**International Network of Religious Leaders Living with or Personally Affected by HIV And AIDS (INERELA+) Statement to The Dutch Parliament**
1. **About INERELA+?**
The **International Network Of Religious Leaders Living with or Personally Affected By HIV And AIDS(INERELA+)**is a global inter-faith network established in 2002 as an African Network of Religious leaders Living with or Personally Affected by HIV and AIDS (ANERELA+) to address inequalities and to provide quality compassionate health care interventions in underserved communities to end preventable deaths and to save lives. INERELA+ was officially registered in **April 2004** in South Africa as a Civil Society Organisation committed to advance health care and save lives. In 2008 ANERELA+ transitioned to INERELA+ **(International Network of Religious Leaders Living with or Personally Affected by HIV and AIDS)**. The name change was due to the growth and expansion beyond Africa into other regions of the world: Asia Pacific, the Americas, Europe and Central Asia which are organized through Regional Networks. INERELA+ has 16 active country/national networks in Africa with a membership **45 555 Religious Leaders from from Baháʼí, Buddhist, Christian, Confucian, Hindu, Muslim.** We are also **present in 5 regional networks in Asia/Pacific, Canada, Americas, Europe and Central Asia.** INERELA+ country networks are constituted and, in some cases, managed by ordained and lay RLs. The interventions of INERELA+ are led by its members, which is a growing critical mass of Religious Leaders **(RLs) (both lay and ordained male and female)** who are embedded in their communities. INERELA+ capacitates member RLs as social change makers using the **Hands-Off manual, ASRHR handbook and SAVE toolkit** so they can deliver Programs in their local communities and support them to address stigma, discrimination, inequalities, poverty and save lives. INERELA+ also uses its **SAVE Model toolkit** to capacitate health professionals in order to strengthen health facilities together with traditional leaders to become agents of change in championing equitable health care by providing quality, timely care in underserved communities.

**Our theory of change can be found** [**here**](https://inerelaorg-my.sharepoint.com/%3Ai%3A/g/personal/bobo_inerela_org/EbCl67B8E19AsXtrTTTRqVYBy5rb7JLoRoHU2v6idtox1Q?e=zy5EEU)**.**

2. **As religious leaders we support the right of key populations**INERELA+ advocates for core religious, and faith values that inherently support human dignity, equality, and justice, which includes the human rights of people living with HIV and key populations. Key populations are those groups most at risk for HIV, including sex workers in all their diversity. Our approach involves loving our neighbours and therefore INERELA+ religious leaders and faith communities reclaim religious texts to promote inclusive interpretations of sacred texts, collaborating with secular organizations, and challenging exclusionary faith practices that perpetuate stigma and discrimination against key populations. We emphasize practical actions and interfaith cooperation to transform harmful norms and advance justice and equality for all.

3. **As religious leaders we support everyone no matter who they are**As an INERELA+ member Religious Leader I am guided by the principle **of “leaving no – one behind”** where our faith teaches us that all individuals possess inherent worth. I have been capacitated and sensitised to serve others first, act as a steward by support everyone regardless of their background. This is due to INERELA+ core religious principles of compassion, universal love, and the inherent dignity of all people which are central to their faith and manifest as an ethical imperative to advocate for justice, foster social cohesion, and work collaboratively for the common good in a diverse world. I am motivated by a spiritual understanding of INERELA+ shared humanity and a belief that their faith compels them to act, and not just to believe. I am motivated to build bridges across cultural, political, and ideological divides, promoting connection, and creating trust and unity within diverse communities.

4. **The USAID budget cuts affect our communities**
The US funding cuts have created critical gaps in the HIV response across Africa where INERELA+ works. The gaps, unless filled, will have severe public health consequences, reversing the gains made thus far in the HIV response.

**Key areas affected:**

* **HIV prevention & treatment commodities**: Reduced access to ART, HIV test kits, PrEP, condoms and contraception increasing the risk of HIV transmission and HIV treatment interruptions. For Zimbabwe cuts occurred during a time of immense financial strain on the healthcare system, leading to concerns about service gaps.
* **Mass job losses**: Workforce shortages due to salary cuts, retrenchments and hiring freezes which is putting pressure on service delivery and patient care. In South Africa the cuts impacted around 40 USAID-funded health projects, leading to the closure of at least 40 clinics with 8 493 PEPFAR funded staff who served over 63,000 people and disrupting services for up to 220,000 people on HIV medication. In Zimbabwe over 1,000 nurses and doctors were directly affected and 19,000 village/community health workers.
* **Service Disruptions**: Closure of many clinics has significantly reduced services such as HIV testing, care, and treatment. Key populations, including adolescent girls, young women, and pregnant women, are at risk of losing access to critical HIV prevention tools like PrEP. There is limited support for advanced HIV disease services, reduced HIV testing, diminished treatment literacy, and increased stigma and discrimination for key populations. From January to June 2025, Zimbabwe recorded 5,932 AIDS-related deaths, up from 5,712 during the same period in 2024.
* **TB Commodities**: Limited availability of diagnostic tools and TB medications, delaying detection and treatment, which could lead to drug resistance.
* **Data monitoring & management systems**: Weakened tracking of disease trends, leading to gaps in evidence-based HIV response planning and decision making.
* **Collapse of Community systems**: Closing of community-led health initiatives, outreach programs, support groups and peer support has disrupted community systems that are vital to the success of the HIV response. We are seeing a total collapse in community-based and prevention programming, especially for key populations who are now entirely left behind.
* **Poverty**: According to an article published by [South Africa’s Institute of Security Studies (ISS)](https://issafrica.org/iss-today/data-modelling-reveals-the-heavy-toll-of-usaid-cuts-on-africa), the US government’s suspension of aid has the potential to force an estimated 5.7 million Africans into extreme poverty by 2026, and this number is likely to increase to 19 million by 2030. If this situation is not addressed, Africa will struggle to achieve the sustainable development goals (SDGs), particularly the reduction of extreme poverty for all by 2030 (SDG 1).

**5**. **What does this mean for countries most affected by HIV/AIDS?**In high-burden countries where INERELA+ works like Malawi (88.5%), Zimbabwe (82.7%), and Mozambique (81.8%) were almost entirely dependent on PEPFAR for their HIV prevention programs while others like South Africa (17%), Botswana, and Kenya were below 25%. **Zimbabwe** has experienced disruptions in testing of pregnant women during prenatal care, early infant diagnosis, paediatric HIV treatment services and the transport system.

Several countries where INERELA+ works have reported closures of some sites delivering HIV treatment or other disruptions in clinical HIV services. Thousands of health workers have been retrenched leading to major service disruptions. In some cases, health workers without prior experience in HIV care have stepped in raising concerns about the quality of care. In **Kenya** approximately 41,000 doctors, nurses, technical and management staff and community workers were being supported by the US government; in **South Africa** 24,000 health workers; in **Mozambique** more than 21,000 health workers.

**Community Health Systems,** including advocacy, service delivery, monitoring, and evidence gathering have been collapsing.  In several instances, even where governments stepped in to fund treatment gaps, most resources are directed towards formal health systems thereby leaving community-based initiatives behind.

The DREAMS Programme, which targeted 2 million adolescent girls and young women in 10 countries in the region was shut down. Programming for key populations has been impacted by the closure of drop-in centers.

**Key populations and human rights:** US funding has been largely halted for projects and programmes focused on addressing stigma and discrimination and enabling legal environments. This often means that monitoring of human rights issues has stopped, intensifying fears of discrimination and human rights violations against people living with HIV and key populations and other vulnerable groups as they are forced to switch from tailored, community-supported services to government services for the general population. In resource-constrained settings, there is a risk that programming for key populations, including HIV prevention and care linkages are not prioritized.

There are growing challenges to accessing HIV prevention and SRH services for adolescent girls and young women given the defunding of HIV prevention services including youth friendly services at community level. Funding for gender-based violence prevention and response programs have dwindled.

**Research and trials**: In **South Africa**, US government-supported research worth about USD 300 million on the HIV vaccine and long-acting PrEP was halted. A large tuberculosis (TB) research study also stopped leading to fears of disruptions of TB service delivery, reductions in treatment adherence and increases in TB transmission and mortality.

 A [Lancet study](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2825%2901186-9/fulltext) for projects suggest that funding cuts from the US could result in more than 14 million additional deaths by 2030, including 4·5 million deaths among children younger than 5 years.

Efforts to pedal through the last mile and attain global AIDS targets by 2030 (**to end HIV/AIDS as a public health threat, achieve zero new infections, zero HIV/AIDS-related deaths and zero stigma and discrimination**) will be challenging.

6. **Our recommendations to the Dutch parliament**

* Whilst as RLs we have been actively advocating for increased domestic budget allocation to critical sectors like health in the long run, we are in the short-term we particularly call for the Dutch government for increased budget allocation and non-restricted funding for health as a driver of socio economic development as well as to turn the crisis into an opportunity to cover the gap that has been created by the USAID fund cuts.
* We are also urging more collaboration between the Dutch government, European donors and private players, and multi - sectoral philanthropists from other developed countries in order to share resources to bridge funding gaps. This will strengthen our health systems and assure access to medication and prevention through acceleration of local manufacturing of vaccines and commodities which requires technology/knowledge transfer and the right to produce medicine locally at a reasonable price.
* We would appreciate if the Dutch government can market our work to strategic aid providers and partners who might be interested in joining hands to allow us to respond aggressively and to ensure continuity of the work that we have been doing.