social capital, religious leaders are in a unique position to open the space for dialogue about issues of sex, sexuality and gender. Furthermore, religious leaders are able to provide the platform, through which changes in internal attitudes and behavior can take place. In addition they often have community and cultural connections where they can influence social and cultural spaces in order to address the livelihood risks and the human rights violation risks that people face.

Motivation for program:

Combined with the SAVE (Safer practices; Access to treatment; Voluntary, confidential and regular counseling and treatment; Empowerment) comprehensive sex, sexuality and gender education, it is envisaged that all young people will be able to access sexual and reproductive health rights (SRHR) services as well as embrace their human rights.

Program Description:

Reduce *stigma, shame, denial, discrimination, inaction and mis-action (SSDDIM)* associated with HIV and AIDS.

Goals:

- To develop inclusive theologies for sexual minorities.
- To give religious leaders the theological tools with which to do theology, deliver sermons and practice pastoral care beyond the accepted heterosexual norms.

Primary approach:

Workshops with SAVE Toolkit

Core objectives:

- To provide participants with a model to communicate on the transmission and prevention of HIV in a non-stigmatizing manner.
- Understanding how stigma contributes to the transmission of HIV and AIDS-related deaths.

Contents:

The SAVE toolkit systematically tackles the stigma, shame, denial, discrimination, inaction and mis-action around HIV and AIDS, and gives comprehensive information related to HIV and methods of HIV transmission and how to mitigate these.

A major challenge on HIV for faith leaders has been the lack of skills in addressing sex, sexuality and gender in their faith communities. The toolkit gives users a step by step methodology of addressing sensitive issues in an open, informative and non-stigmatizing way which does not avoid otherwise difficult issues.

Program History:

The SAVE methodology has been used and taught by INERELA+ since 2005.

Measures and indicators of success:

- Focus group discussions before the start of programs
- Midline and End-line surveys
- Anecdotal stories of success

Examples of Success:

- The Board Chairperson of INERELA+ Mozambique is active within his congregation and the wider community to ensure that the myth that “women bring HIV into the home” is being addressed. In many homes, women discover that they are HIV positive during antenatal visits. When this is revealed within the home, many women and their children are chased out of their homes, resulting in huge livelihood vulnerabilities. Through couple and family counseling he has enabled a number of women to stay within their homes and has ensured that both husbands and wives get tested for HIV.
- In Zambia, through his involvement with INERELA+, the Grand Mufti is encouraging VCT at Mosques during Friday prayers. This mobile testing is run by the Lusaka Islamic Women's Empowerment Initiative. These volunteers have received SAVE training which they use for counseling and testing training from the Zambian Department of Health. By the end of December 2012, 542 people had been tested in mosques and 10% of these had been referred to health clinics.
- In many training workshops, participants have appreciated the in-depth scientific knowledge of HIV.
- Many women have expressed that information on mother-to-child HIV prevention has helped them to better understand why breastfeeding still remains viable for HIV positive mothers. They feel more confident in advising their communities.

- There have been several stories within communities where SAVE trained women have helped other women to access the right information and treatment so that HIV positive women can conceive.

Key learning points:

- People living with HIV are integral to the success of the program.
- Programs that provide safe spaces for young people to interact have the most potential for sustainability.
- Livelihood vulnerability is a major impediment to project implementation.
- HIV positive role models and, more importantly, mentors are needed to help young people make the journey to living positively with HIV.

Support Materials Developed:

SAVE Toolkit
Book: "What's faith got to do with it?"

Contact Details:

National and regional coordinators across Africa
See website for contact details

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Case Study: Networking AIDS Community of South Africa (NACOSA)

Purpose and Vision:

NACOSA builds the capacity of organizations and individuals so they can deliver effective and accountable health services in communities.

Location:

Century City, Western Cape,
South Africa

Countries / Areas where working:

South Africa

Target groups:

NACOSA promotes dialogue between government and civil society and advocate for a united, holistic and multi-sectoral response to HIV, AIDS and Tuberculosis (TB). Specific groups include;

- Faith Based Organizations (FBOs) and members
- Community Based Organizations (CBOs) and members

Motivation for program:

To facilitate an integrated response to HIV, AIDS and TB, and promote better health outcomes in communities.

Program Description:

Ultimate goal:

Collectively turning the tide on HIV, AIDS and TB.

Primary approach:

NACOSA provides broad-based training and technical support to organizations working in community health and social development, so that they can develop the systems and programs to respond to the needs of the sector as identified in the National Strategic Plan (NSP).

NACOSA helps to empower organizations at all levels with a comprehensive capacity building program, which includes training, grant funding, technical support, mentoring and community health systems strengthening.

Core objectives:

Capacity Building: Provide capacity and technical assistance to HIV, AIDS and TB non-governmental organizations and CBOs.

Networking: To build capacity amongst HIV, AIDS, and TB service providers.

Advocacy & Lobbying: To advocate on issues, for example to government, civil society.

Duration:

Training processes vary in length.

Processes are on-going and based on community requirements.

Contents:

Workshops are held where the burning issues regarding stigma are identified.

- Participants are taught the importance of support for people who disclose.
    - How support can be given?
    - Who will be supported e.g. orphans and vulnerable children, ARV (anti-retroviral) clients, etc.
    - What kind of support can/will they render?
    - Who will be responsible for supporting in each focus area e.g. church, school, organization, clinics and/or prisons.
- Community action teams are elected who are responsible to write a plan to mitigate stigma in their respective sub-districts.

Program History:

Created as an outcome of a national conference in 1991 to lobby for and develop the first National AIDS Plan for South Africa, NACOSA is now a **network** of more than 1,200 HIV, AIDS, TB and other related role-players working in communities across South Africa.

Measures and indicators of success:

No baseline survey was done.

Reports regarding these issues are submitted to the National Department of Health. This is the initial stage of the process of reporting.

Change can only be measured when the plans are submitted at the end of the stipulated Governmental reporting cycle, as a monitoring and evaluation plan must be drafted and outcomes measured accordingly.

Key learning points:

- People still die because of stigma,
- People are still uninformed about HIV in communities, thus the slow progress to mitigate stigma,
- Still myths around HIV, AIDS and TB.

Lessons learnt so far with the workshops held:

- This is an on-going process that needs a lot of insight into the way of thinking.
- Changing attitudes does not happen overnight.
- It is hard to monitor and measure behavior and change of attitude.
- Even religious leaders stigmatize HIV positive people.

Support Materials Developed:

Nil

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Case Study: Oneness Development Institute (ODI)

Purpose and Vision:

Our Vision: To see women and youth empowered to transform their lives and society.

Our Mission: To work in partnership with churches, non-governmental organizations, and others stakeholders to train and support people who are among the most vulnerable, including those facing the challenge of HIV and AIDS.

Location:

Beni town , North Kivu Province, Democratic Republic of the Congo

Countries / Areas where working:

Democratic Republic of the Congo

Target groups:

- Faith-based leaders
- Community leaders
- People involved with the pandemic at grassroots level (women, youth and children)
- Children
- Vulnerable people

Motivation for program:

"While the war in the Democratic Republic of Congo is formally over, women and girls remain at risk. The threat and use of violence is constant and includes sexual slavery, kidnapping, forced prostitution, rape and domestic violence. There are increasing incidents of men and boys who are also now suffering the same humiliation, from rape to genital mutilation. All of the victims, regardless of gender, suffer severe emotional trauma. Many are also impacted by HIV and AIDS. 90% of churches located in rural area of North Kivu province in the DRC do not have HIV and AIDS program to reduce discrimination and stigmatization affecting people living with HIV and AIDS. 'HIV and AIDS is a disease of sinners and unbelievers' said many Christians in rural areas."

"In response to HIV and AIDS epidemic ODI inspire churches and NGOs through training to participate in the fight against HIV and AIDS in a caring, active and constructive manner, being aware of their responsibility of solving the socio- economic needs of people living with HIV and AIDS."

"We help put in place strategies that among other things address discrimination and stigmatization in the era of HIV and AIDS. We help churches integrate HIV and AIDS into their programs."

Program Description:

Ultimate goal:

To see women and youth empowered to transform their lives and society.

Primary approach:

Working at developing partnerships at grassroots level between organizations and churches.

The organization uses a multifaceted approach that includes;

- Training,
- Workshops,
- Seminars,
- Counseling services and
- Providing awareness and prevention programs in HIV and AIDS, TB, malaria and other diseases impacting children and youth.

In addition to training, the organization is involved in:

- Community development by providing training and seeds to farmers (especially girls affected by war and HIV and AIDS),
- Helping the formation of co-operatives to work and sell their produce (cabbage, maize, corn and beans),
- Developing savings groups among women and youth, along with skills training to start small businesses such as baking and sewing (women living with HIV work together with others in the community),
- A new hotel management training program with local hotels,
- Food processing, to improve food security and economic independence.

Program History:

Established in 1982, under the name Bibliotheque Vie Nouvelle, the organization provided spiritual and social economic care.

Re-focused in 2005 and became a training center under the name – Oneness Development Institute.

Measures and indicators of success:

- Number of savings groups, and people involved, that have been initiated among women and youth. Currently there are more than 186 women involved.
- The number of people that have undergone small businesses related skills training.
- Training and placement initiatives.
- Number of people able to sustain themselves as result of initiatives undertaken.
- Numbers of people visited and supported.

Key learning points:

- Something as basic as a single visit can make a difference.
- The action of experts cannot replace a personal contact of love and compassion that individuals receive from Christians who are committed to live out of their faith.
- The church leader must educate people to accept those persons, education on how to accept other is a necessary element in ministry to AIDS children.
- “People living with HIV and AIDS are not just a problem, they can become a resource; they are not just miserable, they have their own dignity, they are the people who help us change our hearts, and help us to grow in love and solidarity.”
- We need to listen without judgment, without hidden agendas.

Support Materials Developed:

Nil

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Case Study: Pan African Christian AIDS Network (PACANet)

Purpose and Vision:

The Pan African Christian AIDS Network (PACANet) exists to link churches, Christian organizations and Christian networks in Africa to enhance their HIV and AIDS responses by sharing resources, ideas, skills, experiences and stimulating strategic partnerships.

Location:

Plot 620, Block 257
Concern Rise-Munyonyo
Kampala
Uganda

Countries / Areas where working:

- Swaziland
- Madagascar
- Uganda
- Cameroon
- Burkina Faso
- Liberia and
- Sierra Leone

Networking development processes are currently underway in South Sudan.

PACANet has also interfaced with other countries through regional events, and via dialogue through the E-Forum on several HIV topical aspects with stigma as a crosscutting issue.

Target groups:

Faith leaders are the key door openers to their churches and congregations. The first step in our response is mobilization that targets the leadership.

Follow up activities include various trainings: stigma and discrimination, change agents/ paradigm shifters training, bishops and senior leaders consultation on teachings and practices by the Church as related to HIV and AIDS, then Church HIV and AIDS competence trainings which enhances the leaders with knowledge and skills for action.

Motivation for program:

PACANet was established to position and facilitate the Church to champion a quality and comprehensive response to HIV and AIDS at grassroots level through networking.

PACANet promotes strategic networking, collaboration and partnerships among the Christian fraternity in order to strengthen the fight against HIV and AIDS in Africa.

Program Description:

Ultimate goal:

PACANet is mandated to provide technical support, advocacy, networking and capacity development support to HIV and AIDS responses by the Church in Africa.

Primary approach:

Training, dialogues and events held at different levels both regional and in-country through the CCANets address stigma as a critical issue.

Core objectives:

Technical Support
Advocacy
Networking
Capacity Development

Duration:

Processes vary in length.

Program History:

PACANet is a Christian faith-based organization established in 2002

Measures and indicators of success:

No specific baseline survey was undertaken.

Significant changes are demonstrated by responses at congregational level, church leaders' mobilization and allowing space for people living with HIV and the affected persons to participate freely.

"During our monitoring field visits, we established the following; In Burkina Faso, after attending the mobilization and training, Pastor Tapsoba Issaka Flavien from the evangelical church shared how he had a very negative attitude towards people living with HIV. After attending mobilization and training, he formed AIDS committees in the 8 congregations to focus on HIV and AIDS intervention. He has gone ahead to mobilize congregation members and people from the wider community to uptake the HIV test. He is pushing for linking with CNLS (The National AIDS Secretariat) through the CCANet in Burkina Faso to increase access to HIV counselling and testing for the other congregations in his jurisdiction.

Pastor Betty Kasaija from Hoima Western Uganda testifies how long and far she has come, from a totally negative judgmental attitude and teaching on HIV and AIDS, to a new attitude of compassion after training and now, reaching her congregation and mobilizing annual meetings for women to increase support for people living with HIV and orphans and widows. Apart from what her church is doing, she personally has taken on support for widows and orphans.

Bishop Isaac Aswa, a general overseer of Elim Pentecostal fellowship of Uganda from West Nile, testifies of the impact the Bishops and senior leaders' consultation on the church teachings and practices in relation to HIV and AIDS had on him. "My position had been that people infected with HIV were under a curse from God." The event totally changed his attitude on HIV and AIDS and what he had previously taught. Today all churches in his constituency have taken on HIV and AIDS interventions, and he has gone even further, using his influence to form partnerships both in country and beyond for the HIV and AIDS program which is now part of the ministry agenda.

In Sierra Leone, church leaders from mainly the Pentecostal church were passing on messages of divine healing and stopping people prayed for from taking the HIV test, at the same time those on medication where being stopped. This had a lot of negative impact on the congregations as at one time, it was evident people died of defaulting on taking their medication. The National AIDS Secretariat (NAS) engaged and facilitated NECHRAS (Network of Christian Response to HIV and AIDS in Sierra Leone) to mobilize and consult with the Pentecostal movement on the matter. Senior church leaders have been mobilized and trainings held to address the issue. Today more leaders acknowledge that it was because of a lack of information and adequate knowledge on HIV and AIDS that they held that kind of attitude and teaching. Those transformed recognize the damage caused in the past and are committed to fight stigma and initiate change in Sierra Leone. The journey is still long but change in attitude and action is evident." Doris Bah, National coordinator NECHRAS-Sierra Leo

Key learning points:

- To succeed with initiatives at both leadership and congregational level, stigma stands in the way. Mobilization and transformation training plays a major role for any subsequent positive action.
- Start with leadership as door openers.
- Form action teams, may be called differently but these tend to define the agenda of the Church on HIV and AIDS.
- Attitudes changed must be followed with the right skills to do things right.

Support Materials Developed:

Nil

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Case Study: World Council of Churches: Ecumenical HIV and AIDS Initiative in Africa (WCC – EHAIA)

Purpose and Vision:

The Ecumenical HIV and AIDS Initiative in Africa (EHAIA) is a program of the World Council of Churches (WCC). In response to concerns raised by churches in Africa about the growing challenges of the AIDS pandemic, the WCC together with AACC (All Africa Council of Churches) facilitated several dialogues across Africa culminating in a global consultation in Nairobi, November 2001. This brought together religious leaders from African Churches, the All Africa Conference of Churches, Regional Fellowships, National Councils of Churches, international and African ecumenical partners and related non-governmental organizations to develop a coordinated Plan of Action (POA) to respond to the AIDS pandemic in Africa. This POA consists of 13 commitments to make it possible for church leaders and their congregations to speak honestly about HIV and AIDS, and to act practically in response to it.

Vision: *With this Plan of Action, the ecumenical family envisions a transformed and life-giving church, embodying and thus proclaiming the abundant life to which we are all called, and capable of meeting the many challenges presented by the epidemic. For the churches, the most powerful contribution we can make to combating HIV transmission is the eradication of stigma and discrimination: a key that will, we believe, open the door for all those who dream of a viable and achievable way of living with HIV and AIDS and preventing the spread of the virus.*

Location:

Central Africa Coordinator – Kinshasa-Gombe, Democratic Republic of Congo
Eastern Africa Coordinator – Nairobi, Kenya
Lusophone Africa Coordinator – Luanda, Angola
Southern Africa Coordinator - Harare, Zimbabwe
Western Africa Coordinator – Lomé, Togo
Head Office – Geneva, Switzerland

Countries / Areas where working:

- 42 countries in Africa.
- The work of EHAIA has also reached into theological institutions in many parts of the world.
- WCC-EHAIA literature is used world-wide.

Target groups:

EHAIA works principally with religious leaders at every level, particularly at policy and levels of influence. The focus on working with religious leaders is in response to an expressed need and a request from churches in Africa.

Churches in Africa are rooted in communities, are influential institutions with potential to be a force for transformation – bringing healing, hope and accompaniment to all people affected by HIV and AIDS.

EHAIA also works collaboratively with many relevant key stakeholders and facilitates the interaction of these groups. People living with disabilities are also included in all trainings and meetings in addition to people living with or personally affected by HIV.

Motivation for program:

EHAIA endeavors to mobilize and empower transformational leadership, and to nurture creative and collaborative HIV interventions that address the intersection of the HIV pandemic, gender disparities, sexual and gender-based violence in the churches and theological institutions.

Ultimate goal:

Assisting theological institutions across Africa to mainstream HIV and AIDS into the curricula, at the same time raising awareness and accompanying such leadership to counteract stigma and discrimination, and to become theologically competent in responding to HIV, so that scripture is used to bring life and not oppression, and training to ensure technical competence in responding to the many challenges presented by HIV.

Primary approach:

Principle methods of engagement include:

- Trainings with religious leaders and other key stakeholders in the HIV response, especially people living with HIV.
- Exposure visits between programs.
- Development and provision of HIV sensitive and theologically based materials.
- Considerable HIV resource materials, with a theological basis, have been and distributed widely and freely.

Core objectives:

Responding to the emerging issues raised by the dynamic nature of the virus, introducing Contextual Bible Study methodology, the promotion and provision of counseling and regular HIV testing, introduction of support groups and the creation of safe spaces in churches for dialogue and support in areas of contention are also key features of EHAIA's programs.

Duration:

Processes vary in length.

Contents:

Trainings are in response to identified needs, and appropriate to the context and current responses of the leadership and community requirements.

Program History:

In 2002, EHAIA was launched as an *ecumenical* enabling support structure to accompany churches in this process to become HIV competent; to facilitate necessary trainings, to coordinate between churches and other faith-based organizations and key stakeholders in the response to HIV and to ensure the inclusion and active participation of persons living with HIV. The headquarters are in the WCC Geneva, with close proximity to many of the key organizations dealing with HIV including the UN agencies, as well as many of the resource partners.

Measures and indicators of success:

In its first four years alone, EHAIA trained over 8,000 church related resource persons from all over Africa and is recognized as being a catalyst for the evolution in the way churches in Africa think about and respond to AIDS.

Impact study undertaken (2002 – 2009) found substantial evidence of:

- Changed attitudes and deeper understanding in relation to stigma and discrimination within the churches (as indicated, among others, by the mainstreaming of HIV and AIDS into theological institutions' curricula and a new willingness to "break the silence" on hitherto taboo topics like gender-based violence or alternative masculinities);
- Creation of life-giving theologies and liturgical materials;
- Recognition by churches, their leaders and members and other ecumenical partners of the severity and challenges of the pandemic in relation to sexuality and sexual activity, sexual and gender-based violence and social injustices;
- Increased collaboration and coordination between churches and faith-based organizations (as seen, for example in the creation of inter-church and inter-faith coalitions or platforms);
- Strengthened capacity to promote and implement evidence-based prevention and provided holistic care and support together with other service providers;
- The multiplier effects of EHAIA trainings;
- A higher profile for HIV and AIDS at church-based meetings and for faith-based responses at secular HIV meetings;
- EHAIA collaboration with church stakeholders, ecumenical, national and international development agencies and structures.

Key learning points:

- Involve all critical stakeholders especially people living with HIV and people living with disabilities.
- Acknowledge their strengths.
- Seek inner transformation on issues of stigma and discrimination.
- Share experiences, promotion of SAVE acronym (for Safer practices; Access to treatment; Voluntary, confidential and regular counseling and treatment; Empowerment) rather than ABC (Abstain, Be Faithful, Use Condoms) and explain why.
- Ensure information provided is accurate, up to date and relevant.
- Promote safe spaces for dialogue and engagement.
- Offering voluntary counseling and testing (VCT) on site during workshops and encouraging all, especially Religious Leaders to take advantage of the opportunity to know one's status.
- Use of Contextual Bible Study Methodology to unpack difficult issues and to promote constructive dialogue and action planning.

Support Materials Developed:

Large numbers of books and audio-visual materials have been produced relevant to context and need, including publications on HIV mainstreaming, HIV sensitive sermon guidelines, modules on HIV for extended learning, policy documents, manuals, academic papers and Braille books. Available online at http://www.oikoumene.org/en/resources/documents/wcc-programmes/justice-diakonia-and-responsibility-for-creation/ehaia

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