Towards HIV & AIDS Competent Churches – Realizing Universal Access Goals

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Outline of Presentation

- Introduction
- Role of FBOs in Scaling Up Towards ‘Universal Access’
- What is ‘Church HIV & AIDS Competence’?
- Select Examples of Strategies by FBOs
- Case Study: HIV Prevention Summit 2008
- Towards Strengthening ‘S-S’ Collaboration
- Some Summary Statements
- Conclusion
• Introduction
Source: UNAIDS 2008
Millennium Development Goals

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, TB, malaria and other diseases
7. Ensure environmental sustainability
8. Develop a Global Partnership for Development
2005 G8 Summit at Gleneagles, Final Communiqué: “…working with WHO, UNAIDS and other international bodies to develop and implement a package of HIV prevention, treatment and care, with the aim of as close as possible to universal access to treatment for all those who need it by 2010.”
• Role of FBOs in Scaling Up towards ‘Universal Access’
Main Goal

- ‘Universal Access’ to services by 2010:
  - Prevention of HIV
  - Care and support for “all”
  - Treatment (ART; ‘Opportunistic Infections’)

- Lessons Learned: WHO ‘3 x 5’ Goal?
Prevention of HIV (1)

Existing Prevention Methods:
• Behaviour change programmes
• Counselling and Testing (CT)
• Condoms
• Male circumcision
• Female Initiated HIV Prevention Methods
• Treatment of other Sexually Transmitted Infections (STIs)

(Executive Summary Report, Global HIV Prevention Working Group, on “New Approaches to HIV Prevention: Accelerating research and ensuring future access” August 2006)
Prevention of HIV (2)

- We know that HIV **prevention** is closely associated with the availability of **treatment, care and support**.

- These two agendas: The ‘**prevention agenda**’ and the ‘**care-and-treatment agenda**’ are inextricably linked!

- However, Prevention to HIV infection is key!

- Why ‘**Prevention**’?
  - “For every two people who start on treatment, five are becoming infected with HIV” (UNAIDS Global Report 2008)
  - We cannot treat ourselves out of the epidemic!
Holistic

“Stove-piped” or vertical interventions

- Often provide intensive funding for important needs, e.g. ARVs, malaria
- May leave basic, general health needs unfunded
- 2006 President Clinton hoped HIV/AIDS programs would help all other health initiatives
- Between 2002-2006, successfully provided ARVs to 5,000 needy Haitians — HIV prevalence dropped from 6 to 3%
- But during same period “Haiti...went backward on every other health indicator.” ("The Challenge of Global Health", Laurie Garrett)
HIV & AIDS: Pointers to the Integral Nature of Human Brokenness

- Physically - Ravages of disease, vulnerability
- Relationally - Alienation from family, friends, neighbors
- Emotionally - Shame / stigma (two-edged sword)
- Economically - Can’t work (individuals, nations)
- Spiritually - Those engaging promiscuity, unfaithfulness
  - Those oppressing women, girls, boys
  - Powerless women & girl
- Nutritionally - Can’t eat, can’t afford to feed family
- Educationally - Children can’t go to school
- Environmentally - Limited resources for preservation
- Cyclically/generationally - Children “doomed” for generations
With respect to a ‘Holistic Response’ to HIV and AIDS…
What is ‘Church Competence’?
‘CUAHA Paper’ on HIV & AIDS Competence deals with the following categories:

- Facts on HIV & AIDS
- Sexuality
- Prevention
- Stigma
- Advocacy
- Empowerment
- Leadership
- Healing
- Liturgy & Sacraments
- Counselling
- Testing
- Caring
- Networking

[Source: Hannu Happonnen, ‘Presentation’, Pre-Conference, Mexico City, August 2008]
UNAIDS Strategy for Engaging FBOs

- UNAIDS has developed a strategy for expanding collaboration with FBOs, based on a meeting held in Geneva in April 2008.

- The strategy focuses on three dimensions of FBOs:
  1. Religious leadership,
  2. Faith-based NGOs and development agencies, and
  3. Community level faith groups

10 Areas of Engagement
- GIPA
- Human rights/justice
- Gender
- Children
- Youth
- Marginalized populations
- Prevention
- Treatment
- Care and support
- Stigma and discrimination
Examples of ‘Umbrella Organizations’ and Partners Active in HIV & AIDS Work in Africa

- Pan African Christian AIDS Network (PACANET)
- Churches United Against AIDS in Africa (CUAHA)
- Ecumenical HIV/AIDS Initiative in Africa (EHAIA)
- Council of Anglican Provinces of Africa (CAPA)
- Catholic Medical Mission Board (CMMB)
- Church World Service (CWS)
- African Religious Health Assets Programme (ARHAP)

- Viva Network
- World Relief
- World Concern
- World Vision
- The Salvation Army
- Ecumenical Pharmaceutical Network (EPN)
- Tearfund-UK
- World Conference on Religion and Peace (WCRP)
- Others…?
MAP INTERNATIONAL’S FRAMEWORK FOR BUILDING CAPACITY OF CHURCHES TO RESPOND TO HIV AND AIDS

- Sensitization and Mobilization
- Advocacy
- Capacity building and organizational development
- Scaling up the response
- Church HIV/AIDS policy formulation and strategy development
- Interventions and programmes
Community-based

“Solutions are in the communities” – Dr. Jack Bryant 5/24/08

- Authentically community – based
- Swimming against the current of prevailing paradigm of externally driven interventions
- Our language reflects our struggle: We attempt to “Give power or dignity to communities”
“Community-based” is a belief first:

- a belief that local communities - especially those who have lived in chronic poverty - have the inherent strengths to author their own stories

- to rediscover their capacity to dream

- to learn to evaluate their situation

- to mobilize & organize the resources

- to take constructive steps to improve their world

- to evaluate and continue learning/growing
Dr. Margaret Chan concluded her address to International Federation of Red Cross and Red Crescent Societies – Global Health and Care Forum 2008:

“Primary health care starts with people. Our common humanity compels us to respect people’s universal aspiration for a better life. It compels us to respect the resilience and ingenuity of the human spirit, and the great capacity of individuals and communities to solve their own problems.”
If we believe that communities have the inherent strengths to “author their own stories”, then

Communities don’t need us to:

• “give them dignity”
• “give them power or authority”

They already have it.

• Their Birthright as children of God
• Oppressed, stifled, beaten down – disempowered
• We helped teach them “poverty is their greatest resource”

- Together we can be converted to the belief that:
  - Communities are **partners & resources**, not targets!
Self-empowerment Strategies

MAP’s approach is centered on developing outputs, activities and indicators that help individuals, families and communities develop the “Five I’s” of Self-empowerment:

- **Identity** – Healthy spiritual and psychological aspects of self-worth, self-esteem and self-confidence
- **Ideas** – Ability to envision and dream alternative futures
- **Implementation** – Capacity to act through effective goal-setting, planning and the appropriate knowledge, skills and tools
- **Impact** – Learning through monitoring and evaluation
- **Influence** – Advocating at for just and fair laws, policies, systems and structures
Engage churches as partners in new vision of “...thy will be done on earth as in heaven.”

- Instead of traditional, dualistic view (church deals with spiritual matters, others deal with physical needs), rediscover the gospel of the Kingdom of God.

- You know it is a Christian congregation because:
  - Blind receive their sight
  - Lame walk
  - Oppressed are released from their bondage
  - Poor have good news preached to them
  - Year of the Lord’s favour is proclaimed

[See Luke 4:18-19]
Case Study:
At ‘Kenya HIV Prevention Summit 2008’
The Kenya AIDS Indicator Survey 2007

- Nationally-representative HIV serosurvey
- ~18,000 individuals from nearly 10,000 households
- Includes older adults age 50-64
- Prevalence of HIV, Herpes Simplex Virus-2 and Syphilis
- Coverage of HIV services
- Four Components of KAIS:
  - Household Questionnaire
  - Individual Questionnaire
  - Blood Draw
  - Return of Result
Dramatic disparity in HIV prevalence across provinces

National Prevalence: 7.4%
82% of HIV+ adults do not know they are HIV infected

- 16% Correctly reported HIV positive
- 26% Believed themselves uninfected based on last test
- 56% Never Tested
- 2% Did Not Report Status

15-64 year olds who were KAIS laboratory-confirmed HIV infected, n=1104
...but we are far from the 2010 target of 80% universal CT coverage
Radio is the most common source of HIV information

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Top 5 sources of information, 15-64
• Towards Strengthening ‘South-South’ Collaboration!
Towards Strengthening ‘South-South’ Collaboration!

- Areas to Consider:
  - Historical Similarities
  - Education
  - Trade
  - Tourism
  - Medicine
  - Health, HIV and AIDS
  - Lessons from the ‘Tiger Economies’ of Asia
Summary Statements

- HIV is a clear specific sample of how our response has to be comprehensive in order to alleviate suffering and pain for the person, his/her family, and their communities.

- Isolated interventions on management or prevention are making humanity loose critical time for alleviating this heavy burden and challenge for humanity.

- We all can contribute to the global community fostering comprehensive interventions to alleviate HIV and other illnesses and brokenness in humanity.

- May God keep us faithfully working in the construction of the Kingdom through the ministry of ‘Total Health’!

[Jose Miguel and Luz Stella, Directors, MAP Bolivia Program, June 2008]
Conclusion

- The history of Japan, the Newly Industrialized Countries and lately India and China underscore the fact that …

“Leadership is cause, everything else is effect”!

[Prof. Stephen Adei, in *Leadership and Nation Building* (2006)]
• Thank you!
References

• Carol Ngure, 'Lessons Learned from the KAIS', Presentation at the Kenya HIV Prevention Summit II (NACC, Nairobi, Kenya, September 2008).
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• Professor Stephen Adei, Leadership and Nation Building (Accra, Ghana, 2006)