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# **HIV Education for Church and Community**



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# First, a Glossary of Terms

- 🎗️ PLWH - People Living with HIV
  - 🎗️ Incidence - New Infections
  - 🎗️ Prevalence - Proportion of population infected
  - 🎗️ Mortality - HIV-related Deaths in a given time frame
  - 🎗️ ART - Antiretroviral Therapy
  - 🎗️ PMTCT - Prevention of Mother-to-Child transmission (also called “vertical transmission”)
  - 🎗️ VCT - Voluntary Counseling and Testing (for HIV)
  - 🎗️ MSM - Men who have Sex with Men
  - 🎗️ IDUs - Injection Drug Users
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# Trends over Time in HIV and AIDS

UNAIDS Global Statistics showing trends over time (in millions):

	2001	2005	2010	2015
PLWH	30.0	32.5	34.4	36.7
Incidence (Total)	3.4	2.9	2.5	2.1
Incidence (Adults)	2.8	2.3	1.9	1.9
Incidence (Children)	0.55	0.54	0.29	0.15
Mortality	1.9	2.3	1.9	1.1
PLWH accessing ART	-	1.3	7.5	18.2 (June 2016)

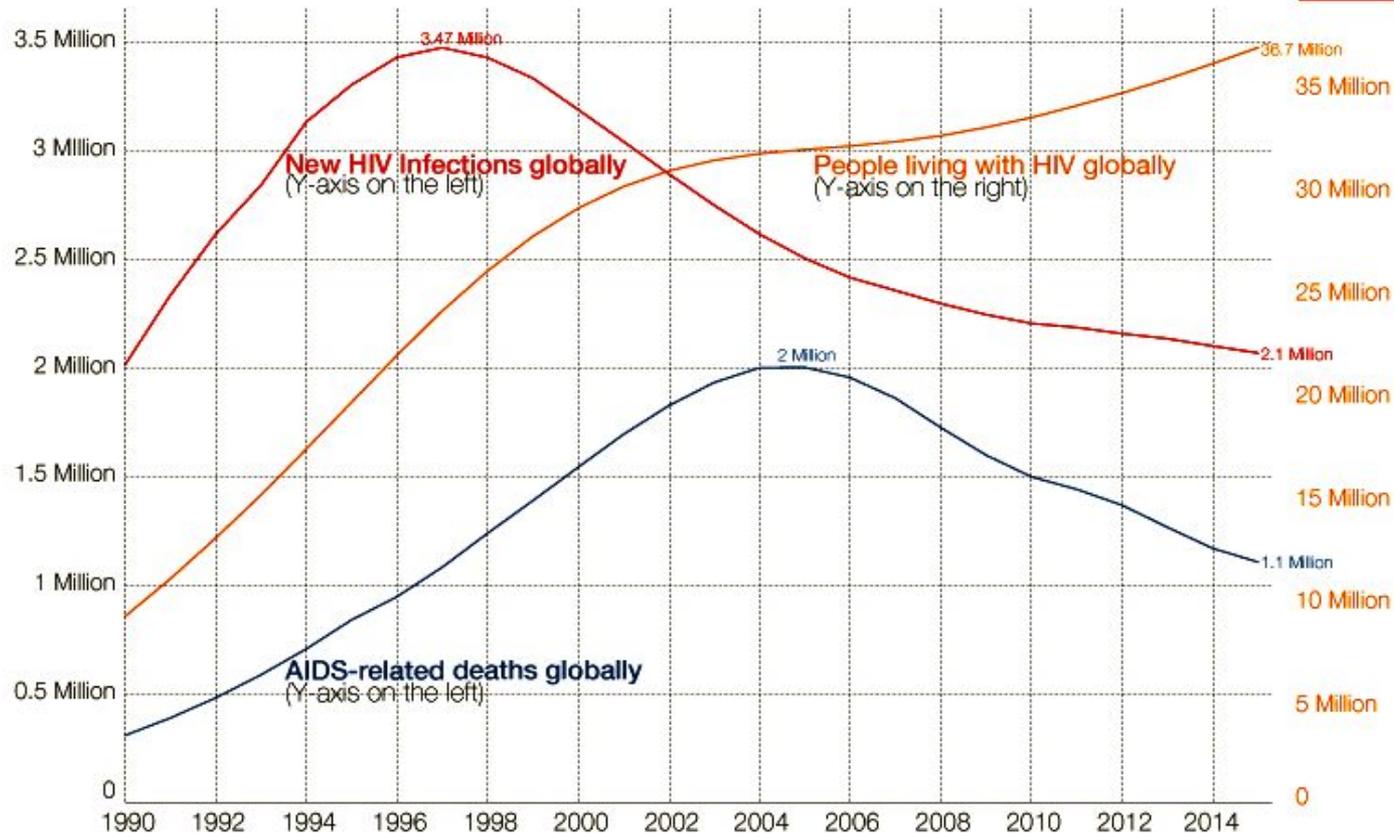
Source: UNAIDS [www.unaids.org](http://www.unaids.org)

Note: Global adult prevalence (15-49 years of age) has been essentially level since 2001 at 0.8%, although with considerable regional variations.

As of the end of 2015, over 78 million people had become infected with HIV since the start of the epidemic, and over 35 million have died.

# Trends over Time in HIV and AIDS

Global number of AIDS-related deaths, new HIV Infections, and People living with HIV (1990-2015) 



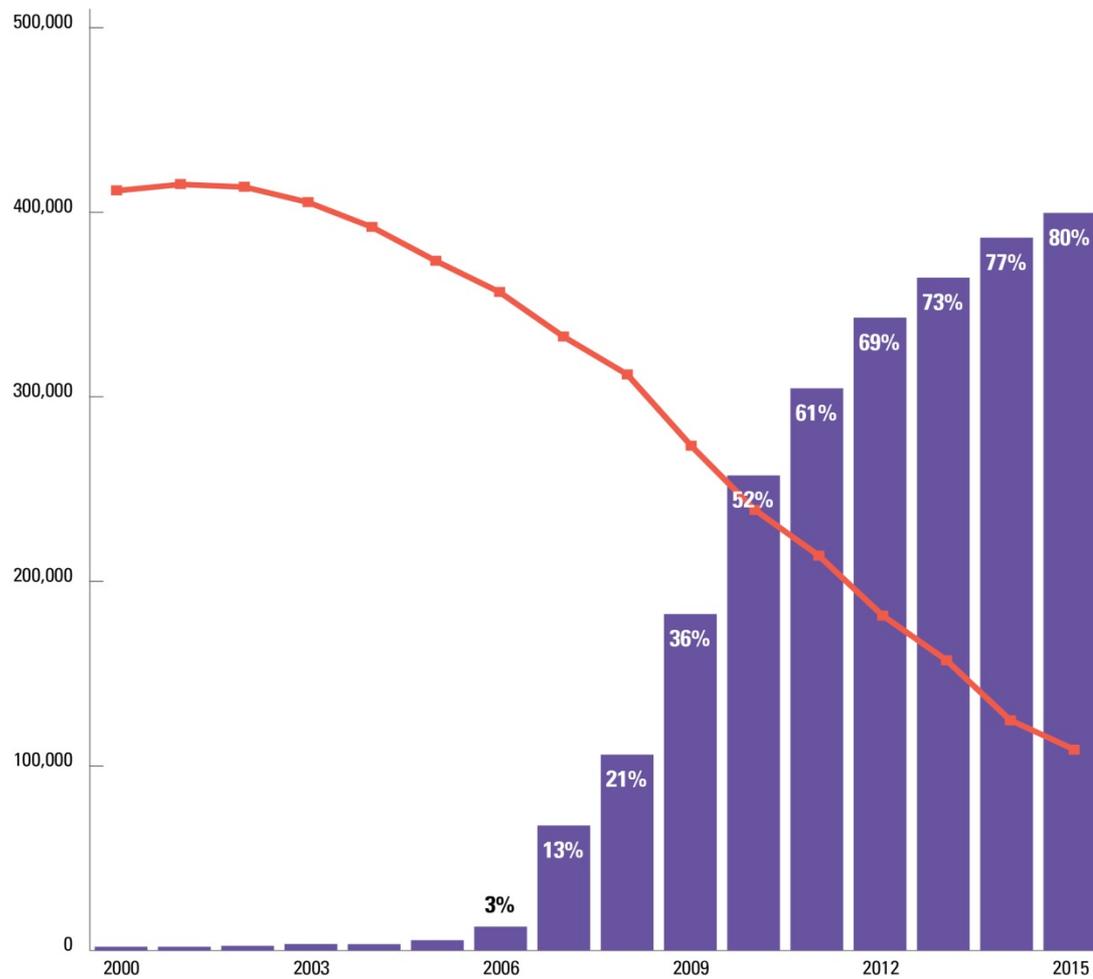
Data source: UN AIDS (via [www.aidsinfoonline.org](http://www.aidsinfoonline.org))  
The data visualization is available at [OurWorldInData.org](http://OurWorldInData.org). There you find more visualizations and research on HIV/AIDS.

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# Trends in Prevention

- ⚡ VCT - HIV testing capacity has increased over time.
  - ⚡ Currently 60% of PLWH know their status.
  - ⚡ The remaining 40% (or over 14 million people) are still unaware of their infection and need to access HIV testing services.
  
- ⚡ ART - there has been an 84% increase in PLWH accessing ART from 2010 to 2015.
  - ⚡ 46% of all PLWH were receiving ART by 2015.
  - ⚡ 7.5 million on ART in 2010; 18.2 million on ART by mid-2016.
  
- ⚡ PMTCT - rapid scale-up has been successful:
  - ⚡ 1% of positive moms in 2000
  - ⚡ 36% in 2009
  - ⚡ 77% as of 2015

# Pediatric Infections vs. Access to PMTCT



# HIV in Children

- ⦿ The most significant gains in reversing the epidemic have been among children under the age of 15 years.
- ⦿ The epidemic among children stems primarily from HIV transmission during pregnancy, childbirth or breastfeeding.
- ⦿ Incidence in children has been cut in half since 2010 and by nearly three quarters since 2001, largely due to scaled-up access to PMTCT programs.
- ⦿ The rate of decline in pediatric incidence is accelerating.
  - ⦿ From 2000 to 2009, new infections dropped 24%.
  - ⦿ From 2010 to 2014, new infections dropped 41%.
  - ⦿ Then from 2014 to 2015, new infections dropped 30% in just one year.
- ⦿ However, 60% of all new pediatric HIV infections in 2014 were estimated to have been acquired during *breastfeeding*.

# HIV in Youth (15-24 years)

- ⦿ Globally, young people account for approximately a third of new HIV infections.
- ⦿ HIV-related mortality is the 2<sup>nd</sup> leading cause of death globally among youth, and #1 in Sub-Saharan Africa (SSA).
- ⦿ A low level of HIV-related knowledge persists among youth around the world, with little signs of improving.
- ⦿ The age of sexual debut is starting to rise among male youth, but (except Africa) is falling among female youth, with increasing numbers initiating sex prior to age 15.
- ⦿ In SSA, women acquire HIV on average about 5-7 years earlier than men, so delaying sexual debut is particularly important.

# HIV and Gender

- ⚡ Globally, HIV is the leading cause of death among women of reproductive age.
- ⚡ Adolescent girls and young women are at especially high risk of acquiring HIV.
- ⚡ HIV prevalence is 1.7 times higher among adolescent girls than among adolescent males in sub-Saharan Africa and has been found to be up to eight times higher among females than males aged 15–19 years in South Africa.
- ⚡ For 1/3 of young women in SSA, their first sex is forced or coerced. So a third of our young women that we've saved (in childhood) from HIV are being raped in their communities.

# HIV and Gender (cont'd.)

- ❧ Women are more vulnerable to HIV than men due to biological, social, and cultural factors.
- ❧ Younger women are more vulnerable than older women.
- ❧ Gender inequalities, differential access to services, and sexual violence also increase women's vulnerability to HIV.
- ❧ In Africa, there is a well-documented pattern of the virus being passed from older men to younger women.
  - ❧ "Sugar daddies"
  - ❧ Coerced sex
  - ❧ Polygamy
  - ❧ Domestic workers
  - ❧ Young women's social disempowerment

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# HIV and Key Populations

- ⓧ HIV prevalence among sex workers has declined modestly since 2011 in a number of regions, including sub-Saharan Africa.
- ⓧ Similarly, HIV prevalence among IDUs also appears to be on the decline in almost all regions.
- ⓧ The same progress is not apparent with respect to gay men and other men who have sex with men.

# Drivers of the HIV Epidemic

The continuing spread of HIV is being driven by:

- ⦿ Undiagnosed HIV infection: over 14 million infected people do not know they are infected.
- ⦿ Too few on treatment: half of all PLWH are not on treatment, and many who start default.
- ⦿ Stigma and Discrimination: including policies that discriminate vs key populations and erect barriers to accessing health services.
- ⦿ Multiple concurrent sexual partnerships.
- ⦿ Low condom use especially in the context of high-risk behaviors.

# Global Strategies - Timeline

- ⦿ 1981 - AIDS first described.
- ⦿ 1987 - WHO Global Programme on AIDS created.
- ⦿ 1996 - United Nations created UNAIDS to be its coordinating body and galvanize worldwide attention to AIDS.
- ⦿ 2000 - (UN) all nations agreed to MDGs, including MDG #6 to combat HIV/AIDS, Malaria, and other diseases:
  - ⦿ 6A - to halt & begin reversing the spread of HIV by 2015
  - ⦿ 6B - to achieve by 2010 universal access to ART “for all those who need it.”
- ⦿ 2001 - creation of the Global Fund for AIDS, TB and Malaria at the UN General Assembly Special Session on HIV/AIDS.

# Global Strategies - Timeline

- ⦿ 2003 - US President George W. Bush established PEPFAR.
- ⦿ Dec. 1, 2014 (World AIDS Day) - UNAIDS announced targets for 2020 aimed at ending the epidemic by 2030.
  - ⦿ Targets include the “90-90-90” strategy:
    - ⦿ 90% of PLWH have been tested and know their status,
    - ⦿ 90% of those who know their status are on ART,
    - ⦿ 90% of those on ART have suppressed viral loads.
- ⦿ 2015 - the new SDGs include a target to end the AIDS epidemic by 2030.
- ⦿ June 2016 - UN Political Declaration signed at General Assembly High-Level Meeting on Ending AIDS that called for intensification of efforts to end AIDS by 2030.

# Global Strategies - “Getting to Zero”

In 2010, UNAIDS unveiled its 2011-2015 strategy, called “Getting to Zero”, which called for:

- 🚫 Zero new infections
- 🚫 Zero AIDS-related deaths
- 🚫 Zero discrimination

# Global Strategies - “Getting to Zero”

To advance towards this vision, the strategy established 10 concrete goals:

## Zero new infections:

1. Cut sexual transmission of HIV by half, including among young people, MSM, and sex workers and their clients.
2. Eliminate vertical transmission of HIV (MTCT) and reduce in half AIDS-related maternal mortality.
3. Prevent any new HIV infections among people who use drugs.

# Global Strategies - “Getting to Zero”

## Zero AIDS-related deaths:

4. Enable universal access to ART for PLWH who are eligible for treatment.
5. Cut TB deaths among people living with HIV by half.
6. Include PLWH and households affected by HIV in all national social protection strategies and ensure they have access to essential care and support.

# Global Strategies - “Getting to Zero”

## Zero Discrimination:

7. Reduce by half the number of countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses.
8. Cut by half the number of countries having HIV-related restrictions on entry, stay and residence.
9. At least half of all national HIV responses address the HIV-specific needs of women and girls.
10. Promote zero tolerance for gender-based violence.

# Global Strategies - “Getting to Zero”

Key concepts in this strategy:

- ⦿ Enhanced viral suppression
  - ⦿ = healthier PLWH = less mortality
  - ⦿ = less HIV transmission = fewer infections
- ⦿ Expanded utilization of prevention methods
  - ⦿ = fewer people getting infected.
- ⦿ Reduced stigma and discrimination
  - ⦿ = more PLWH able and willing to access prevention and treatment services = fewer infections, less mortality.

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# Global Strategies

## HIV Prevention Methods

- ⦿ Behavior change programs including:
    - ⦿ Delay of sexual debut among youth
    - ⦿ Reduction in concurrent sexual partnerships
    - ⦿ Condom use (consistent and correct)
  - ⦿ Voluntary Counselling and Testing (VCT)
  - ⦿ PMTCT as part of routine ANC
  - ⦿ Access to effective contraception
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# Global Strategies

## HIV Prevention Methods (cont'd.)

- ⦿ PEP and PrEP
  - ⦿ Safe male medical circumcision
  - ⦿ Female Initiated HIV Prevention Methods
  - ⦿ Early diagnosis and treatment of STIs
  - ⦿ Harm reduction programs for injection drug users
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# Global Strategies - UNAIDS “90-90-90”

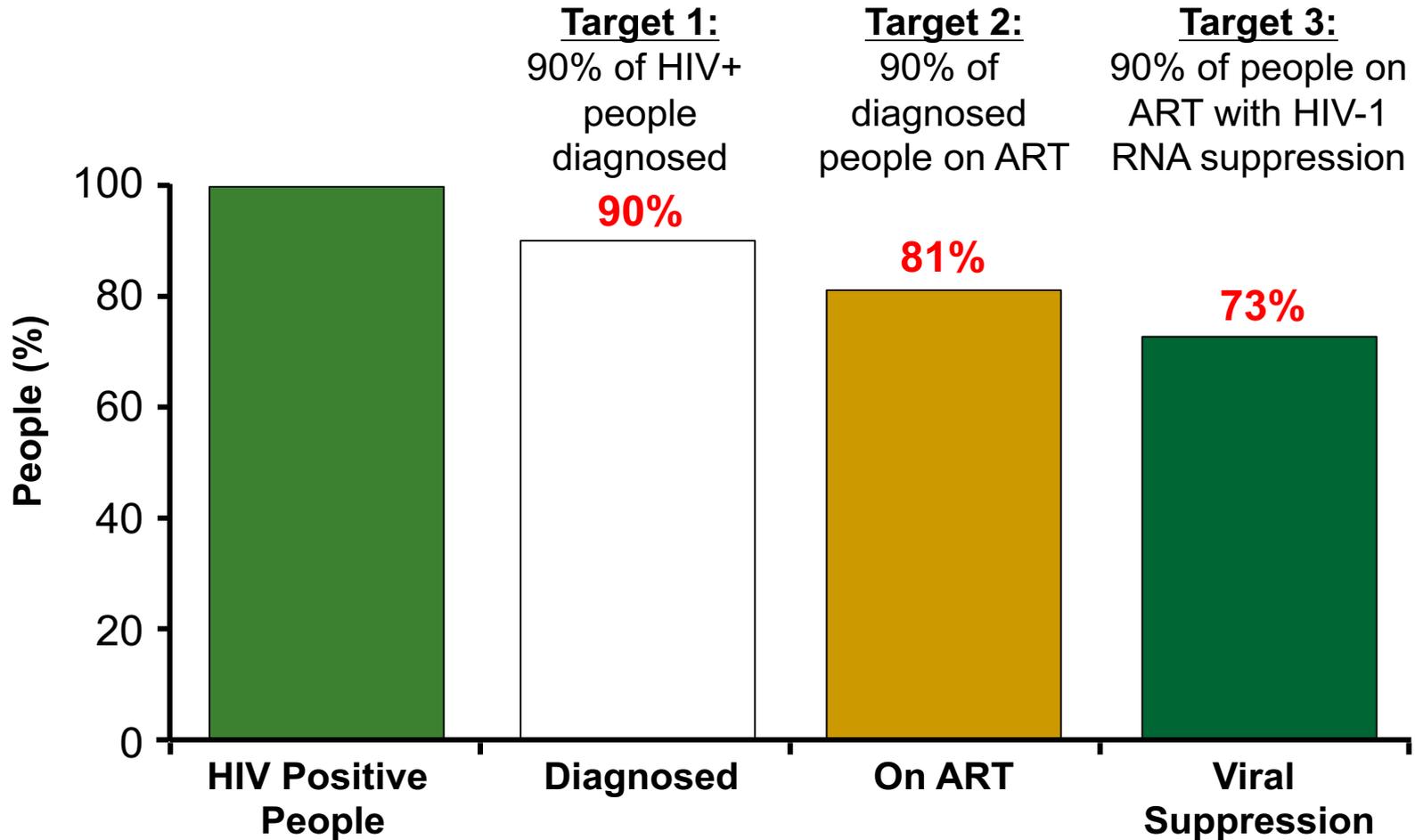
This is a viral suppression strategy, without which we will not see the end of AIDS by 2030:

- Ⓡ By 2020, 90% of all people living with HIV will know their status.
- Ⓡ By 2020, 90% of all people diagnosed with HIV will receive sustained ART.
- Ⓡ By 2020, 90% of all people receiving ART will have viral suppression.

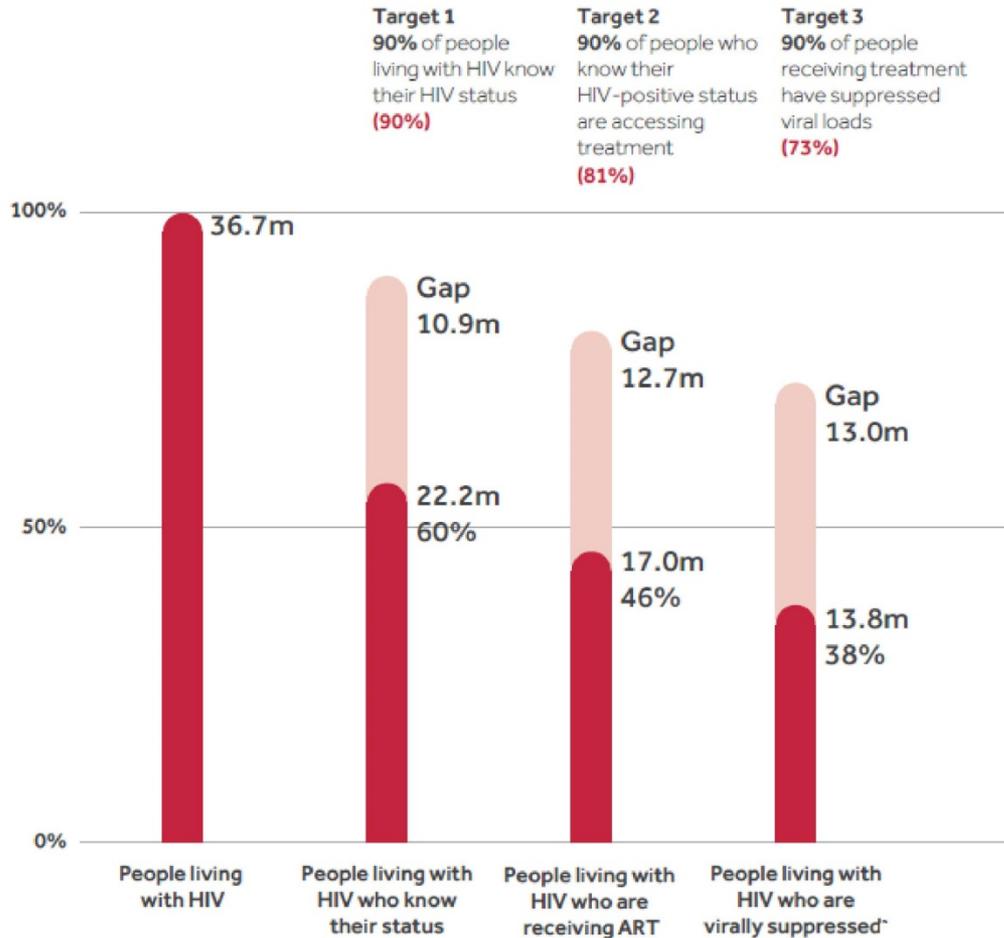
When this is achieved, at least 73% of all people living with HIV worldwide will be virally suppressed.

Modelling suggests that achieving these targets by 2020 will enable the world to end the AIDS epidemic by 2030.

# 90-90-90 Treatment Targets by 2020



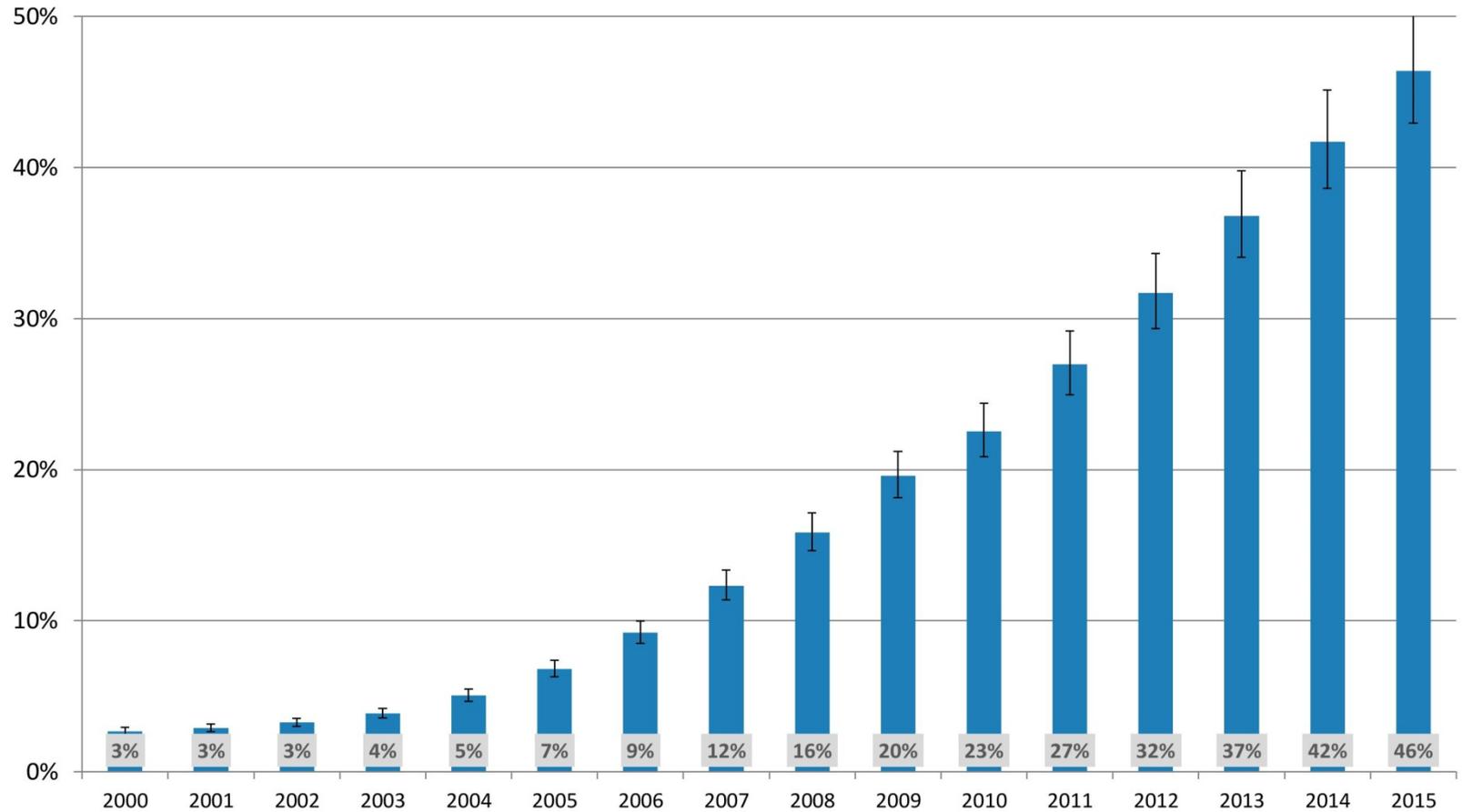
# Improvements are needed at each stage of the cascade of HIV testing and treatment services, 2015



Source: UNAIDS/WHO estimates.



## ART coverage over time



Source: UNAIDS/WHO estimates.

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# Global Strategies - “On the Fast Track”

In 2015, UNAIDS unveiled its 2016-2021 strategy, called “On the Fast Track to End AIDS”, which includes, among other things:

- 🚫 The 90-90-90 strategy
- 🚫 A reduction in new infections by 75%
- 🚫 Achieving zero discrimination

In particular, the AIDS response will need to accelerate progress in geographical settings and among populations where progress has not been shared equitably.

The key is to do the right things at the right place, for the right people and in the right way.

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# Global Strategies - “On the Fast Track”

“Evidence demonstrates that if the current, unprecedented level of HIV service coverage is simply maintained, progress will slip backwards, with rising numbers of people newly infected and more people dying from AIDS-related causes... By seizing this moment, we can end the AIDS epidemic as a public health threat by 2030. The next five years provide a fragile window of opportunity to Fast-Track the AIDS response and empower people to lead dignified and rewarding lives.”

(UNAIDS, 2015, “On the Fast Track to End AIDS”, from the Executive Summary)

# Global Strategies - “On the Fast Track”

## Targets for 2020:

- Ⓡ 90-90-90 targets are achieved.
- Ⓡ Zero new pediatric HIV infections, and mothers are alive and well.
- Ⓡ 90% of young people are empowered with the skills, knowledge and capability to protect themselves from HIV.
- Ⓡ 75% of people living with, at risk of and affected by HIV, who are in need, benefit from HIV-sensitive social protection.

# Global Strategies - “On the Fast Track”

## Targets for 2020:

- ❧ 90% of adults, young people and those in high-prevalence settings, have access to HIV combination prevention and sexual and reproductive health services.
- ❧ 27 million additional men in high-prevalence settings are voluntarily medically circumcised, as part of integrated sexual and reproductive health services for men.

# Global Strategies - “On the Fast Track”

## Targets for 2020:

- 🚫 90% of key populations have access to HIV combination prevention services.
- 🚫 90% of women and girls live free from gender inequality and gender-based violence to mitigate the risk and impact of HIV.
- 🚫 90% of people living with, at risk of and affected by HIV report no discrimination, especially in health, education and workplace setting.

# Global Strategies - “On the Fast Track”

## Targets for 2020 vs 2030:

### Targets for 2020:

- 🎗️ 90-90-90
- 🎗️  $\leq 500,000$  new HIV infections
- 🎗️ Zero discrimination

### Targets for 2030:

- 🎗️ 95-95-95
- 🎗️  $\leq 200,000$  new HIV infections
- 🎗️ Zero discrimination

# Global Strategies - “On the Fast Track”

## Eliminating Stigma and Discrimination:

- Ⓡ Stigma and discrimination may be declining as the HIV epidemic matures and more PLWH live healthy lives thanks to ART.
- Ⓡ A majority of countries with available data show a decline in discriminatory attitudes.
- Ⓡ In particular, there is an association between an increase in ART coverage and a reduction in discriminatory attitudes.

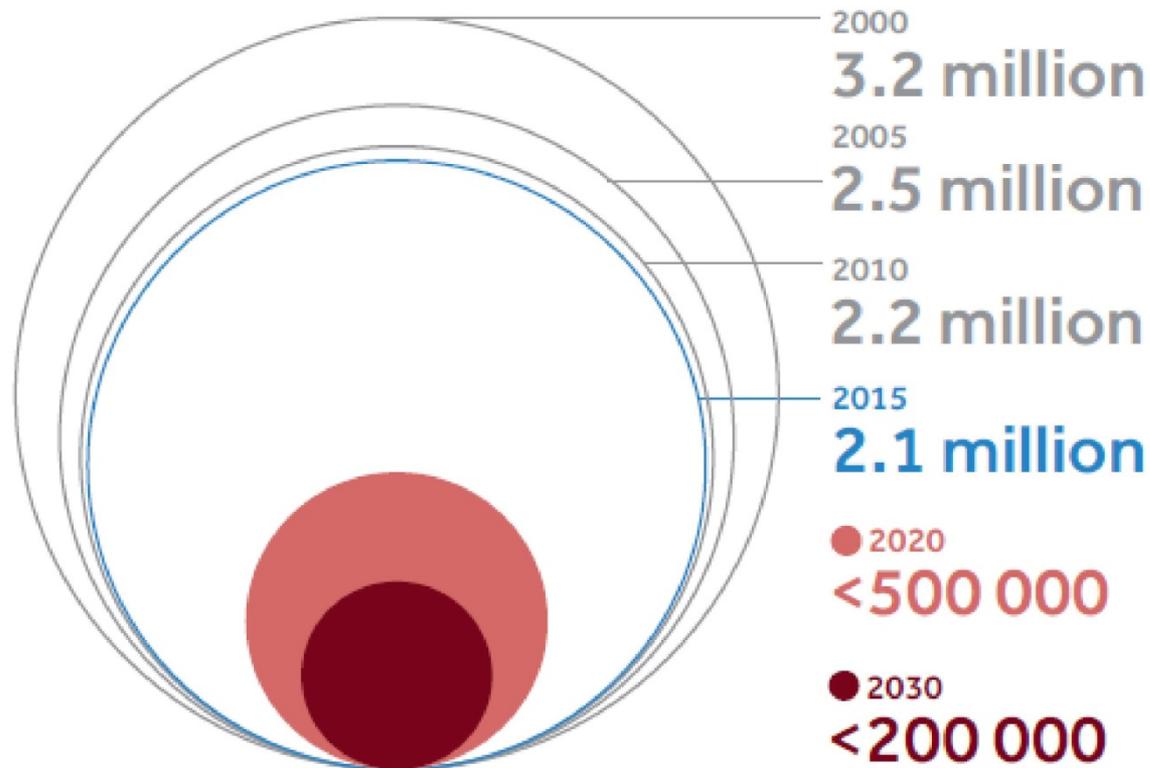
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# Global Strategies - “On the Fast Track”

## Eliminating Gender Inequalities:

- 🚫 The world remains far short of achieving its goal of eliminating gender inequalities and gender-based violence and abuse.
- 🚫 In nine of 16 countries with high HIV prevalence and available data, more than one in three adolescent girls reported having experienced intimate partner violence in the past 12 months.

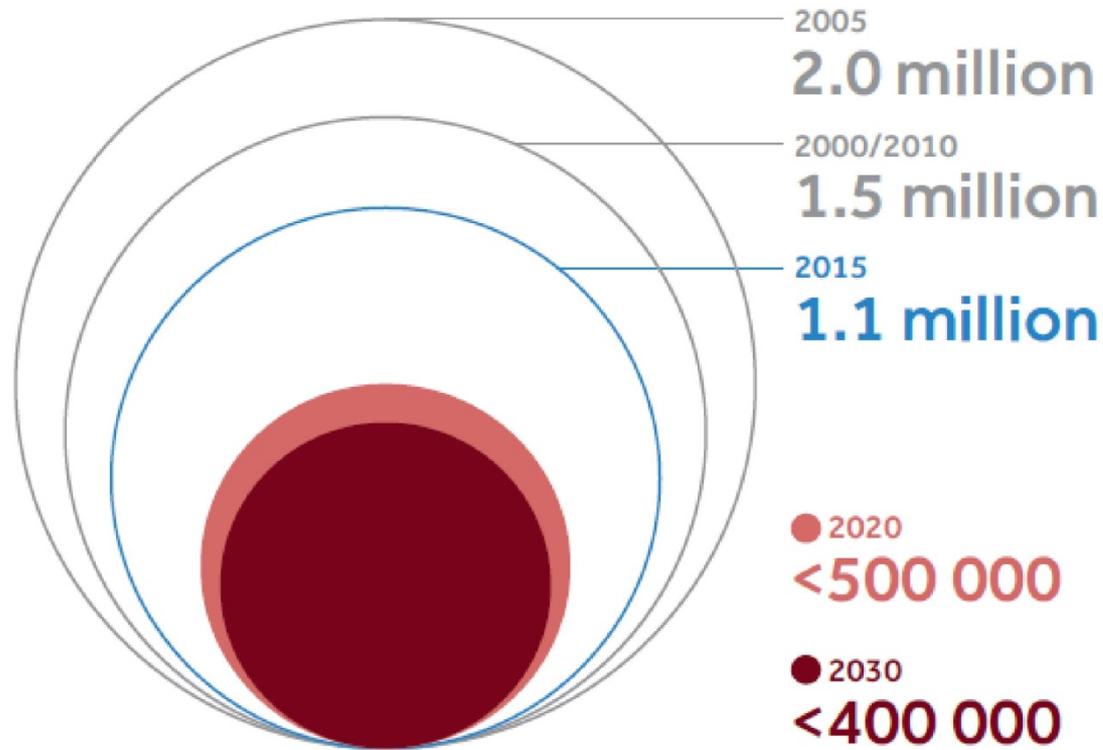
# Number of people newly infected with HIV



Source: UNAIDS/WHO estimates.  
The red shading shows future targets.

# Number of people dying from HIV

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Source: UNAIDS/WHO estimates.  
The red shading shows future targets.

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# The Role of Faith

Why should communities of faith be involved?

- ✚ Because God cares. What touches God's heart should touch the hearts of those who claim to serve Him.
  - ✚ Because core principles of faith speak directly to many of the heart issues that drive the epidemic in a way that secular philosophies cannot.
  - ✚ Because the world now recognizes its need for faith involvement and is reaching out to the faith community for help.
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# The Role of Faith - What does the World Say?

A voice from the global community:

- 🚫 “As the AIDS epidemic has progressed through history, the importance of the faith response has become increasingly apparent.... A strong faith response is critical to achieving the Fast-Track Targets by 2020 and to ending AIDS by 2030.”  
(Luiz Loures, Deputy Executive Director of UNAIDS)

# The Role of Faith - What does the World Say?

A voice from the donor community:

- ✚ “The success of PEPFAR to date has been achieved in large part because of the contributions of faith-based organizations to country efforts on HIV/AIDS, across the entire spectrum of prevention, treatment, and care.”  
(A Firm Foundation, PEPFAR, 2012)
- ✚ “We know that faith communities are key in overcoming HIV ... Religious leaders have powerful voices in mobilizing people to take up testing, treatment and care, and we simply cannot do this without them.”  
(Katherine Perry, Kenya coordinator at PEPFAR)

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# The Role of Faith - What does the World Say?

A voice from the NGO community:

🚫 “In FHI’s experience, partnerships with faith-based organizations have been particularly effective in providing care and treatment, promoting prevention awareness, mobilizing and equipping volunteers, and creating networks and infrastructure.” (William Sachs, FHI 360)

A voice from the voiceless community:

🚫 “ ..... ” (Who will speak for them?)

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# The Role of Faith - Why Faith Involvement?

The faith sector exists from the most localized congregation in the village setting to the largest global faith-based institution. It has the capacity to engage with a single individual or with governments and international organizations.

Here, the term “Faith-Based Organizations” (FBOs) will be used to mean entities found anywhere within the entire scope of the faith sector.

FBOs offer the world a large number of unique advantages and capabilities in the global fight to end the public health threat of HIV and AIDS by 2030:

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# Advantages and Capabilities of FBOs

Motivation: Most faith traditions promote compassion and concern for the sick, the poor, the suffering and disadvantaged.

- ✚ Track records spanning millenia of caring for the sick and dying, the poor and oppressed, the widow and orphan.
- ✚ Moral motivation and shared values among faith groups underpin engagement in development (social justice, human value and dignity, loving one's neighbor, etc.)
- ✚ Advocacy: religious institutions champion the poor, the marginalized, the disenfranchised.
- ✚ Systemic issues that are rightly the domain religious faith include: violence, gender inequality, poverty, human rights, and social justice.

# Advantages and Capabilities of FBOs

## Empowering Structures:

- ✚ They have the widest network coverage globally, the largest constituency of people and an enviable infrastructure, extending from the international community to the most marginalized.
- ✚ They are responsive and committed, often responding quickly to difficult situations and accepting challenges other institutions ignore or quickly abandon.
- ✚ By connecting national networks with grassroots programs, FBOs can respond quickly to pressing needs.

# Advantages and Capabilities of FBOs

## Ongoing, Active Engagement:

- ✚ They already have well-established health service delivery networks and infrastructure.
- ✚ They already play a central role in caring for OVCs, providing PMTCT and other preventive services, and providing treatment and care for PLWHs.
- ✚ They are already engaged in the most remote, rural areas and in the poorest neighborhoods of the world.

## Integrity:

- ✚ They have a record of fiscal responsibility and a divine mandate to be good stewards of the resources allotted them.

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# Advantages and Capabilities of FBOs

## Unmatched “reach” and community access:

- ✚ The faith-based sector is present literally everywhere people live their lives, with enormous outreach as well as “in-reach”.
- ✚ 84% of the world’s population considers itself as religiously affiliated.
- ✚ FBOs are an integral part of life in most societies throughout the world. Their involvement at some of the most significant moments in life (birth, sickness, marriage, death) give them an unparalleled advantage over other sectors in the field of HIV.
- ✚ Faith groups have been called “the doorway into society.”

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# Advantages and Capabilities of FBOs

## Manpower:

- ✚ Highly committed network of staff and volunteers, able to reach even the most remote areas.

## Influence and respect:

- ✚ FBOs have respected and trusted status in local communities.
- ✚ They wield moral authority.
- ✚ They can influence communities, societies and nations.
- ✚ Most government, civil and community leaders are themselves members of faith communities.

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# Advantages and Capabilities of FBOs

## Knowledge of local culture, customs and perspectives:

- ✚ Their integrated role in communities gives them cultural roots in the lives of the people.
- ✚ They can make health information understandable and relevant in a way consistent with community values.

## Holism:

- ✚ They meld together the physical, mental, spiritual and social aspects of human experience as they care for individuals, families and communities impacted by HIV.

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# Advantages and Capabilities of FBOs

## Commitment and Perseverance:

- ✚ They are vision-driven and relationship-oriented.
- ✚ They are usually on the ground responding to need before outside funding arrives and continuing the work long after funding dries up.
- ✚ They remain committed to their communities even in the face of instability, violence, threats, political opposition, outbreaks of disease, etc.

## Ingenuity and Adaptability:

- ✚ They develop innovative ways and means to reach all parts of their communities, and rapidly adapt as needed to changes in their environment while remaining true to their values.

# Advantages and Capabilities of FBOs

## Leadership:

- ✚ The words and examples of faith leaders set the pattern for their communities.
- ✚ They have an essential role to play in transforming social norms, values and practices; and in mobilizing community responses and services.
- ✚ Because faith leaders are trusted, respected and listened to, they can:
  - ✚ Lead the effort to eradicate stigma and discrimination.
  - ✚ Respond to suffering with compassion, to exclusion by inclusion, and to rejection by acceptance.
  - ✚ In so doing they will open the way to reconciliation, hope, understanding, healing, prevention and care.

# Advantages and Capabilities of FBOs

## Faith Leaders Can: (cont'd.)

- Ⓡ Motivate people to reduce their risk behaviors; to know their HIV status; to access and remain engaged in treatment and care; and to live healthy lifestyles.
- Ⓡ Promote responsible behavior that respects the dignity of all persons and defends the sanctity of life.
- Ⓡ Shape social values and inform public knowledge opinion.
- Ⓡ Advocate for enlightened attitudes, policies and laws.
- Ⓡ Promote action from the grass roots up to the national level.
- Ⓡ Influence and encourage each other as well as their congregations to develop “HIV and AIDS competency”.

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# What the Faith Sector Can Do

*“Science and treatment on its own are not enough. We cannot just treat our way out of this epidemic. We need to address the social determinants that are driving the stigma and discrimination to prevent people from getting tested and staying on treatment. We know that the faith communities are central.”*  
(Sally Smith, Senior Advisor for Faith-Based Organizations, UNAIDS)

*“It’s not just medicines and what happens in clinical wards and health centers that will solve this crisis. At the end it’s about how we approach people, about ethics, about what brings us together to work for better societies, societies that our children will be proud to live in.”*  
(Luiz Loures, Deputy Executive Director, UNAIDS)

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# What the Faith Sector Can Do

## Stigma and Discrimination

Why is the issue of stigma and discrimination so important?

- Ⓡ Fear of stigma keeps many people from getting tested and treated.
- Ⓡ The effects of stigma actually cause the disease to spread faster.
- Ⓡ The devastating effects of the stigma on PLWH include societal rejection, loss of livelihood, even suicide.

What actions can the faith community take?

- Ⓡ Educate members about HIV and AIDS, dispelling myths and correcting misinformation.
- Ⓡ Challenge cultural and/or religious influences that may consciously or unconsciously fuel stigma and discrimination.

# What the Faith Sector Can Do

## Stigma and Discrimination (cont'd.)

What actions can the faith community take?

- ✚ Distinguish between the moral and medical aspects of HIV. (Regardless of how the infection was acquired, a person living with HIV has a serious medical condition and needs assistance with the day to day practicalities of living with HIV.)
- ✚ Emphasize compassion and acceptance of people living with HIV.
- ✚ Accept and embrace the participation of PLWH in their congregations, on their committees, and in their programs.
- ✚ Present personal testimonies by PLWH. Personal stories are powerful because they put a human face on the disease.
- ✚ Encourage HIV testing for all members. If all members are tested, then the stigma associated with testing will be significantly reduced. The faith leaders should be the first to be tested.

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# What the Faith Sector Can Do

## Prevention

Aside from increasing access to preventive methodologies, the faith sector is also well placed to:

- 🎗️ Encourage behaviors that reduce or avoid the risk of HIV.
- 🎗️ Promote taking personal responsibility for sexual behavior, including support for traditional values of virginity and faithfulness and protection for the weak and powerless.
- 🎗️ Encourage and support loving, just and honest relationships.
- 🎗️ Promote strong family values and build strong marriages.

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# What the Faith Sector Can Do

## Prevention (cont'd.)

- ⦿ Replace stigma and discrimination with acceptance, love, and commitment.
- ⦿ Advocate for economic and social justice and promote human rights in order to reduce the drivers of HIV transmission.
- ⦿ Establish economic empowerment and skills-building programs for vulnerable populations.
- ⦿ Provide drop-in centers and alternative recreation/entertainment options for adolescents.
- ⦿ Provide safe lodging for long-distance truck drivers.

# What the Faith Sector Can Do

## Pastoral care

- ⦿ Replace stigma and discrimination with acceptance, love, and commitment.
- ⦿ Equip clergy and laity to support all people, especially PLWH, in life-sustaining relationships with their God and their community.
- ⦿ Preach messages and homilies and develop liturgies that:
  - ⦿ help members to identify with those who are poor, sick, suffering, disempowered, stigmatized and marginalized.
  - ⦿ reduce stigma.
  - ⦿ increase AIDS-awareness, dispel myths and increase knowledge and understanding.
  - ⦿ promote life-affirming values and practices, justice, human rights, and dignity.

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# What the Faith Sector Can Do

## Community care and engagement

- ✚ Establish support groups and care programs for PLWH and widows/widowers.
- ✚ Provide youth-friendly services including after-school programs, counseling and SRH services.
- ✚ Support for orphans and vulnerable children.
- ✚ Care for the sick, dying and bereaved, including home-based care and palliative care services.
  - ✚ Train the clergy to counsel and protect the rights of those who survive, especially women and children.
- ✚ Mobilize and equip volunteers
  - ✚ Encourage an enhanced sense of community.
  - ✚ Link learning with caregiving. Enhance local initiative to learn and function collectively.

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# What the Faith Sector Can Do

## Leadership and Advocacy

- ⦿ Model bold and compassionate community and institutional leadership at every level of society.
- ⦿ Strengthen social values.
- ⦿ Encourage involvement by the laity, women and PLWH in AIDS-related programs.
- ⦿ Build networks and collaborative relationships with other faith-based, private, secular and governmental organizations.
- ⦿ Address power, culture, poverty, violence, gender roles, stigma and discrimination.
- ⦿ Be a voice for the voiceless, marginalized and disempowered; defend human rights.

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# What the Faith Sector Can Do

## Leadership and Advocacy (cont'd.)

- ⚡ Advocate for policies and laws that are just and non-discriminatory. Challenge the failure to enforce laws that protect the rights of women and children.
- ⚡ Support dialogue and understanding between faith leaders and key populations, including youth and adolescents.
- ⚡ Create “safe spaces” for sharing experiences across generations.
- ⚡ Challenge cultural traditions and practices that are antithetical to faith teachings and harmful to health; and propose alternative rites, rituals and practices in their place that will affirm what is right, good and healthy.

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# What the Faith Sector Can Do

## Turn Challenges into Strengths

How do you collaborate with others whose values, methods, theology, worldview, or practices may be significantly different than your own? (I.e., condoms...)

1. Differences can be seen as leading to complementary, not conflicting, approaches.
  - ⚡ The central intention, not the methodology, should be the central focus: i.e., to prevent the spread of disease in ways that are both effective and congruent with the convictions of a particular faith tradition.
  - ⚡ Religious norms may be allowed to contour various ways in which effective forms of prevention and treatment are pursued.
  - ⚡ A broader diversity of approaches creates an enriched environment in which more diverse options may benefit a more diverse array of beneficiaries.

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# What the Faith Sector Can Do

## Turn Challenges into Strengths (cont'd.)

2. Constructive engagement while managing differences and showing mutual respect in the pursuit of common goals sets a positive example for the rest of the world to follow.
  3. As FBOs learn to overcome differences with collaborating partners yet without sacrificing their beliefs, consciences or convictions, they become wiser and more greatly empowered to achieve even more significant things. In this way, they turn “stumbling blocks into stepping stones.”
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# What the Faith Sector Can Do

## Turn Challenges into Strengths

How do you affirm core religious values while simultaneously respecting those who reject those values or who live antithetical lifestyles?

- ⚡ This conflict easily leads to judgmental attitudes and stigma directed against the members of certain “key populations”.
  - ⚡ Judgment and condemnation creates a significant barrier separating faith communities from those who are at greatest risk or who are most affected.
  - ⚡ This challenge remains an uphill battle. Nevertheless, where faith communities have been able to bridge this divide, the results have been powerful and transformative.
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# What the Faith Sector Can Do

## Conclusion

The world is recognizing that without the involvement of the faith sector, it will not be able to achieve its goal of eliminating AIDS as a public health threat by 2030.

The faith sector has many strengths and advantages to bring to the global effort.

Now the question is, how will people of faith respond “in such a time as this”?

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*“If you want to go quickly,  
travel alone.*

*If you want to go far, travel  
together.”*



(African proverb)

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# S.A.V.E.

In 2003, INERELA+ introduced the “S.A.V.E.” approach to HIV prevention as a more comprehensive alternative to the narrower “ABC” approach.

- 🚫 The SAVE approach does not shy away from discussing ABC, it simply starts from a different place and hopes to help faith leaders realize that “HIV is a virus, not a moral issue.”

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# S.A.V.E.

Many FBOs, NGOs, communities, religious leaders and other HIV responders have embraced the SAVE approach for several reasons:

- 🚫 The SAVE message originates from a faith-based source, allowing faith based organizations and faith leaders to assume a level of compatibility with their faith and therefore giving confidence to those who use it.
- 🚫 SAVE expands the presentation of information about HIV to include treatment, testing and empowerment in addition to prevention messages.
- 🚫 Growing experience has shown that it contributes significantly to increasing understanding about HIV and AIDS, and has helped reduce HIV related stigma, including that propagated by faith leaders themselves.

# S.A.V.E.

The **SAVE** acronym stands for:

- 🚫 Safer practices,
- 🚫 Access to quality treatment
- 🚫 Voluntary counselling and testing, and
- 🚫 Empowerment.

# S.A.V.E.

## S - Safer practices

This covers all the different *modes* of HIV transmission including:

- 🚫 Use of condoms,
- 🚫 Being faithful to one partner,
- 🚫 Practicing sexual abstinence;
- 🚫 Use of sterile injecting equipment
- 🚫 Ensuring that all blood transfusions are tested for HIV;
- 🚫 Prevention of vertical transmission (PMTCT);
- 🚫 Safer circumcision;
- 🚫 Pre- and Post- Exposure Prophylaxis (PrEP & PEP);
- 🚫 Use of standard hygiene precautions, such as gloves and clean needles for all patients; and
- 🚫 Adherence to treatment.

# S.A.V.E.

## **A - Access to quality treatment**

This includes not only ART, but also:

- 🚫 Treatment for HIV related infections
- 🚫 Provision of good nutrition (particularly to help adherence to ART)
- 🚫 Access to clean water
- 🚫 Quality of services including provision of viral load monitoring, and
- 🚫 Retention to care through psychosocial support.

# S.A.V.E.

## V - Voluntary Counseling and Testing

Testing for HIV should be regular, noncompulsory, and confidential.

- 🚫 If you know you are positive, you can protect yourself and others, and take steps to live a healthy, productive and positive life.
- 🚫 Emphasis is placed on regular retesting especially for higher risk populations including discordant couples, those engaged in sex work and others having multiple concurrent partnerships, and pregnant women.

# S.A.V.E.

## **E - Empowerment** (through education and advocacy)

This is needed to overcome the Stigma, Shame, Denial, Discrimination, Inaction and Mis-action (SSDDIM) associated with HIV:

- ⚡ SSDDIM is a significant challenge to people's uptake of services associated with HIV, and to the ability of PLWH to live productive and healthy lives within their communities and countries.
- ⚡ People need accurate information about HIV to make informed decisions and to protect themselves, their partners and children from HIV.
- ⚡ When PLWH are empowered, they are better able to overcome the stigma and discrimination that could otherwise make their lives so difficult.

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# HIV and AIDS Competent Faith Communities

HIV competent faith communities actively engage in a comprehensive response towards HIV and AIDS.

- ✚ Competency is about *understanding* and *internalizing* the urgency of the situation, and then *responding* to it as comprehensively as possible.
- ✚ At the heart of AIDS competency lies the commitment towards upholding the nearly universal religious principle to show love and compassion for our neighbour in the humility of knowing that we all belong to the frail human family.

# HIV and AIDS Competent Faith Communities

HIV competent communities of faith:

- ⦿ First develop an *inner competence* through:
  - ⦿ internalization of the risks, impacts and consequences and
  - ⦿ accepting the responsibility and imperative to respond appropriately and compassionately.
- ⦿ In order to progress to outer competence, there is need for:
  - ⦿ Leadership,
  - ⦿ Knowledge, and
  - ⦿ Resources.

# HIV and AIDS Competent Faith Communities

## HIV competent communities of faith:

⦿ *Outer competence* involves building theological and institutional capacity in a way that is:

⦿ socially relevant

⦿ inclusive

⦿ sustainable and

⦿ collaborative

Such that:

⦿ the spread of HIV is reduced,

⦿ the lives of the infected and affected are improved,

⦿ the impact of HIV is mitigated, and ultimately

⦿ hope and dignity are restored.

# HIV and AIDS Competent Faith Communities

The core components needed to become HIV competent are:

- ⦿ Attitude changes and elimination of HIV-related stigma and discrimination.
- ⦿ Courageous leadership to acknowledge difficult and unpopular topics.
- ⦿ Theological reflection on the clerical and spiritual demands of HIV and what should be the compassionate faith response.
- ⦿ Strategic planning that is relevant, long-term and backed up with substantial commitment.
- ⦿ Open dialogue on taboo subjects such as human sexuality and sexual matters, particularly those facilitating the transmission of HIV, as well as intravenous drug use.

# HIV and AIDS Competent Faith Communities

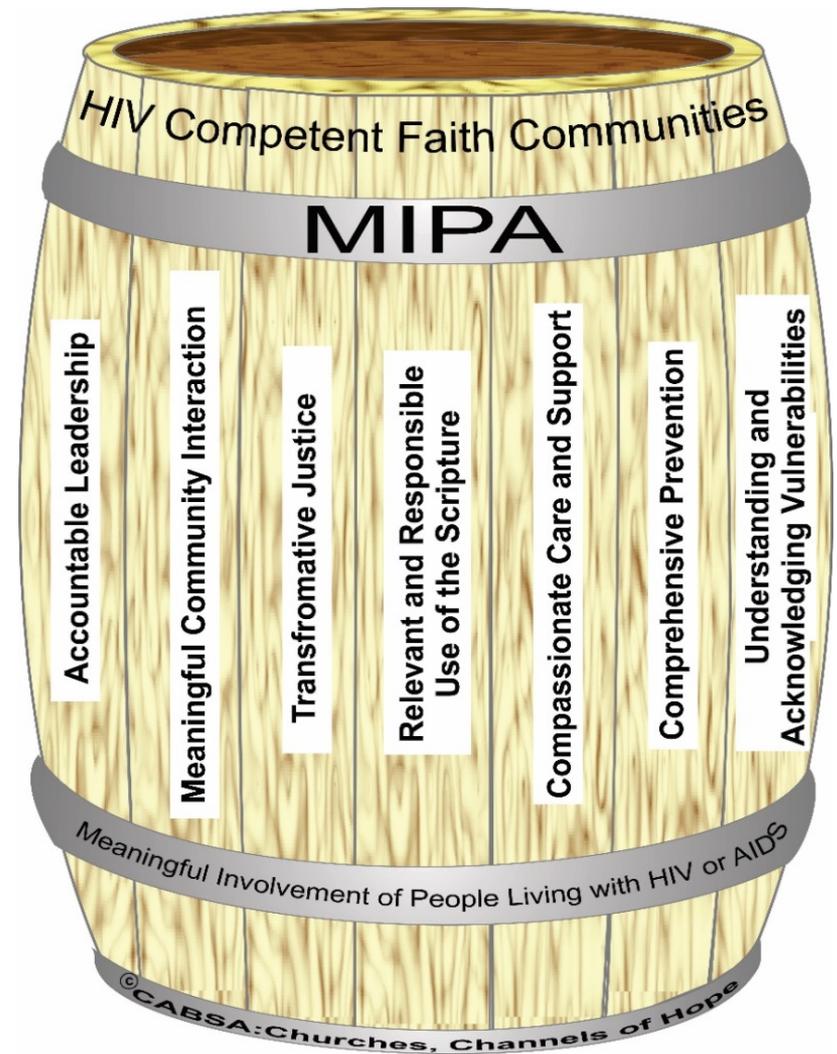
## Core components (cont'd.):

- ⦿ Exposure of accepted practices and traditions that increase vulnerability, particularly those surrounding gender.
- ⦿ Advocacy for human rights and against injustices and inequalities at the local, social, political and international level.
- ⦿ Recognition of the evolving course of the epidemic, and capacity to adjust responses appropriately.
- ⦿ Capacity to predict and respond proactively to the social impact of HIV.
- ⦿ Willingness to accompany those in need – whatever the impact on popularity or financial cost.

# The HIV and AIDS Competency Barrel

CABSA has developed the concept of the “competency barrel”. The barrel has 7 key areas of competency:

- Accountable Leadership
- Meaningful Community Interaction
- Transformative Justice
- Relevant and Responsible use of the Scriptures
- Compassionate Care and Support
- Comprehensive Prevention
- Understanding and Acknowledging our Vulnerabilities



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