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

It is universally recognised that religious leaders have a unique authority that plays a central role in providing moral and ethical guidance within their communities; indeed their public opinions can influence entire nations. INERELA+ looks to empower its members to use their positions within their faith communities in a way that breaks silence, challenges stigma and provides delivery of evidenced-based prevention, care, and treatment services.

MISSION STATEMENT

INERELA+ seeks to empower religious leaders through education, knowledge and skills to live positively, becoming symbols of hope and agents of change who will help eliminate stigma and discrimination within their congregations and communities.

Sixty per cent of people living with HIV are located in sub-Saharan Africa, thus ANERELA+ was merged into INERELA+. Based on the realities of the HIV pandemic in the rest of the world, it was decided to create regional networks based on shared elements of history, language, culture and religion.

INERELA+ has 16 active, country networks in the African Region. We also have a presence in Asia/Pacific, Canada, Americas, Europe and Central Asia.

Since the start in 2006, the networks have grown to encompass over 10,000 members across five continents. These members will mobilise their respective faith communities to provide accurate information and other services to an estimated 2.5 million people around the world, helping to reduce HIV-related silence, stigma, shame, and discrimination, and thereby reducing the number of new infections.
INERELA+ has scaled up its work with religious leaders in a global context of diminishing/inadequate resources for HIV & Aids work, and the loss of momentum of HIV prevention messages in most countries.

If we are to end the spread of Aids by 2030, strategic, multisectoral collaboration is imperative. Greater commitment and cost effective, targeted approaches are part of this.

INERELA+ has adapted its approach to the changing times. For example, we have decided to respond directly to social and economic justice issues that make people vulnerable to HIV. This approach has given us increased access to key populations. Using our spaces of worship to leverage the wisdom of these key populations has led to very progressive ways of tackling and dismantling the various stumbling blocks we encounter within our communities.

One of the success stories we share in this annual report, is an innovative approach to encouraging men to get tested on time. Statistics have shown us that men are still dying of Aids because of delaying testing and failure to take their ARVs consistently.

Our HIV Testing Services campaigns, led directly by religious leaders — who happen to mainly be men — have been very successful in changing men’s behaviour. These campaigns have mostly been implemented in areas where cultural norms have been a deterrent.

We now have a number of champions, who are spreading messages of hope in different countries. HIV Friendly Fridays campaigns in countries like Sierra Leone, have used empowered communities and key populations.

Girls and young women continue to be the most vulnerable group in all societies. Our Comprehensive Sexuality Education and Information projects specifically target this group by creating spaces for girls to openly discuss their struggles and challenges, and to develop life-changing skills.

We have also linked our work to the Sustainable Development Goals (SDGs), with a focus primarily on health, wellbeing and gender equality.

INERELA+’s work has been generously supported by our friends, partners and donors, and we sincerely appreciate their interest and encouragement. It is a mere 12 years to 2030, but much can be achieved in that time if we sustain our vision for a just, Aids-free world, and work together, pray together and serve together to this end.

Reverend Phumzile Mabizela

REFLECTIONS FROM THE EXECUTIVE DIRECTOR’S DESK

UNAIDS recently reported that nearly 21 million people living with HIV are accessing antiretroviral (ARV) therapy — more than half of the 36.7 million people living with HIV are now on life-saving treatment. A Lancet (2017) report states that Aids-related deaths have declined from a peak of about 1.9 million in 2005 to around 1.0 million in 2016, largely due to treatment scale-up.

Developments in the world’s most affected areas — eastern and southern Africa — have been striking. According to a WHO factsheet (November 2017), 70% of lower- and middle-income countries (LMIC) and 89% of fast-track countries have adopted a Treat All policy, while another 10% of all LMIC and 6% of fast-track countries plan to adopt Treat All policy before the end of 2017.

Lifelong ART for pregnant women is nearing universal adoption and full implementation. Routine HIV viral load monitoring has been fully implemented in 58% of LMIC and partially implemented in 25% of LMIC.

Gaps in the 90–90–90 continuum are greater for men, young people, and key populations in all regions, with women typically, disproportionately affected by the epidemic.

Criminalisation, stigma, and discrimination are barriers to accessing care programmes. Funding, too, is a concern.

Virological monitoring remains a serious challenge across countries in Africa due to the unaffordability of these services. Continued reliance on CD4 count testing aggravates adherence challenges.

A 2018 study (Afe et al) cited lack of knowledge, forgetfulness, stigma and discrimination, together with issues of faith healing, as major deterrents to accessing antiretroviral treatment.

INERELA+ sees an opportunity to build the capacity of religious leaders and faith communities. Religious leaders often know their status but hold back from accessing medication because of fear of being seen at hospitals by their congregants and/or being excommunicated from their faith communities.

INERELA+ continues to position itself as a significant interfaith voice in advocating for the reduction of HIV & Aids-related stigma and discrimination and gender justice rights from a faith-based perspective. INERELA+ is unique in its use of comprehensive and interfaith messaging on HIV prevention and management that links emerging science with sacred texts.

Through its training, advocacy and awareness-raising campaigns, INERELA+ emphasises optimal adherence, supports those who adhere to treatment, and encourages positive living.

VISION, VALUES AND ACTION

INERELA+’s work is rooted in the conviction that religious leaders have a role to play as agents of change and transformation with regard to perceptions of HIV & Aids and those infected and affected by it, and actions taken to address it.

I was hiding because of fear of being discriminated against. Even here in the church no one knew the struggle I was going through. But after we were trained we started being open to one another. That set us free and we went to reach out to others both in the church and in the community. - Religious leader from Burundi
INFORMATION SHARING

Information sharing takes place in congregational training; in advocacy meetings; through dialogue with stakeholders and within faith communities; in face-to-face counselling, and community engagement and through the proactive use of print, electronic and social media.

The distribution of the SAVE toolkit remains an on-going activity. The toolkit has been a point of reference for facilitation as well as a stepping stone for networking and collaboration with other stakeholders.

During the period covered by this report, approximately 50,000 congregants were reached and 305 toolkits were distributed: 95 in Uganda; 72 in Nigeria; 66 in South Africa; 45 in Malawi and 27 in Rwanda.

Other IEC produced by INERELA+ throughout the year included quarterly newsletters, pamphlets, generic HIV stigma posters, and specific posters on SGBV, child marriage and teenage pregnancy. Advocacy messages were developed in Portuguese and English and in some cases translated into French.

<table>
<thead>
<tr>
<th>Country Network</th>
<th>Total Number of Congregants Reached</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Burundi</td>
<td>1,699</td>
</tr>
<tr>
<td>DRC</td>
<td>-</td>
</tr>
<tr>
<td>Ghana</td>
<td>8,100</td>
</tr>
<tr>
<td>Kenya</td>
<td>2,020</td>
</tr>
<tr>
<td>Malawi</td>
<td>823</td>
</tr>
<tr>
<td>Mozambique</td>
<td>446</td>
</tr>
<tr>
<td>Nigeria</td>
<td>-</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>-</td>
</tr>
<tr>
<td>South Africa</td>
<td>2,995</td>
</tr>
<tr>
<td>Zambia</td>
<td>-</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>16,083</td>
</tr>
</tbody>
</table>

PROMOTING HIV TESTING SERVICES

In total, 21,959 people were tested in 2017.

Contextual variations inevitably influence the framing, pace and progression of activities from one country to another at congregational and community levels, in pursuit of INERELA+’s three main objectives:

1. To strengthen capacity of religious leaders to be agents of change for HIV and TB prevention, care and treatment by offering training HTS campaigns, information-sharing and drives;
2. To enhance the capacity of religious leaders as agents of change by ensuring human dignity and gender justice, with a specific focus on women and girls and key populations;
3. To capacitate religious leaders to advocate for and promote SRHR

CAPACITY BUILDING

Capacity building workshops held for religious leaders in 2017

<table>
<thead>
<tr>
<th>Date</th>
<th>Location</th>
<th>Religious Leaders</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>Monrovia, Liberia</td>
<td>24</td>
</tr>
<tr>
<td>February</td>
<td>Tansui, South Africa</td>
<td>14</td>
</tr>
<tr>
<td>March</td>
<td>Lome, Togo</td>
<td>26</td>
</tr>
<tr>
<td>March</td>
<td>Anambra &amp; Benue, Nigeria</td>
<td>36</td>
</tr>
<tr>
<td>April</td>
<td>Kpapane, South Africa</td>
<td>12</td>
</tr>
<tr>
<td>June</td>
<td>Randburg, South Africa</td>
<td>40</td>
</tr>
<tr>
<td>August</td>
<td>UKZN, South Africa</td>
<td>25</td>
</tr>
<tr>
<td>November</td>
<td>Johannesburg</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total number of religious leaders trained</strong></td>
<td><strong>203</strong></td>
<td></td>
</tr>
</tbody>
</table>
COUNTERING HIV-RELATED STIGMA AND DISCRIMINATION

INERELA+ continues to advocate against gender injustice, stigma and discrimination towards PLHIV and LGBTI people. The SAVE approach has successfully fostered hope and support for these groups.

THE ROLE OF FEMALE RELIGIOUS LEADERS OPPOSING SGBV

Female religious leaders are an important target group for INERELA+ because of the impact of their advocacy work in relation to young girls and women, who remain especially vulnerable to HIV infection and abuse in patriarchal societies. Twenty-seven female religious leaders were trained in four countries in 2017: Jamaica (29), Nigeria (25), Malawi (50) and Uganda (23).

<table>
<thead>
<tr>
<th>Countries</th>
<th>Number of female religious leaders trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jamaica</td>
<td>29</td>
</tr>
<tr>
<td>Nigeria</td>
<td>25</td>
</tr>
<tr>
<td>Malawi</td>
<td>50</td>
</tr>
<tr>
<td>Uganda</td>
<td>23</td>
</tr>
<tr>
<td>Total</td>
<td>127</td>
</tr>
</tbody>
</table>

Strategies for addressing GBV

Dialogues
A total of 5,284 women, young girls, men, media representatives and religious leaders were reached through INERELA+ GBV initiatives. Survivors of GBV were linked to support and legal services.

Advocacy
Advocacy around SGBV enabled INERELA+ to expand its reach regionally and internationally during the year:

- The Executive Director of INERELA+ attended the launch of the GBV initiative, “Thursday in Black” (TIB) in Jamaica, and the Caribbean Faith Leader’s Consultation in Trinidad during the year.
- In collaboration with WCC/EAA, KENERELA+ participated in a UN discussion on women, HIV and property rights in March as part of the 61st Session of the UN Commission on the Status of Women (CSW) in New York.
- In June, the Executive Director represented the network at the special session assembly during the UNGASS high-level meeting held in New York.

Wherever INERELA+ has a foothold, there were campaigns to advocate for policies against GBV during the annual 16 Days of Activism For No Violence Against Women and Children.

RELIGIOUS LEADERS FOR AGE-APPROPRIATE SRHR AND CSE&I

Thirty-one religious leaders from East and Southern Africa were trained as advocates of adolescent SRHR. An adolescent SRHR handbook was produced, and approximately 2,400 youth were reached in Botswana, Kenya and South Africa.
In INERELA+ Burundi (BUNERLA+) PMTCT campaigns, 187 people were reached. Twelve new cases of HIV positive women were among those screened. These women are currently benefitting from PMTCT interventions.

HIV, SGBV and women’s rights was the theme of a two-day intergenerational dialogue attended by religious leaders, GBV victims/survivors, and representatives from government agencies and human rights groups. As a result, advocacy groups were formed in the proximity of churches where female religious leaders preside, or in communities surrounding mosques. GBV victims/survivors were put in contact with the abuse centre in Bujumbura.

Case Study from Burundi

Female religious leaders in Burundi were trained and supported to by the country network to initiate congregational activities to raise awareness on issues related HIV and SGBV. In May, the women met with survivors and victims of GBV in a safe space which enabled them to share their experiences. One of the women was 70-year-old Mama Ntihabose Leocadie from Vumbi Province in the northern part of Burundi. She had been legally married to her husband for more than 25 years before he vanished to Tanzania and Zimbabwe. She was left to bring up the couple’s five children alone. She engaged in various income-generating activities, including farming, and from here income managed to build a house for her family.

When her husband returned after 20 years, seeing the investments (farms, livestock and property) that Mama Leocadie had acquired, he became violent and abusive. Mama Leocadie was chased out of her house and off her farm and her husband took over her businesses. She engaged in various income-generating activities, including farming, and from here income managed to build a house for her family.

When her husband returned after 20 years, seeing the investments (farms, livestock and property) that Mama Leocadie had acquired, he became violent and abusive. Mama Leocadie was chased out of her house and off her farm and her husband took over her businesses. Mama Leocadie was psychologically, emotionally and physically abused by her husband. After he attacked her with a spade, inflicting serious wounds to her neck right and jaw, she was hospitalised for several months. After being discharged, she was taken to the GBV support centre in Bujumbura by Pastor Violette. After sharing her story, the legal representative, Advocate Dombori Anitha, who was present at the dialogue, in close partnership with BUNERELA+, pledged to assist Mama Leocadie to get legal assistance. The case has been heard twice at the Court of Cassation of Bujumbura. At the first hearing, Mama Leocadie was represented by the advocate, and accompanied by Pastor Tharcisse, BUNERELA+ National Coordinator. In the second court appearance, the judge at the High Court of Kirundo recognised the defendant’s right to share the family property with her husband. Less than a month later, the final judgment was gazetted. BUNERELA+ paid the legal fees to secure the judgment papers. Justice was done and Mama Léocadie was able to benefit from the division of family property. She filed for divorce in court and it was granted.

Disclosure of LGBTI people is rife in the DRC. A 2016 survey of Kinshasa showed that 53% of religious leaders stigmatisate and discriminate against LGBTI people. The 32 participants in a dialogue to tackle prejudice included representatives from the Ministry of Justice’s Multisectoral Programme for the Fight against Aids; religious leaders, LGBTI persons, human rights organisations, the Network of Organisations of People Living With HIV, UNDP and human rights activists. Discussion was frank and supportive. It resulted in the following declaration:

Declaration of the CARITAS Reception Center of 21 September 2017

We, religious leaders participating in the dialogue between religious leaders and the LGBTI community gathered from 18 to 20th September 2017 at the CARITAS Congo Reception Center; considering the stigma and discrimination that LGBTI suffer in our country, recognising that every human being is created by God in his image, and every person to the same right to be treated with dignity, take the commitment to advocate true love, to avoid stigmatisation and discrimination of LGBTIs; to adapt our religious discourse to realities; to inform and train people on the subject of LGBTI people in order to integrate them into Congolese society and to promote their access to health, education and social services.

Working mainly through the Methodist church, the National AIDS Council, and the Muslim community, INERELA+ Ghana has been able to raise awareness about HIV and GBV in congregations and schools in activities largely been headed by women religious leaders.

In a two-day intergenerational, multisectoral dialogue to discuss HIV, SGBV and women’s rights held in Accra in March, referral points for SGBV survivors were identified and collaborative action plans were developed.
KENYA

I started to preach sermons on stigmatisation of people living with the virus – HIV. This was after the training I had facilitated by INERELA+ Kenya...
I noted (an) increase in the number of congregants who visited my office for advice regarding how to handle family members who were infected. – Pastor, Kenya

With funds received by its AIDSFree project, INERELA+ Kenya as able to produce a Khutbah and sermon guides on Children and HIV for use by religious leaders. Both guides were developed in collaboration between religious leaders, USAID, PEPFAR and IMA World Health.

Kenya’s Bishop Godfrey Thuku Kimani of Deliverance Church organised a youth camp for his diocese, bringing together close to 700 young people. The camp, called Overcome, was held at Gilgil campsite in Nakuru country. The youth were educated on teenage pregnancy, the consequence of keeping bad company and other issues affecting adolescent lives.

MALAWI

Testimony from Malawi
Following a teaching organised by religious leaders for the Linthipe Mosque, Sheikh Abubaker was enlightened about the need to open up about one’s HIV status. A few weeks later the Sheikh revealed that 3 of his 4 wives were found positive and were immediately put on ART. He has since testified of the tremendous change in health the general welfare of his entire family. Sheikh Abubaker has taken it upon himself to mobilise fellow Sheikhs within his constituency to go for couple testing and set an example for their congregations.

Through the AIDSFree project, religious leaders trained by INERELA+ Malawi mobilised 11,333 people during HIV Testing week in the Dedza District and in the catchment areas of two Christian Health Association of Malawi (CHAM) health facilities, 379 clients were tested in ANC and 318 in maternity. As a result there were eight new ART initiations for pregnant women and four new ART initiations for breastfeeding women.

INERELA+ Malawi supported one of the trained champions, Bishop of the Anglican Diocese of Upper Shire, Rt Reverend Brighton Malasa who embarked on a 16-16 campaign against GBV in his diocese. The campaign statement was circulated to all the Anglican churches in the diocese and the general public through the Religion and Nation newspapers and also various online publications. Innovative activities which included an 8km solidarity walk to raise awareness around GBV, were supported by all the churches in the diocese.

MOZAMBIQUE

Testimony from Mozambique
“In our church we had problems of girls falling pregnant, but when the youth leader started to implement sexual health and reproductive programme and HIV, since 2016 we have seen decline in terms of pregnancy in our church.”

In Mozambique, MONERELA+’s HIV activities were implemented by 26 active religious leaders through: HIV sensitisation campaigns; congregational and women’s group debates on disclosure; HIV prevention; STIs, Christianity and relationships; the risks of pregnancy; social and behaviour change; debates in mothers’ groups and youth groups; mutual support counselling, and the mobilisation of congregants to support the elderly and to care for PLHIV and children.

NIGERIA

Testimony from Nigeria
In the year 2000, my husband had a blood transfusion when he became ill. Then in 2006, he was tested for HIV and diagnosed positive. The nurse who tested my husband was a pastor’s wife. The doctor who brought the results told the nurses that ‘the pastor (my husband) had messed-up his life’, implying that he the HIV was because of my husband’s promiscuity.

The PEN Chairman in Delta State, Ekpan Unit, was told of my husband’s HIV status without his consent. This is known as ‘harmful disclosure’. During the next meeting, the PEN Chairperson announced that Pastor Monday was HIV positive. Since then, all the pastors stopped coming to our church and even refused to shake hands with my husband and I at meetings. They were scared that they might get infected in the process of greeting.

After being tested at the Agbor Medical Centre, I was also diagnosed HIV-positive. There were no lifesaving drugs (ARVs) in Delta State, so my husband and I were referred to UBTH for ARVs.

In 2008, my husband was killed in a car accident on his way to UBTH to collect his ARVs. Rumours circulated that he died of HIV and church membership which dwindled from 200 to 14 members. I was not able to pay the house rent, the land for the church and the school fees for our four children. Mrs Uche Osabushien (Edited)

The INERELA+ Nigeria (NINERELA+) team facilitated free voluntary HIV testing and counselling during several faith dialogues on HIV, SGBV and FGM. During the course of the year, over 2,000 people were tested in Anambra and 339 in Benu.
In South Africa, INERELA+ trained 52 leaders from 35 churches during 2017.

**HIV testing in congregations**

After congregations in Mopani, Soweto, Alexandra, and Orange Farm opened their doors for HTS, the initiative snowballed, and SANERELA+ was able to identify other interested congregations.

**Testimonies from Mopani, South Africa**

During a testing drive in Apostola ya Modimo church in Mopani District (South Africa) in August, the first person to be tested was a trained religious leader. The 56-year-old woman bishop tested HIV-positive. Her response to her HIV-positive status was to become even more impassioned about mobilising others to be tested. Her message to the people waiting outside the gazebos to be tested was, “Expect the worst and celebrate the nonreactive result!” The bishop visited the clinic the next day to be linked to care.

In September, an HIV+ religious leader from N’Wa-mintwa village shared her first presentation in front of more than 50 church members of the Ascension Church at Selwane in the Mopani District (South Africa). In the brief 20 minutes she was allocated, she shared her experience. At the end of her presentation, another church member came up and disclosed. Courage is contagious and it grows. This champion religious leader was willing to share and inspire more people.

On World Aids Day these figures were noted during a campaign organised by NINERELA+:

<table>
<thead>
<tr>
<th>AGE</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-19</th>
<th>20-24</th>
<th>25-49</th>
<th>50+</th>
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</thead>
<tbody>
<tr>
<td>Male</td>
<td>35</td>
<td>56</td>
<td>73</td>
<td>215</td>
<td>396</td>
<td>544</td>
<td>287</td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>20</td>
<td>9</td>
<td>156</td>
<td>163</td>
<td>494</td>
<td>58</td>
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<td>Positive</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>

The NINERELA+ network coordinator and selected religious leaders were interviewed by media houses on their role in fighting against GBV. This and other advocacy initiatives undertaken aimed to trigger a collective response to SGBV.

Imam Fuad Adeyemi committed to engaging with the national Muslim body to address issues of GBV, which were said to be rampant among community members. Public officials and civil society organisations committed to collaborate with INERELA+ Nigeria to reach Muslim communities.

Voice of Nigeria, ON TV and Radio Lagos held interviews with the network coordinator and selected religious leaders such as Imam Fuad Adeyemi of Abuja and the Methodist Bishop of Nyanga, Bishop Samuel Nortey. The print media also gave coverage to the interviews.

In Sierra Leone, INERELA+ Sierra Leone’s persistence in engaging the National HIV & Aids Secretariat has paid off: the Sierra Leonean Government and partners working on HIV & Aids have adopted the SAVE approach for use in HIV prevention and treatment services.
REGIONAL EVENTS AND VISITS

The Secretariat team visited Zimbabwe, Zambia, Malawi, Tanzania, Ghana, Nigeria, Burundi and Uganda with the aim of getting acquainted with the governance and resource situations of country networks; assessing HIV/SGBV activities implemented at congregational and community level, and participating in intergenerational dialogues on SGBV for women and young girls held in Ghana and Burundi.

INTERNATIONAL EVENTS

A highlight for INERELA+ was the Caribbean Faith Leaders Consultation – in collaboration with the WCC – in Trinidad. The focus was on ending GBV, and eliminating HIV-related stigma and discrimination. Rev. Phumzile Mabizela shared her experience as a female faith leader living positively. Here views were made public in a TV interview that was recorded and shared on YouTube: https://www.youtube.com/watch?v=GFBnvY6jirQ.

Men’s Dialogues

Three Men’s Dialogues on GBV were held during the year: one in Soweto during the 16 Days of Activism for No Violence Against Women and Children on the theme, The Impact of Masculinity on HIV, Counselling and Testing Services; one themed, Take a boy child to work; and one on the theme, The Impact of Masculinity on Sexuality Gender Based Violence. All three were well attended and clearly had an impact on the boys and men who came. Over 1 000 youth, CSOs and religious leaders took part in a second men’s dialogue held in Soshanguve, Pretoria. The Minister of Health was present and the then Deputy President of South Africa, Hon. Cyril Ramaphosa chaired the dialogue, which aimed to get boys and men on board in curbing GBV, HIV and substance abuse.

TANZANIA

During the INERELA+ learning forum held in August 2017 in Tanzania, 51 people were tested. Of these, 16 people who were tested positive were already aware of their status.

UGANDA

INERELA+ Uganda’s HIV/SGBV training workshop in Kampala in July was attended by 23 female religious leaders from the Christian and Muslim communities. The training examined the link between SGBV and HIV, faith community response to SGBV and stigma and discrimination. Participants developed action plans for implementation in congregations and faith communities.

ZAMBIA

The social context in Zambia is overwhelmingly homophobic and transphobic. The LGBTI community in Zambia has been on the margins of mainstream civil society engagement, with some going into hiding for fear of persecution and arrest.

Against this background, INERELA+ Zambia organised a dialogue on the theme, Religion and culture: human rights, and non-discriminatory access to services. It was attended by 33 religious leaders, LGBTI persons, activists and human rights defenders. The dialogue aimed to increase awareness; develop a joint position statement, and establish a functional working group. The outcome was a steering committee and an action plan. The role of religious leaders in providing spiritual and psychological support to LGBTI communities was highlighted.
GOVERNANCE

BOARD MEETINGS

Two board meetings were held: one in Kampala, Uganda, and one in Mozambique. Important discussions were held around the revised strategic plan for 2017–2019 and the possible relocation of the INERELA+ Secretariat to Durban. The Kampala meeting incorporated governance training for country chairpersons and national coordinators. At the Mozambique meeting it was resolved that the Secretariat would remain in Johannesburg and the Executive Director would employ an advocacy officer.

INERELA+ LEARNING FORUM

Members and selected INERELA+ staff met in Dar es Salaam, Tanzania, in August to debate INERELA+’s new strategic direction. Burundi, DRC, Ethiopia, Ghana, India, Malawi, Nigeria, Reunion Islands, South Africa, Sweden, Tanzania, Uganda, Zambia and Zimbabwe participated. In the first get-together of its kind in the history of INERELA+, members were able to share best country network practices. Members recognised the need for robust governance systems and compliance with statutory obligations. The encounter ended on a celebratory note to mark INERELA+’s 15th anniversary.

RELIGIOUS LEADERS RETREAT

At a retreat for 30 interfaith religious leaders and founding members of INERELA+, religious leaders infected and affected by HIV were able to share their experiences. The testimonies of iconic founding members who have led the fight against HIV by example were particularly inspiring.
INERELA+ IS EXPANDING

With support from the Church of Sweden, the INERELA+ Secretariat was able to support a team of religious leaders to attend the INERELA+ launch in Sweden in March. The launch of the network was combined with a SAVE training programme with participants drawn from 30 European countries.

An interim board was elected consisting of JP as Advisory Board Member; Mohamed Fara as Treasurer; Kristina Goranzon as Secretary, and Paul Mokgethi Heath as Regional Coordinator. A second meeting was held in October.

LESSONS LEARNT AND WAY FORWARD

- **Information:** Reports have often been delayed because country networks are slow to provide comprehensive information. This has improved since an M&E officer based at the Secretariat was recruited.

- **Human and financial resources:** Constrained financial and human resources have hampered the expansion of INERELA+’s work. An over-reliance on volunteers is one consequence of this. Religious leaders are encouraged to draw on existing platforms within their congregations for outreach.

- **Communication between married couples:** Congregants, especially women, say the lack of communication between husbands and wives in relation to reproductive health makes behaviour change difficult to achieve.

- **Literacy:** Due to low literacy levels in some communities, people are slow to absorb messages of empowerment and equality and negative cultural and social activities such as early marriages, polygamy and irresponsible sexual behaviour persist.

- **Engaging men:** INERELA+’s approach is to promote male engagement in all its interventions targeting women and girls. A number of religious leaders have been identified to act as champions in different communities. In South Africa more men from faith communities than ever before are turning up for testing especially men from faith communities where religious leaders have received training.

- **Ignorance:** Most faith communities and leaders still struggling to understand topics such as HIV prevention and transmission, and TB.

CONCLUSION

INERELA+’s vision and mission has been expressed through activities undertaken throughout the year. Capacity development initiatives; congregational cascades and dialogue meetings on HIV, SGBV and LGBTI issues offered the various constituents the opportunity to sit side by side and speak openly in a safe space.

The provision of comprehensive information to both religious leaders and congregants is a priceless step toward achieving an Aids-free generation.

The transformative capacity of religious leaders in Africa on HIV programming is crucial in attaining the triple zero goals. Combatting stigma and discrimination against PLHIV, and addressing issues affecting women and girls, remain critical for preventing new HIV infections and mitigating the impact of Aids on human development.