

# A Common Vision:

Faith-based Partnerships to Sustain  
Progress Against HIV

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2019





## AUTHORS

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***John Blevins***

Interfaith Health Program  
Rollins School of Public Health  
Emory University, USA

***Sally Smith***

Leeds Institute of Health Sciences  
School of Medicine  
University of Leeds

## CONTRIBUTORS

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***Ludfine Bunde***

UNAIDS Kenya

***Nyambura Njoroge***

World Council of Churches  
Ecumenical HIV and AIDS Initiatives  
and Advocacy

***Azza Karam***

UN Population Fund and  
UN Inter-Agency Task Force on Religion  
and Development

***Stefano Nobile***

Caritas Internationalis

***Francesca Merico***

World Council of Churches  
Ecumenical Advocacy Initiative

***Jack Palmer-White***

Anglican Communion Representative  
to the United Nations

***Carl Mhina***

University of Cape Town, South Africa

***Koech Rotich***

UNAIDS Tanzania

***Nkatha Njeru***

African Christian Health Associations Platform

***Father Robert Vitillo***

International Catholic Migration Commission

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# GLOSSARY

<b>ABAAD</b>	Resource Center for Gender Equality
<b>ACHAP</b>	The African Christian Health Association Platform
<b>AJWS</b>	American Jewish World Service
<b>ANC</b>	antenatal care
<b>ART</b>	antiretroviral treatment or antiretroviral therapy
<b>ARVs</b>	antiretroviral medications
<b>BAI</b>	Black AIDS Institute
<b>CAFO</b>	The Church Alliance for Orphans
<b>CBAVC</b>	Cambodian Buddhism Association for Vulnerable Children
<b>CBOs</b>	community-based organizations
<b>CBS</b>	Contextual Bible Study
<b>CHAK</b>	Christian Health Association of Kenya
<b>CHAN</b>	Christian Health Association of Nigeria
<b>CHAs</b>	Christian health associations
<b>CHAZ</b>	Churches Health Association of Zambia
<b>CHWs</b>	community health workers
<b>DRC</b>	Democratic Republic of the Congo
<b>ECR</b>	Expanded Church Response
<b>EDARP</b>	Eastern Deanery AIDS Relief Program
<b>EGPAF</b>	Elizabeth Glaser Pediatric AIDS Foundation
<b>EID</b>	early infant diagnosis
<b>EPN</b>	Ecumenical Pharmaceutical Network
<b>ESHA</b>	Ecumenical Solidarity on HIV and AIDS
<b>eVT</b>	elimination of Vertical Transmission
<b>FBHPs</b>	faith-based health providers
<b>FBOs</b>	faith-based organizations



<b>GBV</b>	gender-based violence
<b>GNP+</b>	Global Network of People Living with HIV
<b>GRAIL Project</b>	Galvanizing Religious Actors for Accelerated Identification and Linkage to pediatric ART
<b>HIS</b>	health information system
<b>HIVST</b>	HIV self-test
<b>IAM</b>	Inclusive and Affirming Ministries
<b>IATF</b>	UN Inter-Agency Task Force on Engaging with Faith-Based Actors
<b>ICPH</b>	International Center for Child and Public Health
<b>IHP</b>	Interfaith Health Program at Emory University
<b>INERELA+</b>	International Network of Religious Leaders Living with or Affected by HIV & AIDS
<b>IRHAP</b>	International Religious Health Assets Programme
<b>JLIFLC</b>	Joint Learning Initiative on Faith and Local Communities
<b>KEC</b>	Kenya Episcopal Conference of the Kenya Conference of Catholic Bishops
<b>LGBTQI</b>	lesbian, gay, bisexual, transgender, queer, and intersex
<b>MEDS</b>	Mission for Essential Drugs and Supplies
<b>MenKen</b>	Kenya Male Engagement Network
<b>MEWA</b>	Muslim Education and Welfare Association
<b>MPV</b>	Muslims for Progressive Values
<b>NA</b>	Narcotics Anonymous
<b>NACA (Nigeria)</b>	National Agency for the Control of AIDS
<b>NACC (Kenya)</b>	National AIDS Control Council
<b>NCCI</b>	National Council of Churches of India
<b>NCKK</b>	National Council of Churches of Kenya
<b>NGOs</b>	nongovernmental organizations
<b>PEPFAR</b>	U.S. President's Emergency Plan for AIDS Relief
<b>PVT</b>	prevention of vertical transmission

<b>RFP</b>	Religions for Peace
<b>SAVE toolkit</b>	Safe Practice, Access to Treatment, Voluntary Testing and Counselling, Empowerment
<b>SDGs</b>	Sustainable Development Goals
<b>SGBV</b>	sexual and gender-based violence
<b>SRH</b>	sexual and reproductive health
<b>SRHR</b>	sexual and reproductive health and rights
<b>SUPKEM</b>	Supreme Council of Kenya Muslims
<b>The Global Fund</b>	The Global Fund to Fight AIDS, Tuberculosis and Malaria
<b>TiB</b>	Thursdays in Black
<b>UCT</b>	University of Cape Town
<b>UN</b>	United Nations
<b>UNAIDS</b>	The Joint United Nations Programme on HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>UNHCR</b>	UN Refugees Agency
<b>UNICEF</b>	United Nations Children’s Fund
<b>USD</b>	United States Dollar
<b>USI</b>	Ummah Support Initiative
<b>WCC</b>	The World Council of Churches
<b>WCC-EAA</b>	The Ecumenical Advocacy Alliance (of the World Council of Churches)
<b>WCC-EHAIA</b>	Ecumenical HIV and AIDS Initiatives and Advocacy (of the World Council of Churches)
<b>WHO</b>	World Health Organization
<b>WYWCA</b>	World Young Women’s Christian Association
<b>ZINGO</b>	Zambia Interfaith Networking Group on HIV



# INTRODUCTION

## Purpose of and Background to this report

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR), together with the Joint United Nations Programme on HIV/AIDS (UNAIDS), launched an initiative in 2015 to strengthen collaboration with faith-based partners in response to *The Lancet Series on faith-based health care* and the UNAIDS *The Gap Report*. The purpose of the FBO initiative was scaling up partnerships with faith-based organizations (FBOs) and addressing issues highlighted as important by *The Lancet Series* and the *The Gap Report*.<sup>1,2,3</sup> This report describes the work of the PEPFAR/UNAIDS FBO Initiative between 2015 and 2019, using these two documents as its framework.

*The Lancet Series on faith-based health care* (2015) was a significant watershed in the partnerships between FBOs and the secular public health community.<sup>4</sup> First, it recognized that faith-based health care networks are important, both in the scale and scope of their health care provision and in their understanding of local cultures and practices that affect health. Second, the series argued that more research was required to know how to engage faith actors effectively. Third, it recognized that there is a need to strengthen the evidence base on the scale, quality, and costs of health services provided by faith-based partners, as well as their technical capacity in some areas. Finally, the series acknowledged the complex issues and debates at the intersection of faith, public health, and policy-making, noting some areas of controversy. These include tensions around human rights and gender inequalities, particularly as they affect young women and girls; the barriers facing lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) people in their attempts to access health care; and sharp differences in the advocacy for and provision of sexual and reproductive health and rights (SRHR).<sup>5</sup>

*The Gap Report* (2014) focuses on 12 community groups that are being left behind in the AIDS response. It comprehensively describes the factors which cause these communities to be left behind even as the efforts to end AIDS generate positive outcomes for more and more people. *The Gap Report* then lays out the top four reasons why some of those in each of twelve different communities are left behind and identifies the top four priority actions to close the gap.

The initiative also drew on earlier events beyond *The Lancet Series* and *The Gap Report*. PEPFAR convened consultations in 2012 and 2015 with faith-based partners,<sup>6</sup> and UNAIDS has systematically collaborated with faith-based partners since its establishment.

These collaborations were not limited to UNAIDS and PEPFAR. In 2014, the United Nations Populations Fund (UNFPA) and UNAIDS worked with the Joint Learning Initiative on Faith and Local Communities (JLIFLC) to produce a scoping report on the contributions of faith-based and faith-inspired actors on maternal health and HIV.<sup>7</sup> Key findings from that report informed articles in *The Lancet Series*. Focus areas of the PEPFAR/UNAIDS FBO Initiative were designed to address issues highlighted by *The Lancet Series* and priority actions identified by *The Gap Report* in line with the UNAIDS Strategy and PEPFAR 3.0.<sup>8,9</sup> They include work in six areas: 1) documenting the contributions of faith-based partners, 2) sustaining and strengthening faith-based pediatric and adolescent HIV responses; 3) building the capacity of local, regional, and national FBOs alongside local religious communities to offer compassionate and evidence-based HIV services; 4) challenging gender inequities and sexual and gender-based violence; 5) reducing stigma by articulating a model of justice and inclusion through religious structures and offering services to marginalized communities; and 6) advocating for strong, sustained HIV programs in local, national, and global contexts. For this reason, this report describes the work of the faith-based implementing partners of the FBO Initiative in these areas as compared to the recommendations in *The Lancet Series* and the *The Gap Report*.

However, the report also recognizes that the PEPFAR/UNAIDS FBO Initiative does not stand alone in responding to HIV, that the initiative has its own limitations,<sup>10</sup> and that there has been a much wider response of the faith community to HIV over more than thirty years. Other case studies are therefore included to show the scope of this wider response as illustrative snapshots even though this report cannot comprehensively convey the scale and diversity of the response. For a more detailed overview of the wider faith response to HIV, this report points to additional literature at the end of each chapter. The article by Olivier, J. & Smith, S. (2016) is one paper which attempted to provide a review of faith-based work on HIV.<sup>11</sup> In addition the CHART database held by the University of Cape Town<sup>12</sup> holds approximately 4000 publications on faith responses to HIV. And the accompanying book *Religion and HIV and AIDS: Charting the Terrain*, provides a scholarly analysis of literature in this database in the context of community responses.<sup>13</sup>

## Historical Context

When the first cases of the infection that came to be called HIV were identified in 1981, some quickly offered compassionate responses, providing care to those sick and dying from an illness that did not yet have a name. Some of those initial responses were carried out by people of faith and the conviction behind those initial, local efforts galvanized into larger responses in national and international contexts. The World Council of Churches (WCC) convened its first global consultation on HIV in 1983, and leaders of Roman Catholic health and development organizations began to offer coordinated responses across Europe and Africa at the same time.<sup>14</sup> As soon as medications to treat the infection were made available, faith-based health facilities provided them to patients; today such facilities provide an estimated 30% of all HIV clinical care across the sub-Saharan region of Africa<sup>15</sup>, the region of the world with the highest burden of HIV disease.<sup>16</sup>

These coordinated faith responses to HIV beginning in the mid-1980s preceded any coordinated global response among governments to the global epidemic by a number of years. The Joint United Nations Programme on HIV/AIDS (UNAIDS) would not be created until 1994; The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) followed in 2002, with the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) authorized by the United States Congress in 2003. From the start, these bilateral and multilateral initiatives have always collaborated with faith-based partners.

And yet, the faith response to HIV also had mixed results. Compassion has not been the only faith-based response to HIV. Many religious leaders and FBOs have acknowledged that they have been slow to respond, sometimes refusing to provide services or even abandoning some people living with HIV or at risk for infection at times.<sup>17,18</sup> Such messages and acts of condemnation have helped fuel stigma against people living with HIV or at risk for HIV infection. Such stigma contributes to barriers to care, especially for key population groups (e.g., groups that experience stigma and barriers while also experiencing increased rates of HIV infection, including men who have sex with men, people who inject drugs, and sex workers, transgender people, and prisoners). The most powerful response to such religious messages of condemnation has always been religious messages and acts of compassion. This report examines some influences of religion in the global response to HIV, highlighting the ways in which religion has both contributed to stigma and been a powerful instrument for compassionate care and courageous advocacy.

In the almost four decades since those earliest responses, medical advances have transformed HIV from a terminal diagnosis into a chronic, manageable condition. Policy and funding commitments have moved us closer to the day when such advances are available to anyone in the world who needs them. Global funders have increased their collaboration with faith-based partners. Bilateral and multi-lateral funders and international organizations now work to specifically engage and support religious leaders, faith communities, and FBOs in support of shared health and development commitments in general and of HIV programs specifically.

## UNAIDS Strategic Framework for Partnership with FBOs in the HIV Response

In 2009, the UNAIDS Secretariat developed a Joint Programme Strategic Framework for partnership with FBOs in the HIV response together with FBOs working on HIV, networks of people living with HIV and UNAIDS Cosponsoring organizations. It includes the working definition of FBOs and other faith partners used in this report and important guidelines on roles and responsibilities of both FBOs and international partners in those partnerships (see Annex 1):

Faith-based organizations are defined as faith-influenced non-governmental organizations. They are often structured around development and/or relief service delivery programs and are sometimes run simultaneously at the national, regional and international levels.<sup>19</sup>

Many UNAIDS Cosponsors have also engaged with FBOs responding to HIV. Subsequently, other UNAIDS Cosponsoring organizations developed their own guidance documents for working with FBOs. In 2010, UNAIDS worked with UNFPA to co-found the UN Inter-Agency Task Force on Engaging with Faith-Based Actors (IATF). Since then, the UN Task Force has annually convened these faith-based partners for a series of policy dialogues with donor governments, academics, development, and humanitarian specialists from diverse regions and religions around diverse human rights, development, and peace and security-related issues. The IATF has drawn up criteria for engagement with FBOs<sup>20</sup> in health and development (see Annex 1).<sup>21</sup>

Building on earlier work with FBOs—including those responding to HIV—and based on the recommendations for evidence argued for at the Donor-UN-FBO Consultations in New York in 2014, the World Bank convened a high-level meeting on the importance of faith-based partners to the global health and development agenda in 2015.

At this Consultation, which was co-hosted by the JLIFLC, the World Bank, the UN Interagency Task Force, and the Government of Germany, *The Lancet Series* was launched to highlight the contributions of faith-based partners to global health. Such a consultation demonstrated the importance accorded to FBOs by global funders, UN agencies, and some of the longest standing faith-based and faith-inspired partners to the UN. The key messages conveyed in the meeting also demonstrate this. For example, Jim Yong Kim, the President of the World Bank, referenced the influence of Roman Catholic liberation theology and its focus on “God’s preferential option for the poor” in his own work and commitments. In his opening plenary address Kim noted that “the foundation of everything I have done has been through the notion of a preferential option for the poor ... We looked around the world and asked if there was an approach that made sense, and nothing gave as much clarity as the notion of a preferential option for the poor, and every religion shared that.”<sup>22</sup>

## Partnership with Networks of People Living with HIV

In 2010, a High Level Religious Leaders’ Summit was organized in the Netherlands by the Ecumenical Advocacy Alliance (EAA) and Cordaid, with support from the Dutch Ministry of Foreign Affairs, UNAIDS, the International Network of Religious Leaders Living with or Personally Affected by HIV or AIDS (INERELA+), the World AIDS Campaign, and the European Council of Religious Leaders (Religions for Peace, RFP).<sup>23</sup> Religious leaders met for three days with representatives from networks of people living with HIV and key populations. For some participants this was the first opportunity to hear and learn from one another. The Summit led to a personal commitment by religious leaders to address stigma and discrimination towards people living with HIV, which was followed up by EAA through a series of initiatives in partnership with UNAIDS, INERELA+ and the Global Network of People living with HIV (GNP+). The UNAIDS partnership framework, commitments made by these high-level religious leaders at the Summit, follow-up activities, and memoranda of understanding signed or renewed by faith-based partners have guided UNAIDS’ ongoing partnerships with FBOs working on HIV and the PEPFAR/UNAIDS FBO Initiative.<sup>24</sup>

The tremendous changes over the years in clinical treatment, the development of coordinated HIV programs at local, national, and global levels, and the heightened appreciation of faith-based contributions to those programs have brought us to a pivotal moment in the history of the global HIV response. Resources are being concentrated in part of the world with the highest HIV disease burden to encourage the use of prevention methods and ensure that everyone knows their HIV status, offer treatment to those living with HIV, and maximize the benefits of that treatment. Through these efforts, the number of new infections globally has dropped and the health of those living with HIV has improved. Despite this progress,

daunting challenges remain in making sure that those most in need of prevention, treatment, and support services receive them. Progress has not been equal across countries or communities. While effective responses to those challenges are known, the question remains: will we sustain the vision that lets us see the end of AIDS? This vision will become a reality only if we work together to ensure that every resource is engaged and used to maximum benefit. Because religious leaders, faith communities, and FBOs provide substantial, distinctive resources, strong collaboration with all of these faith-based partners is essential.

Over the past four years, UNAIDS and PEPFAR have been working with their faith-based partners to strengthen and deepen a common vision—the end of AIDS—in six key areas that align with the strategic priorities of UNAIDS<sup>25</sup>, PEPFAR<sup>26</sup>, other global funders, national governments, networks of people living with HIV, and service providers working on the ground:

- **A Vision for Evidence: Clarifying Contributions**
- **A Vision for Pediatric and Adolescent Treatment: Caring Through the Years**
- **A Vision for Capacity-Building: Producing Results**
- **A Vision for Gender Justice: Committing to Equity/Equality**
- **A Vision for Stigma Reduction: Healing Divisions**
- **A Vision for Advocacy: Sustaining Commitments**

This report examines these key areas in six chapters. In addition to describing these areas, each chapter also includes three other sections:

1. *From Vision to Reality: Activities of Implementing Partners*
2. *The Vision Multiplied: Snapshots of Faith-Based Organizations Working on the Ground*
3. *Building the Vision: Progress on the Recommendations of the The Gap Report and The Lancet Series.*

These three sections are described on the following page.

## 1. From Vision to Reality: Activities of Implementing Partners

The PEPFAR-UNAIDS FBO Initiative supports a variety of activities carried out by the following implementing partners:

- *The African Christian Health Association Platform (ACHAP)*
- *Black AIDS Institute (BAI)*
- *Caritas Internationalis*
- *The Ecumenical Advocacy Alliance of the World Council of Churches (WCC-EAA)*
- *The Ecumenical HIV and AIDS Initiatives and Advocacy program of the World Council of Churches (WCC-EHAIA)*
- *The World Young Women’s Christian Association (WYWCA), and*
- *An Academic Consortium of five universities*

A description of each of the partners can be found in Annex II.

## 2. The Vision Multiplied: Faith-Based Organizations Working on the Ground

Scores of faith-communities and FBOs are working at local, regional, and national levels to carry out a variety of

HIV prevention, treatment, and support initiatives. Each chapter in this report provides a series of snapshots to describe the work of some of these faith-based partners working on the ground to make the vision of a world without AIDS a reality. The FBOs featured here represent some of the faith-based partners working alongside UN-AIDS, PEPFAR, and the implementing partners of the FBO Initiative to carry out such work. While it is not possible to provide a comprehensive description of the multitude of FBO responses to HIV, these snapshots are intended to illustrate the breadth and scope of such responses.

## 3. Building the Vision: Progress on the Recommendations of *The Gap Report* and *The Lancet Series*.

This section of each chapter will draw from *The Gap Report* and the articles in *The Lancet Series*. Key recommendations from these two sources provide a framework for describing the progress of faith-based partners in global efforts to address HIV. This report describes the contributions of faith-based partners in carrying out the identified priority actions for four different groups: people living with HIV, adolescent girls and young women, members of key populations communities, and children and pregnant women living with HIV. The table below lists the four reasons identified in *The Gap Report* why some people in each of these four groups are left behind as well as the four priority actions to address those reasons.

Table 1: *The Gap Report* program priorities for four different groups

GROUPS	FOUR REASONS THIS COMMUNITY IS BEING LEFT BEHIND	FOUR PRIORITIES FOR CLOSING THE GAP
<i>People living with HIV</i> <sup>27</sup>	<ol style="list-style-type: none"> <li>1. Human rights violations, stigma, and discrimination</li> <li>2. Access to treatment and services</li> <li>3. Gender-based inequalities</li> <li>4. Criminalization and exclusion</li> </ol>	<ol style="list-style-type: none"> <li>1. Meaningful participation of people living with HIV</li> <li>2. Improve services, including community-based services</li> <li>3. Scale up antiretroviral therapy and integrated health services</li> <li>4. Increase treatment and rights awareness</li> </ol>
<i>Adolescent girls and young women</i> <sup>28</sup>	<ol style="list-style-type: none"> <li>1. Gender-based violence</li> <li>2. Lack of access to health services</li> <li>3. Lack of access to education</li> <li>4. Policies that do not translate into action</li> </ol>	<ol style="list-style-type: none"> <li>1. End all forms of gender-based violence</li> <li>2. Ensure access to quality health services</li> <li>3. Keep girls in school</li> <li>4. Empower young women and girls and challenge and change social norms</li> </ol>
<i>Members of key population communities</i> <sup>29</sup>	<ol style="list-style-type: none"> <li>1. Criminalization and punitive laws</li> <li>2. Absent or inadequate services</li> <li>3. Widespread societal stigma</li> <li>4. Violence</li> </ol>	<ol style="list-style-type: none"> <li>1. Decriminalize sex work and sex between consenting men, change focus of laws on drug use from incarceration to treatment</li> <li>2. Expand prevention, treatment, and support services</li> <li>3. Address institutionalized stigma and discrimination, empower key populations communities,</li> <li>4. Focus on those who commit violence rather than prosecuting those who experience violence. Develop protective social and legal environments.</li> </ol>
<i>Children and pregnant women living with HIV</i> <sup>30</sup>	<ol style="list-style-type: none"> <li>1. Limited access to sexual and reproductive health and HIV services</li> <li>2. Limited access to HIV treatment</li> <li>3. Failure to prioritize children</li> <li>4. Poorly integrated health-care services</li> </ol>	<ol style="list-style-type: none"> <li>1. Improve access to health and HIV services for all women and children</li> <li>2. Ensure treatment is available for all in need</li> <li>3. Invest in pediatric commodities and approaches</li> <li>4. Scale up integrated, family-centered health care services and information</li> </ol>

While *The Gap Report* provides a useful framework for describing the contributions of faith-based partners to priority activities identified by UNAIDS, *The Lancet Series* provides a parallel framework for describing the ways in which PEPFAR and UNAIDS are building the capacity of their faith-based partners to carry out their work. *The Lancet Series* has proven to be a benchmark on research into the emerging field of religion, health, and development because it systematically describes the substantial contributions of FBOs to health service delivery, identifies both

the distinctive opportunities and challenges involved in the partnerships between FBOs and public health and development funders and practitioners, and names key research topics for furthering our understanding of religion's influences on the fields of health and development.

The table below describes recommendations from *The Lancet Series* (2015), as well as the priority areas that must be addressed in order to implement those recommendations.

Table 2: **Key recommendations from *The Lancet Series* on faith-based health care**

RECOMMENDATION/SOURCE	PRIORITY FOCUSES
<p><b>Conduct research into the precise nature and implications of faith roles in HIV care and services (Karam, Clague, Marshall, and Olivier; Olivier et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ For service delivery research, move beyond simply calculating scope to include mixed method and comparative approaches that address reach, service to the poor, quality, trust, volunteer mobilization/support, and financing</li> <li>▪ Expand to traditions outside Christianity</li> <li>▪ Survey research and publish in non-Anglophone languages</li> <li>▪ Broaden focus to include areas beyond sub-Saharan Africa</li> <li>▪ Develop more robust conceptual understanding of religion</li> <li>▪ Research beyond service provision to encompass religion's social capacity to influence norms, perceptions, politics, and policies</li> </ul>
<p><b>Build on the lessons learned from the 2014-2015 Ebola outbreak (Marshall and Smith).</b></p>	<ul style="list-style-type: none"> <li>▪ Strengthen knowledge of religious demography, institutions, and relationships so that faith communities/FBOs could be readily mobilized</li> <li>▪ Strengthen approaches to community engagement carried out by public health organizations to be more systematic, multidisciplinary, and informed about/respectful of cultural norms, beliefs, and practices</li> <li>▪ Strengthen knowledge of the religious dimensions of behavior change (e.g., burials), and highlight the value of community expertise and the need to draw on it more purposefully and systematically</li> </ul>
<p><b>Develop research initiatives in health systems strengthening for faith-based, non-profit health providers. (Olivier, et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Identify strategies for health providers to adapt to changing financing</li> <li>▪ Document the contribution of faith-based health providers to universal health coverage</li> <li>▪ Build infrastructure for capacity-building, focusing on joint strengthening of programmatic and administrative capacities</li> </ul>
<p><b>Develop research initiatives on the influences of religion on cultural, social, and political norms and perspectives. (Tomkins, et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Describe similarities and differences on norms and perspectives <i>within</i> a religious tradition and <i>across</i> religious traditions</li> <li>▪ Focus on the effects of religion's influences on marginalized populations.</li> <li>▪ Develop platforms for identifying shared commitments between religious leaders and health policy-makers</li> </ul>
<p><b>Strengthen multisectoral partnerships that include governmental programs, civil society organizations, FBOs/health providers, and local faith communities (Buckingham and Duff).</b></p>	<ul style="list-style-type: none"> <li>▪ Measure and improve communication of the scope, scale, distinctiveness, and results of faith-based groups' work in health care</li> <li>▪ Appreciate respective objectives, capacities, differences, and limitations.</li> <li>▪ Increase investments in faith-based groups, while requiring transparent fiscal management</li> <li>▪ Exchange and build core competencies in health and faith in both secular and faith-based groups, and inspire innovation and courageous leadership</li> <li>▪ Refrain from using religious teachings to undermine evidence-informed public health practices; refrain from using secularist ideology to undermine effectiveness of faith-based groups' work in health</li> </ul>



Each chapter of this report will use these two tables to describe the progress made through the FBO Initiative in building FBO capacity and in employing that capacity to address the primary drivers of disparities in health outcomes for people living with HIV.

We invite you to read further about the work of faith partners across these six focus areas and commit yourselves to the vision described on the following pages—the end of AIDS.



PHOTO: WCC/Paul Jeffrey



The purpose of this chapter is twofold. First, the chapter describes findings from two research initiatives carried out by the Academic Consortium, an implementing partner of the UNAIDS/PEPFAR FBO Initiative. In Kenya, the consortium conducted a secondary analysis of national health services data to calculate the percentage of HIV services offered by faith-based health providers (FBHPs). In Tanzania, the consortium conducted a comparative case study of HIV services offered by an FBHP and by a governmental health facility to assess differences in clinical outcomes, costs, and patient satisfaction. Second, the chapter describes efforts to coordinate the capacities and contributions of national level faith-based health systems by describing the work of implementing partners in this area. This report uses the UNAIDS definition of an FBO: “faith-based organizations are defined as faith-influenced non-governmental organizations. They are often structured around development and/or relief service delivery programs and are sometimes run simultaneously at the national, regional and international levels. A faith-based health provider (FBHP) is an FBO that provides health services.”<sup>31</sup>

Faith-based partners offer substantial, essential resources for achieving the vision of a world free of AIDS. In 2006, research carried out by two members of the Academic Consortium—the International Religious Health Assets Programme (formerly the African Religious Health Assets Programme) at the University of Cape Town and the Interfaith Health Program at Emory University—published findings from a study of religious health assets in addressing the HIV epidemics in Zambia and Lesotho. The study,

sponsored by the World Health Organization (WHO), made clear the substantive contributions of FBHPs both in tangible (e.g., in the scope of services provided) and intangible (e.g., in the trust offered to FBOs and religious communities by people in local communities) ways. The method of religious health asset mapping employed in the study and detailed in the report of the work<sup>32</sup> has demonstrated that faith-based partners provide substantive and essential resources to improve the health of people around the world. However, the depth and reach of those resources is not clear. For a number of years, there have been varied, numerous claims about the contributions of FBHPs to health service provision; such claims generally name the percentage of health services provided by the faith-based sector in a range of 30-70%. In fact, efforts to track the source of those claims has demonstrated that they are anecdotal, with little foundation in any quantitative analysis.<sup>33</sup> Efforts to end AIDS will require a clear understanding of the capacity of partners working on the ground to provide HIV care and treatment. For this reason, quantitative assessments of FBHP contributions as conducted by the FBO Initiative are important.

The UNAIDS/PEPFAR FBO Initiative is working to build knowledge that will advance our understanding of the contributions of FBHPs. When the initiative was launched, it identified a number of universities to support an Academic Consortium that would carry out research and provide technical support to implementing partners as they carry out their work.

### **The Academic Consortium of the UNAIDS/PEPFAR FBO initiative is comprised of the following universities:**

Emory University (Atlanta, USA)

St. Paul’s University (Limuru, Kenya)

University of Cape Town (Cape Town, South Africa)

Muhambili University of Health and Allied Sciences (Dar es Salaam, Tanzania)

University of Jos (Jos, Nigeria)

In 2017, the Academic Consortium conducted a secondary analysis of HIV health services data in Kenya, calculating the percentage of services offered by FBHPs.<sup>34</sup> To allow for greater granularity in the analysis, the services were calculated down to an individual facility level. The key findings in the analysis are summarized below.

## HIV Services Provided by FBHPs in Kenya

### The percentage of health facilities in Kenya that are owned by religious organizations

In 2017, the master list of all licensed health facilities in Kenya listed 10,941 separate facilities; of these, 1,005 identified as faith-based facilities (see <http://kmhfl.health.go.ke>). Kenya has three national-level faith-based health systems. The **Christian Health Association of Kenya (CHAK)** is a network of facilities founded and supported by Protestant Christian denominations or congregations. The **Kenya Episcopal Conference (KEC)** of the Kenya Conference of Catholic Bishops represents facilities founded and supported by Roman Catholic dioceses across Kenya. The **Supreme Council of Kenya Muslims (SUPKEM)** represents health facilities founded

and supported by local mosques across Kenya. In addition to these faith-based health systems, a number of independent FBOs provide health services. Taken as a whole, faith-based facilities represent just over 9% of all health facilities in the country. In certain areas of service provision, the percentage is higher; for example, FBHPs comprise almost 15% of voluntary counseling and testing (VCT) centers and 16% of primary care hospitals. CHAK facilities comprise about 34% of all FBHPs, KEC provides 39%, SUPKEM provides about 1% and other faith-based facilities make up the remaining 26%.<sup>35</sup> While the CHAK, KEC, and SUPKEM networks are well-known, established partners in the provision of health care in Kenya, this group of “other providers” is diverse and not well connected, either to these existing networks or to each other.

Table 1.1: Number and percentage of faith-based health facilities

	FAITH-BASED ORG. (TOTAL)	CHAK	KEC	SUPKEM	OTHER FAITH-BASED	ALL FACILITIES	% FAITH-BASED
<b>ALL REGISTERED HEALTH FACILITIES</b>	1,005	339	391	12	263	10,941	9.2%
<b>Selected types of facilities</b>							
Basic Primary Health Care Facility	184	52	81	1	50	1,588	
Comprehensive Primary Health Care	11	2	5	1	3	186	5.9%
Dispensary	679	257	241	9	172	4,593	14.8%
Medical Clinic	6	2	3	0	1	3,552	<1%
Primary Care Hospital	62	10	34	1	17	387	16.0%
Secondary Hospital	4	1	3	0	0	29	13.8%
Stand-Alone VCT Centre	21	4	7	0	10	141	14.9%
<b># of facilities offering HIV Services</b>							
Prevention	342	94	144	3	101	3,788	9.0%
Treatment	189	50	95	1	43	1,580	12.0%
Risk reduction for key populations	104	32	48	1	23	1,062	9.8%
Risk reduction for priority populations and priority geographical areas	74	21	37	1	15	874	8.5%
HIV Testing	331	90	140	3	98	3,582	9.2%
PMTCT	251	64	116	3	68	2,497	10.1%

Source of data: Kenya Master Health Facility List (<http://kmhfl.health.go.ke>)

The numbers on the previous page reflect facilities across four sectors—governmental, faith-based, non-governmental, and private practice. Of these four sectors, two—non-governmental and faith-based—represent not-for-profit private providers who provide a substantial proportion of the services to people with lower incomes.<sup>36</sup> Faith-based facilities comprise 75% of this sector and 78% of the health facilities offering various

types of HIV services, including prevention, treatment, risk reductions for key populations, risk reduction for priority populations and priority geographic areas, and prevention of vertical transmission (PVT) of HIV (see Table 2). In short, faith-based facilities provide essential coverage that supplements services provided by government facilities for Kenyans living with HIV without a significant source of payment for those health services.

Table 1.2: **Not-for-profit private health facilities (faith-based and non-governmental)**

	FAITH-BASED ORGANIZATIONS	NON-GOVERNMENTAL ORGANIZATIONS	% FAITH-BASED
<b>ALL REGISTERED HEALTH FACILITIES</b>	<b>1005</b>	<b>329</b>	<b>75.3%</b>
<b><i>Selected types of facilities</i></b>			
Basic Primary Health Care Facility	184	44	80.8%
Comprehensive Primary Health Care	11	3	78.6%
Dispensary	679	2	99.7%
Primary Care Hospital	62	13	82.7%
Secondary Hospital	4	0	100%
Stand-Alone VCT Centre	21	76	21.6%
<b><i># of facilities offering HIV Services</i></b>			
Prevention	342	95	78.3%
Treatment	189	50	79.1%
Risk reduction for key populations	104	55	65.4%
Risk reduction for priority populations and priority geographical areas	74	45	62.2%
HIV Testing	331	90	78.6%
PMTCT	251	36	87.5%
<b>TOTAL</b>	<b>1291</b>	<b>371</b>	<b>77.7%</b>

Source of data: Kenya Master Health Facility List (<http://kmhfl.health.go.ke>)

## The percentage of HIV services by FBHPs in Kenya's high-priority counties

The Kenya AIDS Strategic Framework<sup>37</sup> focuses programs and services in Kenyan counties with the highest incidence of HIV infection and the highest disease burden. Incidence refers to the number of new infections per 100 residents annually and burden refers to the cumulative total number of people living with HIV. Table 1.3 summarizes data from the Kenya Health Information System (HIS) on HIV treatment encounters. The table shows the aggregate numbers of HIV clinical visits provided to people living with HIV who are on regular antiretroviral treatment (ART) to prevent or slow the progression of HIV disease. The number of clinic visits for adults (>15 years of age), children (0-15 years of age), and total number (the sum of adult and children visits) are summarized for the high,

medium, and low incidence clusters across all health facilities. The Kenya HIS allows users to disaggregate data to facility level in order to determine the percentage of HIV services provided by the identified FBHPs in the county clusters. The table reflects this, showing the number of visits provided by FBHPs in 2017 (the last year in which full data were available when the Academic Consortium conducted this analysis) and the overall percentage of visits provided by the faith-based sector. Nationally, FBHPs provide just over 20% of all of all patient visits for HIV-related treatment with ART therapy in hospitals or clinics (henceforth 'treatment visits') and almost 25% of pediatric treatment visits.<sup>38</sup> Across all 47 counties, the percentage of adult and pediatric HIV treatment visits provided by FBHPs ranges from a high of 56% in Tharaka-Nithi (adult) and 58% in Nairobi (pediatric) to 0% for both adult and pediatric visits in Mandera County.

Table 1.3: Composite number of HIV clinical visits along with number and percentage of visits by faith-based providers in high, medium, and low-incidence counties

	VISITS BY ADULTS CURRENTLY ON ART	VISITS BY ADULTS CURRENTLY ON ART SEEN BY FBHPS	% OF VISITS PROVIDED BY FBOS	VISITS BY CHILDREN CURRENTLY ON ART	VISITS BY CHILDREN CURRENTLY ON ART SEEN BY FBHPS	% OF VISITS PROVIDED BY FBOS	VISITS BY ALL CURRENTLY ON ART	VISITS BY ALL CURRENTLY ON ART SEEN BY FBHPS	% OF VISITS PROVIDED BY FBOS
<b>High 9 COUNTIES</b>	3,557,403	536,625	15.1%	373,834	60,854	16.3%	3,931,237	597,479	15.2%
<b>Medium 28 COUNTIES</b>	4,305,227	1,097,596	25.5%	416,220	133,121.4	32.0%	4,721,447	1,230,717	26.1%
<b>Low 10 COUNTIES</b>	945,912	151,872	16.1%	104,120	23,624	22.7%	1,050,032	175,496	16.7%
<b>NATIONAL TOTAL</b>	8,808,542	1,786,093	20.3%	894,174	217,599	24.3%	9,702,716	2,003,692	20.7%

Note: The numbers in this table are the sum of reported visits by health facility in each cluster (for the overall numbers) and by each FBHP in each cluster (for the numbers provided by FBHPs). The percentage is calculated by dividing the number of visits by FBHPs by the overall number. The data on reported visits is derived from the Kenya Health Information System ([hiskenya.org](http://hiskenya.org))

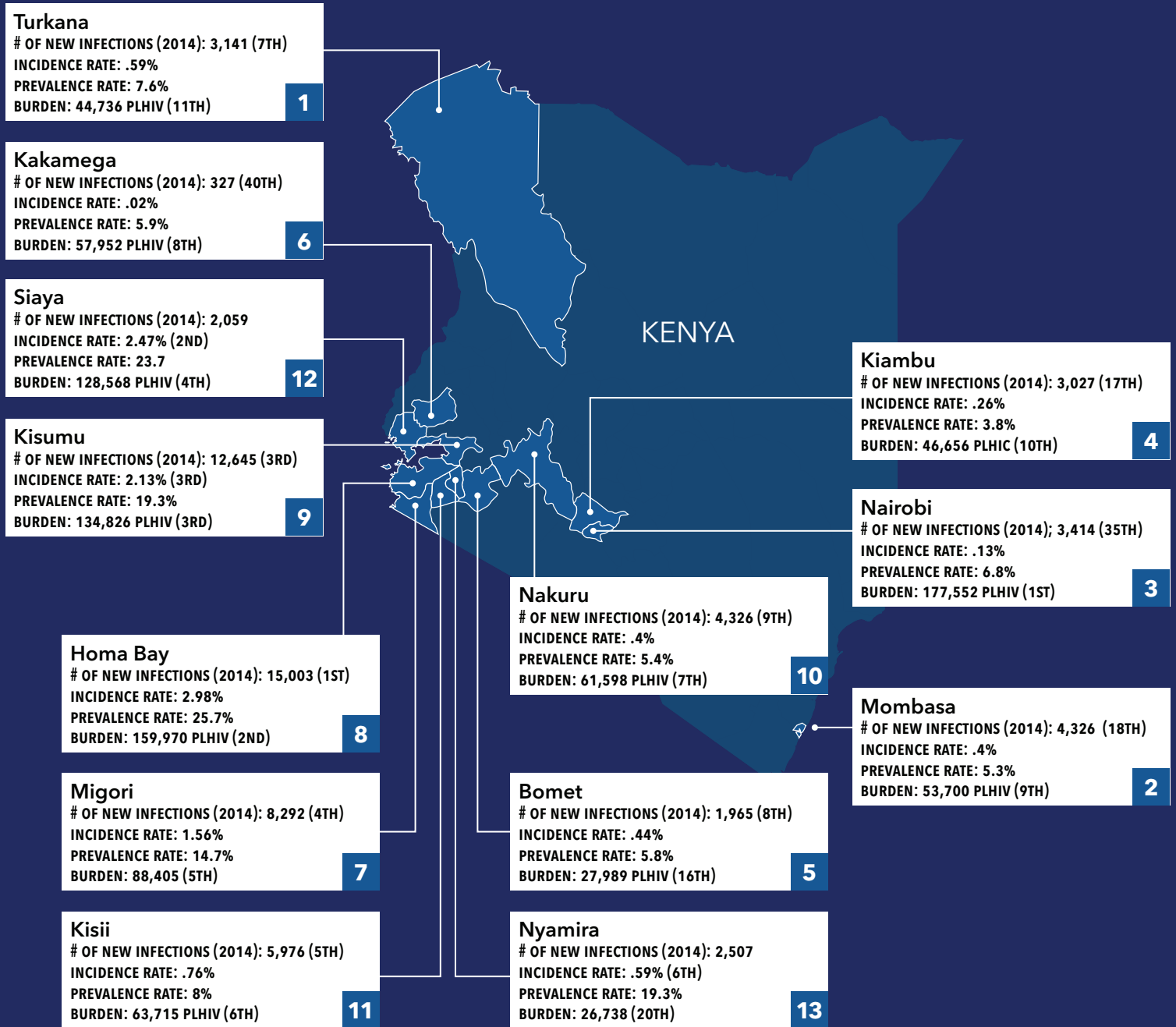
The country's AIDS strategic framework also focuses on 10 high-burden counties. According to Kenya HIS data, 24.1% of adult HIV treatment visits were provided by FBHPs across the high-burden cluster (Range: 48.3% (adult) in Mombasa and 58% (pediatric) in Nairobi to 10.3% (adult) and 9.3% (pediatric) in Siaya). For a full breakdown on the number and percentage of HIV clinical visits in each of Kenya's 47 counties, see <http://ihpemory.org/kenya-overview/kenya-county-data/>

Identifying, mobilizing, and maximizing resources in high-incidence counties is essential because they represent the areas with the highest number of new cases. Likewise, such resources are essential in high-burden counties because they represent the areas with the highest number of people living with HIV. Because many

counties are both high-incidence and high-burden, a total of thirteen counties emerge as high priority—counties which fit into at least one of these two clusters. Table 1.4 shows that 25% of adult HIV clinical visits and 26% of pediatric clinical visits in these high-priority counties were provided by FBHPs with 25% of all visits provided by the faith-based sector. 1,072,405 people living with HIV are residents of these 13 counties, representing 71.5% of the national estimate of 1,500,000 people living with HIV in Kenya.<sup>39</sup> In data provided in the *Kenya HIV Prevention Roadmap*, the document that laid out the prevention strategy for focusing on high-, medium-, and low-priority counties, 67,008 people across these 13 counties were newly infected with HIV in 2014, 66.0% of the 101,573 new infections nationally.<sup>40</sup>

# FIGURE 1 AND TABLE 1.4: NUMBER AND PERCENTAGE OF HIV CLINIC VISITS PROVIDED BY FBHPs IN ALL PRIORITY COUNTIES

(RANKED BY PERCENTAGE OF ALL HIV VISITS TO THOSE CURRENTLY ON ART PROVIDED BY THE FAITH-BASED SECTOR)



RANK	COUNTY	ADULTS CURRENTLY ON ART	ADULTS CURRENTLY ON ART SEEN BY FBHPS	% FAITH-BASED	CHILDREN CURRENTLY ON ART	CHILDREN CURRENTLY ON ART SEEN BY FBHPS	% FAITH-BASED	ALL CURRENTLY ON ART	ALL CURRENTLY ON ART SEEN BY FBHPS	% FAITH-BASED
1	Turkana	50,868	27,310	53.7%	7,612	4,456	58.5%	58,480	31,766	54.3%
2	Mombasa	383,693	185,509	48.3%	32,282	17,796	55.1%	415,975	203,305	48.9%
3	Nairobi	1,259,858	504,588	40.1%	88,710	67,378	76.0%	1,348,568	571,966	42.4%
4	Kiambu	289,051	100,017	34.6%	23,037	7,853	34.1%	312,088	107,870	34.6%
5	Bomet	72,539	23,209	32.0%	8,721	2,037	23.4%	81,260	25,246	31.1%
6	Kakamega	311,665	67,725	21.7%	36,850	7,122	19.3%	348,515	74,847	21.5%
7	Migori	518,810	106,301	20.5%	55,945	12,021	21.5%	574,755	118,322	20.6%
8	Homa Bay	823,777	132,557	16.1%	86,566	17,441	20.1%	910,343	149,998	16.5%
9	Kisumu	819,666	113,154	13.8%	80,536	12,216	15.2%	900,202	125,370	13.9%
10	Nakuru	274,890	35,400	12.9%	27,041	2,954	10.9%	301,931	38,354	12.7%
11	Kisii	216,397	26,841	12.4%	22,407	2,746	12.3%	238,804	29,587	12.4%
12	Siaya	672,645	69,292	10.3%	72,275	6,717	9.3%	744,920	76,009	10.2%
13	Nyamira	107,811	2,561	2.4%	12,731	266	2.1%	120,542	2,827	2.3%
	<b>TOTAL</b>	<b>5,801,670</b>	<b>1,394,464</b>	<b>24.0%</b>	<b>554,713</b>	<b>161,003</b>	<b>29.0%</b>	<b>6,356,383</b>	<b>1,555,467</b>	<b>24.5%</b>

Sources of data: Kenya Health Information System (<http://hiskenya.org>), Kenya AIDS Strategic Framework (2015) ([https://nacc.or.ke/wp-content/uploads/2015/09/KASF\\_Final.pdf](https://nacc.or.ke/wp-content/uploads/2015/09/KASF_Final.pdf))

The percentages of visits provided by FBHPs varies widely across the counties. The highest percentage of 54% is found in Turkana County—a large, predominantly rural county in north western Kenya that encompasses almost 20% of the country’s entire land area. The lowest—at

only 2.3%-- is found in Nyamira County. FBHPs provide a substantial proportion of services in urban areas. This is especially true in Nairobi—where 45% of all visits were provided by FBHPs—and Mombasa—where 49% of all visits were provided by FBHPs.

Table 1.5: **Breakdown of faith-based facilities providing/not providing HIV services in high-priority counties**

COUNTY	# OF FBHPS OFFERING HIV SERVICES	TOTAL # OF FBHPS	FBHPS NOT PROVIDING HIV SERVICES
Bomet	3	6	<b>3 (50%)</b> CHAK: 1, KEC: 1, SUPKEM: 0, OTHER: 0
Turkana	19	40	<b>21 (52.5%)</b> CHAK: 8, KEC: 13, SUPKEM: 0, OTHER: 0
Nyamira	15	16	<b>1 (6.3%)</b> CHAK: 1, KEC: 0, SUPKEM: 0, OTHER: 0
Kisumu	15	19	<b>4 (21.1%)</b> CHAK: 1, KEC: 3, SUPKEM: 0, OTHER: 0
Nakuru	8	55	<b>47 (85.5%)</b> CHAK: 20, KEC: 7, SUPKEM: 1, OTHER: 19
Homa Bay	19	29	<b>10 (34.5%)</b> CHAK: 6, KEC: 4, SUPKEM: 0, OTHER: 0
Siaya	15	17	<b>1 (5.9%)</b> CHAK: 1, KEC: 0, SUPKEM: 0, OTHER: 0
Migori	15	28	<b>13 (46.4%)</b> CHAK: 8, KEC: 5, SUPKEM: 0, OTHER: 0
Kisii	12	17	<b>5 (29.4%)</b> CHAK: 3, KEC: 2, SUPKEM: 0, OTHER: 0
Nairobi	46	110	<b>64 (58.2%)</b> CHAK: 21, KEC: 19, SUPKEM: 2, OTHER: 22
Mombasa	7	15	<b>8 (53.3%)</b> CHAK: 2, KEC: 4, SUPKEM: 0, OTHER: 2
Kakamega	18	31	<b>13 (41.9%)</b> CHAK: 2, KEC: 2, SUPKEM: 0, OTHER: 9
Kiambu	13	75	<b>62 (82.7%)</b> CHAK: 19, KEC: 18, SUPKEM: 1, OTHER: 24
<b>TOTALS</b>	206	458	<b>252</b> <b>55% OF ALL FBHPS IN HIGH PRIORITY COUN- TIES ARE NOT PROVIDING HIV SERVICES</b> <b>CHAK: 93; KEC: 78; SUPKEM: 4; OTHER: 77</b>

Source of data: Kenya Master Health Facility List (<http://kmhfl.health.go.ke>)



Any strategy for reaching the end of AIDS in these high-priority counties will require all resources to be identified and maximized. While FBHPs are clearly currently providing essential services in these counties, the potential contributions of FBHPs that are working in the counties but are not currently providing HIV services are not yet known. While table 1.5 shows that 252 FBHPs working in the 13 high-priority counties are not currently providing any HIV clinical care, the actual service capacity represented by these providers is not known. Further, the available data offer no insights into possible expansion of capacity among the 208 FBHPs that do provide HIV clinical services in the high-priority counties. Finally, 30% of the FBHPs not currently providing HIV clinical services are not part of existing, established faith-based health networks (CHAK, KEC, or SUPKEM) and efforts to enlist them as partners in HIV care would have to be carried out site by site. Nonetheless, in planning for increased services in areas with high HIV incidence and burden, identifying and mobilizing untapped or underutilized capacities will be important in order to achieve universal access to HIV services; while the resources for such expansion can come from many sectors (including expansion of services in governmental facilities), FBHPs may also provide substantial resources toward these objectives.

The data on HIV health services in Kenya demonstrate the substantial and essential contribution of FBHPs. In summary, the analysis of that data reveals that:

- FBHPs account for ~9% of all health facilities in the country
- FBHPs provide ~20% of all HIV clinical visits to people living with HIV on ART in Kenya
- Among the 13 high-priority counties with the highest HIV incidence rates and HIV burden, FBHPs provide ~25% of all health services.
- While FBHPs affiliated with Christian communities provided the majority of HIV services provided by the faith-based sector, FBHPs supported by Muslim communities provided substantial services in some communities. This is true especially in Mombasa, where Muslim FBHPs provided over 35% of HIV services.
- Over 25% of HIV services provided by FBHPs occur in organizations not affiliated with Kenya's national faith-based networks. While some of these facilities may offer substantive services and may be trusted among residents in their local communities, no information about the organizational structure, capacities, or quality of care among these organizations is known and further research on these organizations is urgently needed.

## Beyond the Data: A Comparative Case Study in Tanzania

Calculating the percentage of HIV services offered by FBHPs is important because it provides quantifiable data rather than mere anecdotal claims; nonetheless, it does not contribute to an analysis of the relative advantages or disadvantages of services provided by FBHPs in comparison to other types of providers and the ways in which FBHPs complement national HIV service delivery. Such comparative analyses are expensive, resource-intensive, and time consuming because they require an analysis of various types of data, including clinical records, fiscal data, and qualitative data on patients' and providers' perceptions. The FBO Initiative supported a pilot of this type of comparative case study in Tanzania.

Researchers at the University of Cape Town (UCT), a member of the Academic Consortium of the FBO initiative, conducted the case study across three different HIV treatment centers—a Christian, faith-based facility; a governmental facility managed by the Ministry of Health; and a governmental facility managed by the local government.<sup>41</sup> Data from the two governmental facilities were combined and compared to data from the faith-based facility. UCT researchers surveyed a total of 618 people living with HIV seeking care at these facilities to assess affordability, availability, and acceptability. 336 people living with HIV from the faith-based facility and 282 people living with HIV from the governmental facilities were surveyed. Findings were disaggregated by demographic variables, including gender, age, educational attainment, years living with HIV infection and in HIV care, and marital status. Researchers also gathered data from clinical records to assess retention in care and optimal clinical outcomes in HIV care. Case studies are useful methods for an in-depth analysis of a strictly identified and controlled context; however, the findings from a single case study do not offer generalizable data for facilities beyond the narrow context in which the case study occurred.

### Findings on clinical outcomes and retention in care

Indicators for this measure provide information on the clinical management of HIV disease and successes or challenges in managing HIV disease progression.

INDICATOR	FAITH-BASED FACILITY N=336	GOVERNMENT FACILITY N=282
Mean # of years with HIV	9	7
Mean # of years on ART	8	7
Mean CD4 count with standard deviation in parenthesis	635 (320)	505 (332)
Self-reported adherence to ART regimens	94%	95%
Late appointments in the last year:		
0	62% (207/336)	53% (151/282)
1-2	35% (117/336)	39% (109/282)
>2	3% (12/336)	8% (22/282)

#### What does this analysis reveal?

Indicators of clinical outcomes among patients in both facilities demonstrate both successes and causes for concern in the clinical management of HIV disease. There were high levels of patients reporting for their medical visits (only 3% of patients in the faith-based facility and 8% of patients in the governmental facilities missed two or more appointments). On average, people living with HIV seen by the faith-based facility had been on ART regimens longer (8 years v. 7 in the governmental facilities) and had been living with HIV longer (9 years v. 7 years in the governmental facilities); this same group of patients had a higher CD4 count (635) than the count of patients seen in governmental facilities (505). The standard deviation across the range of counts for all participants indicates a large variation in CD4 counts; the standard deviation for patients in the faith-based facility was 320 while it was 332 for patients in the governmental facilities. CD4 cells are a type of blood cell that comprise the body's immune system in part; HIV targets these cells, destroying them as the virus replicates and thereby weakening the immune system. Lower CD4 counts indicate a compromised immune system and the CD4 counts in both groups of patients indicate an intact immune system.

#### Findings on availability of services

Indicators for this measure provide information on the extent to which facilities provide the kinds of services that people living with HIV most value with minimal disruption to patients' schedules.

INDICATOR	FAITH-BASED FACILITY N=336	GOVERNMENT FACILITY N=282
Attend closest clinic	17% (56/336)	37% (105/282)
Mean time in minutes to travel to clinic	74	57
Hours of clinic convenient (% yes)	91% (306/336)	89% (251/282)
Mean time in hours at clinic	4.1	2.8
Other chronic health condition? (% yes)	29% (98/336)	16% (45/282)
Of those with a chronic health condition, received care for both at the clinic (% yes)	99% (97/98)	96% (43/45)

#### What does this analysis reveal?

A majority of patients in both types of facilities live closer to another facility which could provide them with HIV services but opt to attend these clinics. And so, while the location of these facilities is not as convenient to the patients seen there when measured by distance, in fact, patients are choosing to attend these facilities over those which are closer. Some of those surveyed indicated that they chose the more distant facilities to avoid possible stigmatization if members of their community inadvertently saw them reporting to an HIV clinic in their local area. Patients spent between

two to three hours in transit to and from the facilities (one-way transport to the faith-based facility was 74 minutes versus 57 minutes to the governmental facility), though many patients seemed to be willing to take this amount of time in order to receive care at the more distant facilities. In fact, approximately 90% of patients said the operating hours of the facilities were convenient. The faith-based facility saw a higher proportion of patients with other chronic health conditions than did the governmental facilities (29% versus 16%). On average, patients seen in the faith-based facility spent more time at each visit than those seen by the governmental facilities (4.1 hours versus 2.8); while the complexity of providing care for multiple chronic conditions to a majority of the patients in the faith-based facilities (60% versus 37% for the government facilities) may contribute to this increased time, such an increase could represent an inconvenience for patients.

### **Findings on acceptability of services**

Indicators for this measure provide information on the extent to which facilities offer patient-centered care and work with patients in respectful ways.

INDICATOR	FAITH-BASED FACILITY	GOVERNMENT FACILITY
Providers always listen	96%	91%
Treated respectfully	94%	88%
Experienced negative judgement from facility staff	16%	19%
Saw medical doctor on the visit	98%	87%

### **What does this analysis reveal?**

On qualitative measures related to patients' perceptions that they were treated well, both types of facilities had high scores overall, with no significant differences between the two across most measures. Approximately 90% of patients in the facilities felt that providers always listened to them (96% in faith-based v. 91% in governmental facilities) and treated them with respect (94% in faith-based v. 88% in governmental facilities). The percentage who indicated that they had never experienced negative judgements from the health facility staff was not as high though still the majority (84% in faith-based v. 81% in governmental facilities). Only one measure demonstrated significance: patients were able to see a medical doctor on the majority of their visits on 98% of visits to faith-based facilities compared to 87% of visits to governmental facilities.

### **Findings on affordability of services**

Indicators for this measure provide information on the costs associated with seeking care in each type of facility.

INDICATOR	FAITH-BASED FACILITY	GOVERNMENT FACILITY
Has a form of health insurance	32%	10%
Formal employment	13%	11%
Mean monthly income (USD)	44	26
Borrowed money for healthcare (%Yes)	56%	54%
Sold asset to pay for care	26%	20%
Reduced number of meals	42%	49%
Mean direct cost of a clinic visit (in US dollars)	\$1.6	\$0.10
Mean other costs (in US dollars) (food, transportation, accommodation)	\$2.3	\$1.4
Mean annual costs for care (in US dollars) (including direct, other, and indirect costs reflecting time lost at work for visits)	\$27.2	\$11.6

## What does this analysis reveal?

Out-of-pocket costs were substantially higher for patients in the faith-based facility than for those in the governmental facilities. The direct cost for each clinic visit was \$1.60 (USD) in the faith-based facility v. just \$0.10 (USD) in the governmental facilities. Associated indirect costs such as transport, food, and accommodation were also higher in the faith-based facility when compared to the governmental facilities (\$2.30 v. \$1.40). Most patients had no formal employment (87% in the faith-based facility v. 89% in the governmental facilities). While the percentage differences on this indicator were minimal, differences on two other indicators were more divided. The average annual income for patients in the faith-based facility was approximately \$528 compared to \$312 in the governmental facilities and 32% of patients in the faith-based facility had some form of medical insurance v. only 10% of patients in the governmental facilities. On an annual basis, the average overall costs (direct and indirect) for care in the faith-based facility was more than double that of the governmental facilities (\$27.20 v. \$11.60). This represented approximately 5% of annual income for patients in the faith-based facility v. 4% for patients in the governmental facilities. Taken together, these findings challenge a common claim about FBHPs that they provide care to the poorest of the poor without regard to ability to pay.<sup>42</sup> While this analysis did not assess whether the FBHP refused care based on ability to pay, on the whole it did provide care to patients with an income that was higher on average than the income of patients seen in the governmental facilities.

## From Vision to Reality: Activities of Implementing Partners

### *The African Christian Health Association Platform (ACHAP)*

The findings described above demonstrate the substantial capacity of FBHPs to offer HIV clinical services. In countries such as Kenya and Tanzania, the majority of faith-based HIV services are provided through national-level networks of FBHPs known as Christian Health Associations (CHAs); CHAs function as national health systems that complement the governmental health system. The *African Christian Health Association Platform (ACHAP)*, one of the implementing partners in the FBO Initiative, represents CHAs across sub-Saharan Africa. As part of the FBO Initiative, ACHAP is working to build the capacity of these faith-based health systems (see Chapter 3 on capacity-building) and to support the development of a global database on faith-based health facilities in collaboration with the Health and Healing Programme of the WCC. That program convened a gathering of key stakeholders as part of the 2017 ACHAP Biennial meeting in Lesotho to set strategic plans for health and healing activities of the WCC.<sup>43</sup> Working in coordination with the WCC Programme, ACHAP is supporting efforts to implement such databases in Democratic Republic of the Congo (DRC) and in Nigeria in collaboration with

the Christian Health Association of Nigeria and Caritas Nigeria, the national member of Caritas Internationalis. This kind of global database is urgently needed in order to ensure a strategic deployment of resources in global HIV strategies and also to mobilize all health resources in response to a humanitarian emergency. In the 2014-2015 Ebola outbreak in western Africa, the lack of such a database hampered a rapid, coordinated response between governmental, civil society, and faith-based facilities.<sup>44</sup>

ACHAP plays an important role in building the capacity of these faith-based health systems and in linking service providers to FBOs and networks that provide medical supplies and essential medications to health facilities. These organizations represent a substantial contribution to national supply chains in many regions of sub-Saharan Africa. For example, the *Mission for Essential Drugs and Supplies (MEDS)*<sup>45</sup> has built a national supply chain infrastructure in Kenya that serves not only faith-based facilities but also ships such medications and supplies to other licensed health facilities.<sup>46</sup> With funding from PEPFAR, MEDS served as the primary supply chain for HIV medications in the country for a number of years. Similarly, ACHAP's partner *IMA World Health*<sup>47</sup> provides supplies and direct health services in a number of countries with poor health service infrastructures, including Sudan, South Sudan, and DRC through the Capacity-Plus project.<sup>48</sup> Finally, the *Ecumenical Pharmaceutical Network (EPN)*<sup>49</sup> is an ACHAP member that is building supply chain capacity across the region. EPN was begun as a program of the WCC before becoming a registered non-governmental organization in Kenya. CHAK supported EPN's launch, providing office space and personnel support. Now headquartered in Nairobi, EPN continues to work with ACHAP (which is also housed in the headquarters of CHAK) to coordinate supply distribution across the sub-Saharan region.

## The Vision Multiplied: Faith-Based Organizations Working on the Ground

### *Bomu Hospital and MEWA Hospital*

The networking and organizational capacity provided by the CHA structure makes possible the scope of the service provision described in this chapter. To focus only on this capacity, however, would miss important emerging organizations and capacities that do not operate in the same networked structure as the CHAs. For example, as was noted above, 26% of HIV health services are provided by FBHPs that are not part of Kenya's two CHA networks, CHAK (a network of facilities primarily supported by Protestant Christian communities) or KEC (a network of facilities sponsored by the Kenya Conference of Catholic Bishops). Many of these providers are Christian facilities that are not in either network, but there are also substantial HIV services provided by Muslim facilities. In Kenya, some of these facilities are affiliated with SUPKEM but others are independent Muslim facilities providing care to thousands of people.

For example, in Mombasa County, two Muslim FBHPs account for 90% of all treatment visits to people living with HIV on ART that are provided by the faith-based sector. In fact, these two facilities—*Bomu Hospital*<sup>50</sup> and the *Muslim Education and Welfare Association Hospital (MEWA)*<sup>51</sup>—account for 44% of all HIV treatment visits in the county, including those provided by governmental facilities. Further, these organizations seek to reach hard-to-reach and vulnerable communities. Bomu provides services to children, adolescent girls, and young women. An analysis of county-level data from the Kenya HIS reveals that 51% of all HIV treatment visits to girls under the age of 15 in Mombasa County and 50% of all pediatric visits (regardless of gender) were provided by Bomu. MEWA is a Muslim FBO that provides low-threshold outreach and harm reduction services to people who inject drugs, as well as step-up services that include both intensive outpatient treatment and residential treatment programs. MEWA sponsors specific programs for women and their children. Kenya HIS data reveal that MEWA provides 7,065 treatment visits to people who inject drugs living with HIV and 160 visits to children living with HIV whose parents are people who inject drugs living with HIV.

## Understanding the Vision: Further Information on the Topics Discussed in this Chapter

The Interfaith Health Program (IHP) at Emory University, is one of the academic partners of the UNAIDS/PEPFAR FBO Initiative. IHP has placed the health services data for Kenya online. From these web pages, readers can see the percentage of adult HIV, pediatric HIV, and voluntary counselling and testing visits provided by FBHPs on a count-by-county basis. The geospatial location and contact information of the FBHPs in each county is also available; the names of all faith-based facilities in each county are provided, including those that did not report any HIV service data. For further information, go to: <http://ihpem-ory.org/kenya-overview/>

The University of Cape Town is home to the International Religious Health Assets Programme (IRHAP). IRHAP has generated a significant amount of research of FBHPs, both for the FBO Initiative and in other activities. For information about IRHAP resources and research, go to: <http://www.irhap.uct.ac.za/> and click on the “research” and “resources” tabs. Jill Olivier, director of IRHAP, co-edited a 3-volume series on faith-based health care. The volumes are:

- *The Role of Faith-Inspired Health Care Providers in Sub-Saharan Africa and Public-Private Partnerships: Strengthening the Evidence for Faith-inspired Health Engagement in Africa, Vol 1.* <http://hdl.handle.net/10986/13572>
- *The Comparative Nature of Faith-Inspired Health Care Provision in Sub-Saharan Africa: Strengthening the Evidence for Faith-inspired Health Engagement in Africa Vol 2.* <http://hdl.handle.net/10986/13570>

- *Mapping, Cost, and Reach to the Poor of Faith-Inspired Health Care Providers in Sub-Saharan Africa and Public-Private Partnerships: Strengthening the Evidence for Faith-inspired Health Engagement in Africa Vol 3.* <http://hdl.handle.net/10986/13573>

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- For information on the **African Christian Health Association Platform (ACHAP)**, visit the organization’s website at: <https://africachap.org>
  - For information on the **Mission for Essential Drugs and Supplies (MEDS)**, visit the organization’s website at: <http://www.meds.or.ke>. For a case study on MEDS published by the World Health Organization, visit: [https://www.who.int/hiv/pub/prev\\_care/meds/en/](https://www.who.int/hiv/pub/prev_care/meds/en/)
  - For information on **Bomu Hospital**, please visit the organization’s website at: <http://www.bomuhospital.org>
  - For information on the **Muslim Education and Welfare Association (MEWA)**, please visit: <https://www.mewa.or.ke>. For information on the MEWA hospital, go to: <https://www.mewa.or.ke/projects/mewa-hospital>.
  - Information on the **Ecumenical Pharmaceutical Network** can be found at: <https://www.epnetwork.org>
  - For information on **IMA World Health**, visit the organization’s website at: <https://imaworldhealth.org>
  - The **Joint Learning Initiative on Faith and Local Communities (JLIFLC)** is an open-source learning platform that documents the contributions of FBOs and religious communities on health and development initiatives. JLIFLC makes considerable resources available through its website, including resources on HIV and health care provision: [https://jliflc.com/resources/?\\_topics%5B%5D=54](https://jliflc.com/resources/?_topics%5B%5D=54)

## Building the Vision: Progress on the Recommendations of *The Gap Report* and *The Lancet Series*

This chapter has provided evidence to show the potential scope of services, looking at examples from Tanzania and Kenya to understand the scope of services provided by faith-based partners that address the following priorities laid out in *The Gap Report*. While this chapter does not describe the types or qualities of these services, this information is found in subsequent chapters.

Table 1.6: *The Gap Report* program priorities addressed in this chapter

GROUPS	REASONS THIS COMMUNITY IS BEING LEFT BEHIND	PRIORITIES FOR CLOSING THE GAP
<i>People living with HIV</i>	<ul style="list-style-type: none"> <li>▪ Access to treatment and services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Augment health services offered by governmental programs, including community-based services</li> <li>▪ Scale up antiretroviral therapy and integrated health services</li> </ul>
<i>Adolescent girls and young women</i>	<ul style="list-style-type: none"> <li>▪ Lack of access to health services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure access to quality health services</li> </ul>
<i>Children and pregnant women living with HIV</i>	<ul style="list-style-type: none"> <li>▪ Limited access to sexual and reproductive health and HIV services</li> <li>▪ Limited access to HIV treatment</li> <li>▪ Poorly integrated health-care services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Improve access to health and HIV services for all women and children</li> <li>▪ Ensure treatment is available for all in need</li> <li>▪ Scale up integrated, family-centered health care services and information</li> </ul>

The following three key recommendations and priority focuses from the articles in the special issue of *The Lancet* (2015) are also explored in this chapter.

Table 1.7: Key recommendations from *The Lancet Series* addressed in this chapter

RECOMMENDATION/SOURCE	PRIORITY FOCUSES
<b>Conduct research into the precise nature and implications of faith roles in HIV care and services (Karam, Clague, Marshall, and Olivier; Olivier et. al.).</b>	<ul style="list-style-type: none"> <li>▪ For service delivery research, move beyond simply calculating scope to include mixed method and comparative approaches that address reach, service to the poor, quality, trust, volunteer mobilization/support, and financing</li> <li>▪ Expand to traditions outside Christianity</li> </ul>
<b>Build on the lessons learned from the 2014-2015 Ebola outbreak (Marshall and Smith).</b>	<ul style="list-style-type: none"> <li>▪ Strengthen knowledge of religious demography, institutions, and relationships so that faith communities/ FBOs could be readily mobilized</li> </ul>
<b>Strengthen multisectoral partnerships that include governmental programs, civil society organizations, FBOs/health providers, and local faith communities (Buckingham and Duff).</b>	<ul style="list-style-type: none"> <li>▪ Measure and improve communication of the scope, scale, distinctiveness, and results of faith-based groups' work in health care.</li> </ul>



PHOTO: Veronica Davison



Pediatric and adolescent HIV services reveal both the scope of contributions from FBOs and the tensions between proven HIV prevention efforts and the teachings of some religious traditions. This chapter examines both those contributions and tensions, highlighting the scope of pediatric HIV services provided by many FBOs and describing efforts by some faith-based partners to offer adolescent prevention and treatment services that include comprehensive SRH services.

A comprehensive approach to lowering incidence rates of HIV in children requires two approaches: prevention of vertical transmission (PVT) of HIV and comprehensive HIV clinical care and support for children and adolescents living with HIV and their families.<sup>52</sup> In recent years, investments in PVT of HIV have been successful in reducing the number of children born with HIV. However, diagnosis and treatment for children who are living with HIV remains a major challenge. The 2016 Political Declaration on HIV and AIDS includes a set of specific, time-bound targets for children and adolescents that must be reached by 2020 to end the AIDS epidemic by 2030 within the framework of the Sustainable Development Goals.<sup>53</sup> These targets were identified as an outcome of the first Vatican Dialogue on pediatric HIV convened by Cardinal Turkson and organized by Caritas Internationalis, UNAIDS, and PEPFAR in April 2016. In response to the Political Declaration, UNAIDS and PEPFAR launched the *Start Free, Stay Free, AIDS Free* framework for action in 23 focus countries in 2017 as a set of human rights-based interventions to end AIDS as a public health threat among children. The partnership has resulted in more babies being born HIV-free and children already living with HIV have been able to remain AIDS-free throughout adolescence and into adulthood. And yet, despite the progress made, only 54% of the 1.7 million children living with HIV globally are accessing life-saving ART.<sup>54</sup> There is, in short, much work still to be done.

Faith-based health providers, faith-based non-governmental organizations, and local religious communities are essential partners in that work not only because they provide substantial resources for pediatric HIV treatment and support services but also because they offer additional support services not always available in all facilities and because local communities often perceive them as trusted partners.<sup>55</sup> The faith sector is the largest nongovernmental provider of pediatric HIV service globally<sup>56</sup> and in 2012, religious communities donated an estimated five billion dollars annually to support HIV programs, an amount that approaches the funding by all bilateral and multilateral funders combined.<sup>57</sup>

A study in six sub-Saharan countries by the United Nations Children's Fund (UNICEF) and the World Conference of Religions for Peace (RFP) showed that religious orga-

nizations provided support services to 140,000 orphans and children, including children living with HIV. These services were carried out by a variety of FBOs, including local community-based organizations (CBOs), national or global nongovernmental organizations (NGOs), local religious communities, and religious coordinating bodies. Whereas faith-based CBOs and NGOs have secular equivalents in civil society, local congregations are unique from all other types of organizations providing pediatric services. The scope of their contributions is substantial. 74% (238 out of 322) of all faith-based pediatric initiatives identified in the six countries studied were carried out through local congregations.<sup>58</sup> UNICEF is not the only United Nations Cosponsoring agency that recognizes the contributions of faith-based partners to the progress made in pediatric HIV treatment. The United Nations Population Fund (UNFPA) has partnered with faith-based non-governmental organizations in support of pediatric HIV initiatives, adolescent reproductive rights and adolescent SRH in twenty-eight countries: Algeria, Bangladesh, Botswana, Brazil, Cambodia, Colombia, Egypt, Ghana, Guatemala, Honduras, Jamaica, Kenya, Kyrgyzstan, Madagascar, Malawi, Malaysia, Mauritania, Oman, Pacific Island Countries, Pakistan, Papua New Guinea, Philippines, Senegal, Sierra Leone, Tajikistan, Timor-Leste, Uganda, and Yemen. Faith-based partners working on the ground in partnership with UNFPA have represented a spectrum of religious traditions, including Buddhism, Christianity, Hinduism, Islam, Jainism, Sikhism, and Zoroastrianism.<sup>59</sup>

The contributions of faith-based partners are not limited to faith-based non-governmental organizations and local congregations. FBHPs also provide substantial pediatric HIV clinical services. The analysis of HIV treatment data carried out by the Academic Consortium demonstrates this. Across Kenya, 24% of all the treatment visits that provided ART to children living with HIV were provided by FBHPs. That percentage increases to 26% in the 13 counties with highest incidence and HIV disease burden; as noted in chapter one, FBHPs in three of those counties provided over half of all those treatment visits (59% in Turkana, 58% in Nairobi, and 55% in Mombasa).

Many faith-based providers of services for women living with HIV have made PVT programs a priority. In doing so, they help prevent new infections by ensuring that expectant mothers who are HIV-positive receive ART that keep them healthy while also lowering the likelihood of vertical transmission during pregnancy or the birth process. For children who are living with HIV, the services that these same faith-based partners provide are ensuring that many children living with HIV are growing into adolescence and adulthood. And yet, faith-based pediatric HIV programs face distinctive challenges in working to address the prevention and treatment needs of this rapidly growing



cohort of adolescents living with HIV. Some of these faith-based programs face a tension between religious or moral teachings on sexual behaviors championed by traditional or conservative religious traditions and a combination of HIV prevention messages, a reformation of traditional gender norms and roles, gender equality, and SRH services that are cornerstones of an effective public health response to addressing HIV in adolescents. Negotiating between these two frameworks is difficult, and faith-based pediatric HIV programs often struggle to address the HIV prevention and sexual health needs of these adolescents.<sup>60</sup>

Some faith-based pediatric HIV programs are working through these tensions to build adolescent HIV programs. For example, **The Eastern Deanery AIDS Relief Program (EDARP)** provides HIV services across 14 sites around Nairobi to over 26,000 children, adolescents, and adults living with HIV in Nairobi and over 90% have achieved and maintained complete viral load suppression.<sup>61</sup> Likewise, the **Mai Tom House of Hope** in Ho Chi Minh City, Vietnam, provides services for children and orphans living with HIV. As ART coverage for the children in the program has improved, the number of adolescents living healthily with HIV has grown, and the program has opened a separate residence for adolescents. The program is committed to providing not only HIV clinical care for these young people but also educational and economic support.<sup>62</sup> The **World YWCA (WYWCA)** provides funds to local organizations through the Power to Change Fund<sup>63</sup> to ensure that the voices of women and girls are heard in HIV prevention and support efforts. WYWCA also supports a safe spaces initiative to create an environment for inter-generational dialogue that examines the social factors that make women more vulnerable to HIV infection and works to address the stigma and discrimination that is often carried out by appealing to those social factors.<sup>64</sup>

In 2013, three faith-based networks - Caritas Internationalis, ACHAP and WCC-EAA (each of whom later became implementing partners of the UNAIDS/PEPFAR joint initiative) - convened a two-day consultation in Zambia on PVT with the support of UNAIDS. Over 70 participants representing governmental, secular civil society, networks of women living with HIV and Muslim and Christian organizations from 16 countries attended.<sup>65</sup> At the consultation, Dr. Dhally Menda, Director of Health Programs for the Churches' Health Association of Zambia (CHAZ)<sup>66</sup>, described the challenges inherent in providing PVT services and pediatric HIV treatment as well as their innovative efforts to address those challenges. Dr. Menda named three challenges:

1. Too few expectant mothers accessing antenatal care (ANC), especially in the first trimester, creating challenges for diagnosing HIV and offering PVT services

2. Too many deliveries in Zambia occur in the home, creating obstacles for following PVT protocols during labor and contributing to morbidity and mortality due to birth complications
3. A lack of HIV treatment and diagnostic services for children

Dr. Menda concluded that these three factors contribute to high rates of under-five mortality in Zambia, especially for children living with HIV. In response to these challenges, Dr. Menda outlined seven initiatives CHAZ has implemented to increase uptake of PVT, ANC, and pediatric HIV services:

- Deliver PVT services in locations most convenient for mothers. CHAZ offers PVT programs at 63 static and mobile sites, where they use a holistic, family-centered approach that complements government services, particularly in rural areas
- Create demand for PVT services by linking it to marriage counselling, post-test clubs, and other community mobilization efforts, and working with opinion leaders, health workers, and community-based health care workers (CHWs)
- Ensure the quality of PVT services by participating in the development and implementation of national policy and guidelines
- Advocate for resources and finances going to CHAZ members to ensure they can provide good leadership and good governance
- Encourage the development of high-quality community-based health care workers, volunteers, and services
- Supplement the national supply chain for medical and non-medical products by procuring ARVs and other commodities in line with the government standards
- Provide technical support to partners for reporting, monitoring and evaluation in order to improve service delivery<sup>67</sup>

Local faith communities, faith-based NGOs, and FBHPs have each provided substantial services to children living with HIV and their families, serving as some of the first providers of pediatric HIV services and still providing more services to orphans and vulnerable children than any other non-governmental sector across the world today.<sup>68</sup> As we work to make the vision of a world without AIDS a reality, the contributions of these faith-based partners will be essential.

## From Vision to Reality: Activities of Implementing Partners

Various implementing partners working on the UNAIDS/PEPFAR FBO Initiative are leading faith-based responses to pediatric and adolescent HIV services

### *Caritas Internationalis*

Since the Caritas Internationalis General Assembly in 1987, the Confederation has given priority attention to both global and local responses to the pandemic of HIV and AIDS, including the related epidemic of tuberculosis. Caritas has organized training of its own staff and volunteers, as well as those engaged in other Catholic Church structures, to develop compassionate, non-judgmental responses to those living with or affected by HIV. In 2009, Caritas Internationalis launched the HAART for Children Campaign, an advocacy campaign aimed at assuring child-friendly fixed-dose combinations to children living with HIV; within this framework, Caritas has helped organize regional and global consultations with national government partners, representatives from different faith traditions, UN staff, public health experts, young people, and people living with HIV, to build partners' capacity to care for children living with HIV, scale-up diagnostic and treatment tools, address PVT, and engage national and local FBOs to advocate for ongoing support of pediatric HIV care. One of the latest consultations was held in April 2016 in Rome, and set a roadmap for ongoing faith-based engagement on pediatric HIV by 1) naming the pressing challenges and obstacles to pediatric HIV services, 2) establishing priorities to further the gains made in treating pediatric HIV, and 3) identifying the core commitments of faith-based pediatric HIV providers and religious leaders. For each of these three areas, participants generated a list of topics which were influential in guiding future work of the initiative (see footnote for the list of topics).<sup>69</sup>

With the support of other partners within the UNAIDS/PEPFAR FBO Initiative and its national chapters, Caritas Internationalis organized a regional consultation, held in Abuja, Nigeria, in June 2017, aimed at promoting wider engagement of national and local FBOs as well as national government partners representatives from different faith traditions, UN staff, public health experts, young people, and people living with HIV in the overall program of action toward implementing the UNAIDS/PEPFAR Framework for Action "*Start Free. Stay Free. AIDS Free*" as well as the roadmap adopted in 2016. The focus of the regional consultation was on Eastern and Southern Africa and Western and Central Africa, with special focus on Nigeria, Zimbabwe and DRC. At the end of the consultation, participants drafted national action plans to strengthen the engagement of FBOs in early diagnosis and treatment for children living with HIV. These efforts were coordinated with pediatric HIV responses at the national level in each country.

In particular, Caritas Internationalis, supported by its national chapter, followed up the regional consultation

with sub-national trainings for religious leaders in Nigeria and DRC aimed at reducing stigma and discrimination towards children living with HIV and engaging religious leaders in identifying and referring children living with HIV to services. The GRAIL Project (Galvanizing Religious Actors for Accelerated Identification and Linkage to pediatric HIV) serves as a bridge between local congregations and accredited pediatric HIV health providers. The project trained priests and religious leaders of Catholic Church communities on pastoral and scientific aspects of effective treatment and support of people living with or at risk for HIV infection. These leaders could then deliver audience-appropriate HIV prevention and stigma reduction messaging to their communities and act as a bridge between identified health centers and their communities by leading teams of Church Health Advisors (ideally serving or retired health workers and volunteers). These advisors worked with high-risk mother and child pairs and tracked (1) immunization status; (2) recurrence of symptoms of communicable diseases such as fevers, diarrheal disease, respiratory tract infection, and skin infections assisted by a screening tool; and (3) referral for HIV testing and counseling and ART initiation where indicated. Furthermore, Caritas Nigeria and Caritas Congo ASBL (Caritas DRC) supported community-based medical outreach activities for children aged 0-15, with special attention to children 0-5. The two Caritas Internationalis member organizations, in collaboration with local church health teams and local health facilities, provided: (1) medical screening for children, including the identification of factors that increase HIV risk; (2) eye examinations; (3) medications for common childhood conditions; and (4) follow-up referrals for children with medical conditions that could indicate HIV infection. These initiatives were embedded in local congregations, which provided a structure for maintaining the activities over time without any significant outside funding or oversight.

After 12 months of intervention, GRAIL Nigeria trained 179 religious leaders (including 89 priests) covering 21 states (including high-priority states due to HIV prevalence). These trained clergy reached 21,712 adults and 22,197 children aged 0 - 15 years with age-appropriate HIV messaging promoting diagnosis and treatment of children living with HIV. In addition, trained clergy referred 21,142 children for HIV testing (with 21,130 tested); 106 of whom were diagnosed with HIV infection and started on ART. In the DRC, religious leaders reached 29,971 adults and 2,543 children aged 0-15 were referred to health facilities for appropriate HIV testing. 1,779 children were tested and 33 were diagnosed with HIV infection. However, due to a lack of availability of appropriate child-friendly ART combinations in DRC, only 17 are now accessing treatment. Caritas is working to implement a similar program in Kenya, Côte d'Ivoire and Tanzania.<sup>70</sup> The lack of available pediatric HIV medications is a serious challenge. The initiative is also working with UN partners and pharmaceutical companies to scale up the production of pediatric HIV medications.

## WCC-EAA

The principle that “the more we can speak and act together, the better our impact for justice will be” stands at the core of the WCC-EAA’s work on pediatric HIV. Based on this value, the WCC-EAA builds partnerships and collaborations among different faith traditions, as well as between faith-based and non-faith-based actors; it operates as a platform for networking, information sharing, and capacity building to disseminate HIV information in faith communities and to increase the quality of FBO services, including services for HIV-positive children and adolescents. It also mobilizes and builds the capacity of influential religious leaders, FBOs, and young people in their advocacy efforts at national and international levels. In collaboration with its partners around the world, the WCC-EAA creates opportunities for religious leaders to use their powerful voices to call for justice, protect the rights of children and adolescents, address stigma and discrimination, and hold governments and UN agencies accountable for the commitments they have made to promote prevention, testing, care, and optimal treatment for children living with HIV. The WCC-EAA also engages children and young people in religious schools and places of worship to become advocates for their peers living with HIV.

The WCC-EAA considers pediatric HIV a justice issue and believes that religious leaders and faith communities have a responsibility to bring about change. In June 2017, on the Day of the African Child, the WCC-EAA launched a Call to Action – *Act Now for Children and Adolescents Living with HIV*<sup>71</sup> – in which religious leaders and representatives of FBOs called on governments to fund pediatric HIV national plans; promote early diagnosis of HIV infection in infants; push for optimal pediatric formulations and access to TB drugs; eliminate stigma and discrimination; and address food insecurity. To support the implementation of the Call to Action, WCC-EAA and the Kenya chapter *INERELA+* have established an interfaith FBO Steering Committee in Kenya which is mobilizing faith advocacy activities to scale up testing and treatment for infants, children, and adolescents. This steering committee works closely with the National AIDS Control Council (NACC) in Kenya as a key partner in NACC’s strategic plan for faith-based engagement.

In addition, since the launch of the faith initiative, the WCC-EAA has been working to establish a group of champions on pediatric HIV. The “WCC-EAA Faith Pediatric HIV Champions” can be powerful agents for action on pediatric HIV in their countries and at global levels. These champions are identified in collaboration with local churches, schools, and national partners. They call on governments and other key stakeholders to reach the 2020 Prevention and Treatment Targets for Children and Adolescents, as agreed upon by all UN member States in the 2016 “Political Declaration on Ending AIDS.” Through their efforts, these champions seek to mobilize and equip national leaders to increase knowledge, demand, and

uptake of pediatric HIV services in faith communities. Champions can be religious leaders, youth leaders, children, CHWs (including volunteers). Champions for children and adolescents living with HIV are asked to support the following actions:

1. Sign the WCC-EAA Call to Action: “Act now for Children Living with HIV”,<sup>72</sup> and promote it;
2. Share information on pediatric HIV within their faith community, including through sermons (aided by resources such as “Khutbah and Christian Sermon Guides on children and HIV” which are described more fully below) and encourage families to bring babies and children for testing;
3. Advocate for key decision makers to address pediatric HIV bottlenecks at the global level and in their country, and set up meetings with them;
4. Issue video messages on pediatric HIV, testing and treatment for adolescents, and against stigma and discrimination, to be shared in their place of worship’s website and social media; and
5. Organize events in their communities to raise awareness about children and adolescents living with HIV.

Sermon guides are key to supporting advocacy efforts by faith leaders and a better understanding of issues related to HIV in faith communities. Faith-based partners have developed and disseminated sermon guides, created audience-specific curricula on HIV prevention and treatment, and created effective models for managing stigma to engage local communities on the clinical and social issues impacting pediatric HIV efforts. Sermon and Khutbah guides for children and faith leaders on HIV, developed by *INERELA+* Kenya, IMA World Health, USAID, PEPFAR, and the Partnership for an HIV-Free Generation were launched at the WCC-EAA “Day of the African Child event” in June 2017 and distributed among the participants.<sup>73</sup> These guides draw on the religious teachings of Christianity and Islam as well as the technical guidelines of NACC to reflect the principles of human rights and gender equality. The Day of the African Child event mobilized 1,000 children, adolescents and faith leaders from 13 congregations and seven religious schools to share information on the importance and value of testing and treatment. In preparation of the event, *INERELA+* Kenya organized trainings in the places of worship and religious schools to inform and engage children, young people and religious leaders on testing and treatment challenges and benefits.

The WCC-EAA regularly hosts events with religious leaders and children to raise awareness on pediatric HIV in faith communities and to mobilize action. In November 2018, the WCC-EAA, in collaboration with EDARP and *INERELA+* Kenya, organized a gathering of more than 500 children, youth, religious leaders, government

representatives, and UN agencies with workshops and trainings on pediatric HIV for faith leaders and young people and voluntary HIV testing and TB screening. These trainings balanced evidence-based pediatric HIV prevention and treatment models with key messages from religious traditions in support of comprehensive HIV programs.

A series of High-Level Dialogues held at the Vatican with pharmaceutical companies, manufacturers, regulatory authorities, donors, FBOs, UN agencies, networks of people living with HIV, and other key stakeholders resulted in significant and sustained commitments for pediatric HIV testing and treatment programs. Each of the Dialogues was convened by His Eminence Peter Kodwo Appiah Cardinal Turkson, Prefect of the Dicastery for the Promotion of Integral Human Development, and organized by a planning team composed by PEPFAR, UNAIDS, WHO, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Caritas Internationalis and WCC-EAA.

The goal of these High-Level Dialogues was to determine the most effective ways to improve access to both HIV diagnostics and optimal ARVs for children living with HIV, with the ultimate objective of reducing morbidity and mortality among this highly vulnerable group. Participants put forward a variety of steps they have taken or could take to expand access to early infant diagnosis (EID) and viral load testing, as well as to identify more HIV-exposed children and quickly link them to testing and treatment services. They also presented further steps that needed to be taken to accelerate the development and roll-out of priority pediatric formulations of ARVs, including streamlining regulatory processes, improving financing for the whole spectrum of pediatric formulations development and introduction, and ensuring wide availability and uptake of such optimal formulations.

The WCC-EAA has developed the online tracker of the Rome Action Plan<sup>74</sup> and is part of the monitoring team which advocates for the commitments of the Plan to be upheld.

### **The Academic Consortium**

St. Paul's University, a member of the Academic Consortium located in Kenya, conducted interviews and focus group discussions to better understand the influence of religion on stigma and how faith-based health systems can minimize stigma and maximize support for children and adolescents living with HIV and AIDS. Findings from this research are being used to develop and implement a curriculum to equip FBOs and religious leaders to assess their policies and activities to ensure they reflect the needs and priorities of adolescents living with HIV. This information will also inform future activities in the *Framework for Dialogue*<sup>75</sup> approach.

### **WCC-EHAIA**

In Kenya, WCC-EHAIA worked with the National AIDS Control Council (NACC) Faith Technical Working Group and the staff of PEPFAR and UNAIDS Country Office

to host an interfaith national consultation.<sup>76</sup> In Zambia, WCC-EHAIA worked with the INERELA+ Zambia Chapter, the Zambia Interfaith Networking Group On HIV (ZINGO), the Churches Health Association of Zambia (CHAZ), and the UNAIDS Country Office to host a similar interfaith national consultation.<sup>77</sup> These consultations brought together an intergenerational group of adolescents and young people, national faith leaders, theologians, people living with HIV (among them faith leaders, adolescents and young people), FBHPs, and the national YWCA to identify ways that faith-based partners could support the national AIDS response.

The consultation aimed to identify synergies between the faith initiative and existing national plans and develop a roadmap for the first year with a strong monitoring and evaluation framework. This encouraged the buy-in and support of the country-level partners, multilateral partners, FBOs and faith leaders, parents, and people living with HIV in local communities and at national levels so as to facilitate discussions related to stigma and discrimination, age-appropriate HIV services, and SRH. As a result, the initiative created an intergenerational safe space for faith leaders to engage with adolescents and young people on the subject of sex and sexuality and HIV-related stigma and discrimination and sexual and gender-based violence (SGBV). Increasing mutual understanding and support among faith communities, adolescents and young people is key to supporting young people who seek guidance and accompaniment on HIV prevention, testing, treatment, and elimination of vertical transmission (eVT). Such health services can only be addressed in contexts where young people can discuss their questions about healthy behaviors, the characteristics of healthy and equitable gender relationships, and the importance of sexual and reproductive health without fear, stigma or judgment.

The consultations demonstrated the importance of creating intergenerational safe spaces for faith leaders and people living with HIV to engage with adolescents and young people on these sensitive topics. Facilitators during both consultations included experts from the CHAs, World and National YWCAs and INERELA+. The consultations used three methodologies—namely Contextual Bible Study (CBS)<sup>78</sup>, Intergenerational Safe Spaces<sup>79</sup> and INERELA+'s SAVE toolkit (Safe Practice, Access to Treatment, Voluntary Testing and Counselling, Empowerment)<sup>80</sup>—to promote interactive involvement of all participants. In addition, the dialogues included personal narratives on HIV testing, eventual disclosure, challenges with treatment adherence and “faith healing only” messages, stigma and discrimination, rape (including child sexual abuse), drug use, and how to overcome some of these barriers. Facilitators provided evidence on HIV prevalence and on SGBV.

Importantly, the consultations highlighted the urgent need to promote treatment adherence in faith communities where “faith healing only” is encouraged.

This damaging approach encourages people on ARVs to default from treatment and rely only on prayer, a practice that sometimes leads to death. WCC-EHAIA introduced its worldwide campaign to address GBV called *Thursdays in Black (TiB): Towards a World without Rape and Violence* by distributing promotional materials (pins and bookmarks) and encouraging every participant to wear black attire on Thursdays. Many churches and universities in countries such as Nigeria<sup>81</sup> and Uganda<sup>82</sup> have embraced the TiB campaign.

Finally, the consultations provided a platform for collecting messages by religious leaders for the WCC campaign “Leading by Example: Religious Leaders and HIV Testing.” The campaign was launched on World AIDS Day 2016 with a morning prayer service at the Ecumenical Centre in Geneva, Switzerland.<sup>83</sup>

After the interfaith national consultations, the National YWCA facilitated workshops in four counties in Kenya (Nairobi, Mombasa, Kisumu and Siaya) and four districts in Zambia (Chama, Chipata, Kaoma and Lusaka) to strengthen faith community partnerships to fast track national workshops for empowerment of girls and young women. In Kenya, the consultations focused on:

- Engaging and collaborating with UNAIDS, NACC, the PEPFAR DREAMS (Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe) initiative<sup>84</sup>, and national youth networks working on HIV for a strengthened response to end HIV and related stigma and discrimination
- Fostering intergenerational dialogues among traditional leaders, interfaith religious leaders, young women and girls
- Referring young women and girls to SRH services and HIV testing, counselling and treatment.

The objectives of the workshops in Zambia were to:

- Roll out the Inter-faith intergenerational workshops in Chama, Chipata, Kaoma and Lusaka
- Build mutual understanding and support among faith leaders in the communities.

In both Kenya and Zambia, the four workshops were facilitated in a similar manner to the national consultations, using the same tools and methodologies. The workshops began with prayers and participants were encouraged to take whatever they had learned seriously and be good ambassadors and champions by sharing the knowledge gained with their peers. They were encouraged to be assertive and to avoid high risk behavior. They went home with the chorus ‘stand your ground and let men know your stand for you to succeed’.

Participants were also reminded that avoiding high risk behavior is not women’s responsibility alone. Using key messages from WCC-EHAIA’s *Transformative Masculinities and Femininities* program the consultations re-enforced

men’s role in prevention and risk reduction and highlighted the importance of HIV prevention services for men as well as women.

Subsequent national interfaith consultations led by national AIDS authorities and UNAIDS Country Offices in Nigeria, Tanzania, Zambia, Zimbabwe, and DRC led to the development of a national faith HIV action plan (Kenya developed their own national faith action plan, ‘Maisha’ in 2015, which provided a model for others).<sup>85</sup> The consultations also addressed pediatric HIV, bringing other implementing partners in the FBO Initiative to the table to develop and carry out specific programs in each country in partnership with national religious leaders and faith-based partners.

## The Vision Multiplied: Faith-Based Organizations Working on the Ground

The UNAIDS PEPFAR FBO initiative has supported specific projects through the implementing partners, examples of which are included above. This next section provides some examples of other faith-based initiatives and projects working to increase access to HIV treatment, care, and support for children and adolescents.

### Hope of Children

Hope of Children is a local community organization in Cambodia. Founded by a Buddhist community in 1992 as an HIV orphanage, Hope of Children currently works to help children living with or affected by HIV by providing housing, nutritional support, education, and vocational skills. Hope of Children runs a local restaurant to raise money for the organization; the restaurant is staffed entirely by former program participants.<sup>86</sup>

### Cambodian Buddhism Association for Vulnerable Children (CBAVC)

CBAVC provides a variety of programs for children in Cambodia. One of the organization’s three focus areas is community primary care, which includes program focuses on HIV prevention education and support.<sup>87</sup>

### Shanti Ashram and the International Center for Child and Public Health

For over 30 years, Shanti Ashram has been working in India to empower women and ensure that vulnerable children thrive. Inspired by the example of Mahatma Gandhi’s vision of Sarvodaya, Shanti Ashram has launched the International Center for Child and Public Health (ICPH)<sup>88</sup>, which has provided primary health care and social services to children in over 100 communities across India, including children living with HIV. ICPH services extend to the broader community through nutrition services; preventive health, and wellness initiatives; a mobile hospital; and a comprehensive laboratory. ICPH offers targeted services and support for children living with HIV as they grow into adolescence and adulthood, working to ensure that educational, economic, and health resources are available. ICPH is a member of the Global Network of Religions for Children.<sup>89</sup>

### **The Church Alliance for Orphans (CAFO)**

CAFO is an inter-faith initiative established in 2002 in Namibia to offer care and support to orphans and vulnerable children. The Council of Churches in Namibia provided the administrative structure to establish CAFO. With funding from various global HIV and public health funders including UNICEF, PEPFAR, and the Ford Foundation, CAFO has provided various services, including HIV prevention and support programs to over 30,000 orphans in Namibia. The alliance has distributed millions of dollars to local religious communities and funded various NGOs, including both faith-based and civil society organizations. CAFO also links local religious communities to broader community programs working to support orphans and vulnerable children.<sup>90</sup>

### **FOCUS 1000**

Focus 1000 works to provide children in Sierra Leone with the essential resources they need in the first 1,000 days of life. This work is built on the trust and relationships developed through HIV programs in Sierra Leone and across western Africa. These crucial first days of life are decisive in setting the trajectory for children's physical and emotional development. Focus 1000 sponsors inter-religious pediatric health initiatives in every district in Sierra Leone by establishing and supporting Christian and Islamic Action Groups. These groups work hand in hand with the Sierra Leone Indigenous Traditional Healers Union to build inter-religious dialogue, fashion health information using religious frameworks, and offer integrated pediatric health and educational services.<sup>91</sup> These inter-religious networks were essential in building trust for emergency public health efforts to address the Ebola response in 2014-2015 after health officials had initially failed to integrate religious rituals into their programs for safe and dignified burials.<sup>92</sup> Such efforts built on the trust and relationships built through HIV programs in Sierra Leone and across western Africa. In addition, Focus 1000 conducted a national study in Sierra Leone to assess the availability of antenatal services and PVT services, perceptions of PVT services, and the barriers to those services. Findings informed efforts to enhance the availability and quality of PVT services offered by the National AIDS Control Program.

### **Hope Cape Town**

Hope Cape Town is a community-based HIV prevention, treatment, and support initiative in the Western Cape province of South Africa. The initiative has worked hard to integrate African traditional spiritualities and traditional healing practices into these initiatives. Traditional healers known as sangoma work alongside HIV clinical nurses in providing various programs for mothers and children, including PVT programs.<sup>93</sup>

### **Ummah Support Initiative (USI)**

Established in 2003, USI is a Nigerian, Islamic faith-based organization that offers support to women and children living with or affected by HIV and serves as a national

leader on pediatric HIV issues. USI works with religious leaders, clinics, schools, and local NGOs to organize support for orphans and their caregivers in Nasarawa, FCT, Kano and Bauchi Nigeria. The organization also advocates for increased awareness about HIV in Muslim communities and eliminating stigma for people living with HIV across Nigeria. USI has specific programs for street children, women and youth, and internally displaced persons. With headquarters at the National Mosque Complex in Abuja, USI has regional field offices five Nigerian states. USI carries out other initiatives, including sexual health; reproductive rights; HIV services for women, children, and adolescents; HIV stigma reduction; and nutritional support for children and families in vulnerable economic and social situations.<sup>94</sup>

### **Understanding the Vision: Further Information on the Topics Discussed in this Chapter**

- For information on the **Mai Tam House of Hope**, please visit the organization's website at: <http://www.maitamhouseofhope.com>.
- To find out more about the **Eastern Deanery AIDS Relief Program**, please visit <http://www.edarp.org>
- For a full report on the consultation in Zambia co-sponsored by the **Churches Health Association of Zambia, WCC-EAA, Caritas, and ACHAP**, see: <http://bit.ly/ZAMBIA-report>
- The full report on the **2016 Caritas Pediatric and Adolescent consultation** can be found at: <https://www.caritas.org/wordpress/wp-content/uploads/2016/04/ActionPlan.pdf>
- For a video describing the Caritas GRAIL project, go to: <http://bit.ly/Caritas-GRAIL-Project>
- For information on **WCC-EAA's Leading by Example campaign**, visit: <http://bit.ly/WCC-EAA-Leading-By-Example>
- To find out more about **WCC-EAA's pediatric HIV activities**, please visit: <http://bit.ly/WCCEAA-paediatric-call-to-action>
- The sermon and khutbah guides on children and HIV for faith leaders were launched at the **WCC-EAA Day of the African Child** event (June 2016). The guide for Christian sermons can be found here: <http://bit.ly/WCCEAA-sermon-guide>. The khutbah guide can be found here: <http://bit.ly/WCCEAA-khutbah-guide>

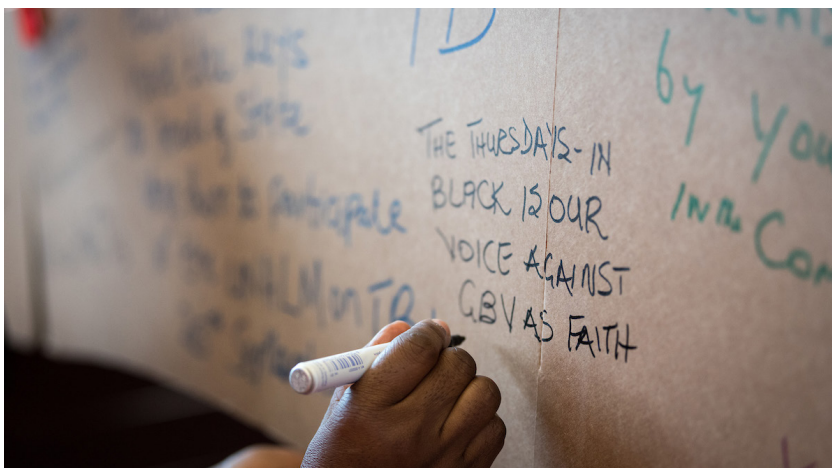
- For further information on the **Vatican High Level Dialogues on Pediatric HIV**, see: <https://www.oikoumene.org/en/press-centre/news/dialogue-addresses-improving-hiv-testing-and-treatment-for-children>; <https://www.oikoumene.org/en/press-centre/news/range-of-organizations-commit-to-improve-hiv-diagnosis-and-treatment-for-children-and-adolescents>
- The **Pediatric HIV Rome Action Plan** with commitments by pharmaceutical and manufacturers companies, regulatory authorities, donors, UN agencies and FBOs is available at <https://www.paediatrichivactionplan.org/>
- For further information about **WCC-EAA mobilization events** with faith leaders and young people, see: <https://www.oikoumene.org/en/what-we-do/children-adolescents-and-hiv>; <https://www.oikoumene.org/en/press-centre/news/faith-on-the-fast-track-for-children-living-with-hiv>. Also, see <https://www.oikoumene.org/en/press-centre/news/working-toward-an-aids-free-generation> and <https://www.oikoumene.org/en/press-centre/news/201d-2013-201d-2019s-time-to-take-action>
- The **National AIDS Control Council in Kenya** has developed a strategic plan for engaging the faith sector. For more information, see: <http://bit.ly/NACC-faith-sector-action-plan>
- For information about **Hope of Children**, visit: <http://hopeofchildren.net/about/index.html>
- For information about the **Cambodian Buddhist Association for Vulnerable Children**, please visit: <http://www.cbavc.org>
- To find out more about **Shanti Ashram and the International Center for Child and Public Health**, please visit: <http://www.icphhealth.org>
- The website for the **Global Network of Religions for Children** can be found at: <https://gnrc.net/en/>
- The website for **Focus 1000**, the non-profit focused on child health and wellness in Sierra Leone, can be found at: <http://focus1000.org>
- For more information on **HOPE Cape Town**, visit: <http://www.hopecapetown.com>. For a brochure that describes the initiative with traditional healers, see: <http://bit.ly/hope-capetown-traditional-healer>. The chair of the Board of Trustees of Hope Cape Town is Reverend Stefan Hippler, a Roman Catholic priest. Father Hippler has written on the integration between western clinical models and spiritual practices of religious healers; see <https://stefanhippler.com/tag/sangoma/>.
- To find out more about the various projects of the **Ummah Support Initiative**, please visit: <https://usi.org.ng/projects-implemented/>

## Building the Vision: Progress on the Recommendations of *The Gap Report* and *The Lancet Series*

This chapter has laid out the opportunities and challenges of faith-based HIV services to children and adolescents living with HIV. Organizations and activities profiled in the chapter support the priorities laid out in *The Gap Report*.

Table 2.1: *The Gap Report* program priorities addressed in this chapter

GROUPS	REASONS THIS COMMUNITY IS BEING LEFT BEHIND	PRIORITIES FOR CLOSING THE GAP
<b>Adolescent girls and young women</b>	<ul style="list-style-type: none"> <li>Gender-based violence</li> <li>Lack of access to health services</li> <li>Lack of access to education</li> <li>Policies that do not translate into action</li> </ul>	<ul style="list-style-type: none"> <li>Ensure access to quality health services</li> <li>Keep girls in school</li> <li>Empower young women and girls and challenge and change social norms</li> </ul>
<b>Children and pregnant women living with HIV</b>	<ul style="list-style-type: none"> <li>Limited access to sexual and reproductive health and HIV services</li> <li>Limited access to HIV treatment</li> <li>Failure to prioritize children</li> <li>Poorly integrated health-care services</li> </ul>	<ul style="list-style-type: none"> <li>Improve access to health and HIV services for all women and children</li> <li>Ensure treatment is available for all in need</li> <li>Invest in pediatric commodities and approaches</li> <li>Scale up integrated, family-centered health care services and information</li> </ul>



PHOTOS: WCC/Albin Hillert; WCC/Ivars Kupcis



The activities in this chapter also reflect the following recommendations and priority focuses from *The Lancet* series:

Table 2.2: **Key recommendations from *The Lancet* Series addressed in this chapter**

RECOMMENDATION/SOURCE	PRIORITY FOCUSES
<p><b>Conduct research into the precise nature and implications of faith roles in HIV care and services (Karam, Clague, Marshall, and Olivier; Olivier et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Expand to traditions outside Christianity</li> <li>▪ Broaden focus to include areas beyond sub-Saharan Africa</li> <li>▪ Develop a more robust conceptual understanding of religion</li> <li>▪ Research beyond service provision to encompass religion's social capacity to influence norms, perceptions, politics, and policies</li> </ul>
<p><b>Build on the lessons learned from the 2014-2015 Ebola outbreak (Marshall and Smith).</b></p>	<ul style="list-style-type: none"> <li>▪ Strengthen knowledge of religious demography, institutions, and relationships so that faith communities/FBOs could be readily mobilized</li> <li>▪ Strengthen approaches to community engagement carried out by public health organizations to be more systematic, multidisciplinary, and informed about/respectful of cultural norms, beliefs, and practices.</li> </ul>
<p><b>Develop research initiatives on the influences of religion on cultural, social, and political norms and perspectives. (Tomkins, et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Focus on the effects of religion's influences on marginalized populations.</li> <li>▪ Develop platforms for identifying shared commitments between religious leaders and health policy-makers.</li> </ul>
<p><b>Strengthen multisectoral partnerships that include governmental programs, civil society organizations, FBOs/health providers, and local faith communities (Buckingham and Duff).</b></p>	<ul style="list-style-type: none"> <li>▪ Appreciate respective objectives, capacities, differences, and limitations.</li> <li>▪ Refrain from using religious teachings to undermine evidence-informed public health practices; refrain from using secularist ideology to undermine effectiveness of faith-based groups' work in health.</li> </ul>



*The Lancet* Series on faith-based health care raised questions regarding quality, capacity and acceptability of care provided by FBOs. Many community FBO and faith-based health facilities face numerous challenges in sustaining or growing their organizations and improving the quality of the services they provide. In response to key recommendations from *The Lancet* Series, the UN-AIDS/PEPFAR FBO Initiative supports a number of capacity-building initiatives to strengthen FBOs in their work.

### From Vision to Reality: Activities of Implementing Partners

#### *The African Christian Health Association Platform (ACHAP)*

ACHAP has carried out a variety of capacity-building activities. ACHAP holds a biennial meeting of the national CHAs who are member organizations of the platform at which training and capacity building initiatives form a central part of the agenda. In 2017, it sponsored a day-long pre-conference institute on the FBO Initiative in collaboration with the Academic Consortium and hosted a plenary session on research priorities for the CHAs that featured a dialogue between country representatives and researchers from universities within the Academic Consortium. ACHAP is working to strengthen linkages among CHA members in Francophone West Africa and held its 2019 biennial meeting in Cameroon in order to increase participation among western African CHAs and affiliated organizations. Biennial meetings are held in both English and French, with translation services for plenary presentations and some breakout sessions offered in both languages.

In Kenya, ACHAP helped launch an HIV testing and counseling guide for religious leaders. The guide was developed by ACHAP in partnership with NACC, INERELA+ Kenya, CHAK, SUPKEM, The Seventh Day Adventist Church, the National Council of Churches of Kenya, IMA World Health, St. Paul's University (one of the members of the Academic Consortium), the Organization of African Instituted Churches, and the Evangelical Alliance of Kenya.

The HIV/AIDS counseling guide calls on religious leaders to be:

- Considerate of the full spectrum of the physical, psychological and socio-economic needs of clients, with the goal of enabling them to attain optimal physical, mental and social health and functioning
- Appreciative of the role of ongoing support, including information, to help avoid transmission to others
- Cognizant of the place of science in addressing HIV but continuing to support people using religious tools they ascribe to in such ways that offer support and do no harm
- Respectful of individual religious convictions and beliefs of people seeking counseling and therefore in no way seeks to proselytize.

ACHAP developed the guide after realizing that religious leaders did not have the necessary skills to offer HIV and AIDS counseling to members of their congregations. In addition to developing the curriculum, the implementing partners are using it to train religious leaders.<sup>95</sup>

ACHAP worked with the UNAIDS Country Office in DRC to convene a national consultation on faith-based engagements in late 2017; following that meeting, ACHAP has been working with local and regional FBHPs to lay the groundwork for establishing a new, national-level CHA in the DRC. In 2018, ACHAP launched a peer mentorship initiative in which senior leadership from smaller, newer CHAs travelled to larger, well-established CHAs for onsite learning on programmatic, fiscal, and administrative management of the organization. Finally, ACHAP piloted a curriculum to address stigma in health care settings in collaboration with the Christian Health Association of Nigeria (CHAN). Selected CHAN staff were recruited as trainers on the curriculum, and they will conduct a series of workshops for all CHAN facilities in regions with the highest HIV disease burden. This initiative will also inform the development and rollout of a national curriculum on stigma reduction in Nigeria being developed by the Academic Consortium in partnership with the National Agency for the Control of AIDS (NACA), Nigeria's multi-sectoral body, to set priorities and develop national strategic plans. The curriculum will be implemented through the member bodies of the NACA.

#### *The Academic Consortium*

Representatives of the implementing partners at the 2017 annual meeting of the UNAIDS/PEPFAR FBO Initiative asked the Academic Consortium to develop a training platform that could introduce common approaches to, and strengthen program design, implementation, and evaluation among the implementing partner staff and organizations within their respective networks. In late 2018 and early 2019, the consortium convened a series of four webinars with lectures from faculty at St. Paul's University, Emory University, and the University of Cape Town; panel discussions with consortium faculty; and representatives from the Christian Health Association of Ghana, case studies, and Q/A with webinar participants.

The series, entitled *Building Capacity Among Global FBOs to Address HIV in Clinical and Community Contexts*, had the following learning objectives:

#### **Webinar 1: *Using a logic model to guide program design and activities***

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**Description:** This webinar provides an overview to participants on how to use a logic model to design programs and develop activities in order to achieve desired deliverables. Participants will understand the relationships among goals and objectives, inputs (resources), outputs (activities and audiences), and outcomes.

**Objectives:**

- a. Describe the key components and theoretical assumptions of a logic model.
- b. Assess organizational capacities in relation to feasible interventions.
- c. Apply a logic model to a case.

#### **Webinar 2: *Designing a Program to Demonstrate Impact***

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**Description:** This webinar focuses on outputs and outcomes in the logic model. These elements allow an organization to identify what it can feasibly achieve and to accurately plan for deliverables and measurement of outcomes.

**Objectives:**

- a. Describe the flow and causal relationships across the logic model.
- b. Define outputs, outcomes, and impact.
- c. Describe methods (quantitative, qualitative, and mixed) for measuring outputs, outcomes, and impact
- d. Case application (what happens in the real world—e.g., organization and funder conflict)
- e. Identify the ways in which capacity built for demonstrating evidence can be a resource for the organization itself.

#### **Webinars 3 and 4: *Generating Evidence on the Distinctives of Faith-Based Organizations in the HIV Response***

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**Description:** These webinars occur in a series with webinar three focused on faith-based health facilities and webinar four focused on faith-based community organizations or local faith communities. The webinars provide an overview of the literature on the distinctive characteristics of FBOs that can affect HIV services. Participants learn how to identify and employ distinctive religious health assets to address HIV. Topics include: 1) distinctive FBO resources including trust, longevity/sustainability in communities apart from funding, access to supplemental funding, and access to volunteers; 2) distinctive FBO challenges including religion as a driver of stigma (and how FBOs can address this), and tensions between religious priorities and health priorities. In addition, the webinar addresses ways to build the evidence for these distinctives and strategies for FBOs communicating those distinctives to different audiences.

**Learning Objectives:**

- a. Summarize distinctive characteristics of FBOs and their impact
- b. Describe the history of research on the distinctive characteristics of FBOs.
- c. Distinguish between anecdote and evidence.
- d. Develop various messages on FBO distinctives for various purposes (e.g., advocacy in civil society, making the case to funders, building support in religious communities)
- e. Build capacity for research (both formal research initiatives and informal efforts to document impact) that builds the evidence of faith-based distinctives.

All webinars were video recorded and webinar content can be accessed without charge on the website of the Interfaith Health Program at Emory University: <http://ihpemory.org>.

## WCC-EAA

The WCC-EAA facilitates, hosts, and supports trainings and workshops to build the capacity of FBOs, churches, and partners for a more effective HIV response. Some examples include trainings on pediatric HIV and TB to religious leaders with INERELA+; trainings on HIV self-testing to faith community volunteers and Community Health Workers (CHWs) with EDARP in Kenya; and the Framework for Dialogue consultations through which religious leaders and people living with HIV identify joint actions to address stigma and discrimination. In addition, the WCC-EAA collaborates with UN agencies and other partners to develop technical information on HIV prevention, testing, and treatment and to challenge stigma and discrimination. These materials, such as the Q&A document on HIV self-test (HIVST) for faith communities<sup>96</sup>, have been adapted for use by FBOs and other faith-inspired partners.

Following the Framework for Dialogue activity with EDARP, the WCC-EAA facilitated trainings on HIVST to reach “hard-to-find” individuals at risk for HIV infection in February and March 2019. This project aimed at training 350 EDARP staff, CHWs and peer mentors with the technical skills and communication skills to deliver HIVST kits to high risk individuals including men, young adults, men who have sex with men, sex workers, and people who inject or use drugs. Trainings familiarized participants with the appropriate techniques for using HIVST and the skills required for HIV Accompanied Self-testing. Participants were also trained in the use of data collection tools to track important future outcomes for HIVST. 471 participants successfully completed the approved Kenyan Ministry of Health two-day training curriculum on HIV Self Testing. These individuals trained in the use of HIVST are using 5,000 OraQuick tests to target and prioritize individuals from key populations, men who have never been tested, young adults who have never been tested, and sexual partners of EDARP HIV-positive clients. Results on the impact of the project will be available in autumn 2019.

Another capacity building activity by EDARP in collaboration with the WCC-EAA following the Framework for Dialogue program was a six-hour training for EDARP staff (February and March 2019) on the updated 2018 Kenya National HIV Guidelines; identification and referrals for clients experiencing SGBV; understanding and outreach to key populations; HIV treatment support for children and adolescents, and HIVST awareness and strategies.

EDARP has been providing comprehensive HIV and TB prevention, care and treatment, including ANC and PVT, in the eastern slums of Nairobi since 1993. EDARP services have now expanded to 14 sites with 390 staff, and over 1,200 community health educators and peer mentors. The HIV epidemic is constantly changing and evolving with new treatments, new interventions and improved strategies to achieve epidemic control. Updating FBOs staff and volunteers is critically important and an ongoing challenge.

The CHWs were divided into five groups, with each group discussing specific topics:

- The benefits of self-testing and the roles of CHW
- GBV: strategies to identify and intervene; discussion on the appropriateness and availability of PEP and PREP
- The preparation of new HIV-positive pediatric/ adolescent clients and the involvement of guardians in care to maximize adherence and retention in care
- PVT: the role of the CHW in ANC, post-natal care and support, and breast feeding, with an emphasis on viral suppression
- Adherence issues: where and when does it start? How does viral suppression impact individual and community health? Who are the key populations and what is the role of CHWs in providing identification, care, and support?

These trainings aimed at 1) enhancing identification of new HIV-positive individuals particularly among key populations, adolescents and young people; 2) ensuring person-centered, targeted care to key populations already enrolled in care at EDARP facilities to improve their outcomes and quality of life; and 3) improving the identification of gender-based violence survivors to provide immediate post-SGBV care and provide appropriate referrals.

Each of these trainings were well received by participants and fostered robust discussions and conversations. The care and support of individuals who are members of key populations by FBOs can provide challenges, both for the organizations and clients. Yet when FBOs incorporate accurate information as well as sacred scriptures in the trainings and the emphasis is placed on “welcome,” or *karibu*, and not on judgement, then their contributions can be important, especially to members of key population groups for whom faith is significant. This attitude, improvements in communication strategies, and improved clinical interventions hold promise for improved quality of care for all individuals impacted by the HIV epidemic. Participants evaluated the trainings, stating that they increased their understanding and compassion for providing welcoming clinical services for members of key populations. EDARP data currently indicates that 91% of their over 26,000 HIV positive clients have achieved viral load suppression.

In addition to trainings and workshops, the WCC-EAA has become a platform for building a coordinated inter-faith voice on issues related to HIV and building dialogue between faith communities and networks of people living with HIV and key populations. The faith-based response to HIV and AIDS has become more visible and integrated because of the increased engagement and coordination of faith-based representatives by the WCC-EAA over the past six International AIDS Conferences.

The International AIDS Conference provides extensive opportunities for sharing and networking across all levels of care and response to the epidemic. In 2016, the WCC-EAA organized and coordinated FBOs participation in the interfaith preconference and the faith activities in the main conference under the theme “Faith on the Fast Track”; in 2018, the WCC-EAA “Faith Building Bridges” preconference and activities focused on increasing access, eliminating stigma and discrimination, promoting human rights, and building bridges. Various sessions at the conference examined capacity:

- Needs assessment of the clinical knowledge and skills of HIV service providers at CHAK health facilities
- Overcoming religious barriers to HIV testing and treatment
- Innovative approaches to increase access to HIV testing services for hard-to-reach populations

An evaluation of the interfaith conference by participants immediately after the event and in a subsequent three-month follow up revealed that the conference impacted knowledge, skills, and intentions in relation to capacity building. Participants who had worked in the field of HIV for less than five years noted the largest gains in knowledge and skills, whereas all participants identified commitments to focus on inter-organizational and community partnership building and organizational capacity-building. Participants who had worked in the HIV field for longer than five years noted that the conference provided an important opportunity to modify or strengthen current activities or develop new ones on the basis of information presented or the partnerships that were established. One participant noted that her organization had assessed their HIV programs as a result of information gathered at the interfaith pre-conference. The organization is using that assessment to better establish current capacity and set baselines in order to establish a long-term plan for program improvement.<sup>97</sup>

### WCC-EHAIA

After the two intergenerational and interfaith national consultations in Kenya and Zambia and the four follow-up workshops facilitated by National YWCA in each country, WCC-EHAIA worked to develop training manuals for religious leaders to address treatment adherence and faith healing in Africa for Anglophone and Francophone countries. To develop these manuals, WCC-EHAIA planned and facilitated interfaith consultations in Uganda (English) and Rwanda (French). In each consultation, WCC-EHAIA engaged national AIDS authorities, UNAIDS Country Offices, Interfaith National Councils, INERELA+ and CHAs. The consultation in Uganda included participants from Kenya, Tanzania, Zambia, Nigeria and Zimbabwe. In Rwanda, participants came from Burundi and DRC.

Objectives for each consultation included:

1. Listen to people living with HIV on the challenges that prescription of “faith healing only” poses to HIV treatment adherence in Africa.
2. Identify and define the essential elements required to build the capacity of faith leaders and communities to support HIV testing, treatment uptake, and adherence to ART.
3. Identify and describe innovative faith initiatives that have been used to promote harmonization of medicine and faith healing in the context of HIV in Africa.
4. Define the role of faith communities and faith leaders in advocacy for universal access to life saving medication.
5. Describe the ways in which sacred texts can be a significant resource in equipping religious leaders to challenge negative theologies and promote HIV treatment adherence
6. Develop strategies for faith communities to effectively communicate with diverse specialists to address negative approaches to faith healing only in the context of HIV in Africa.

As in the previous consultations in Kenya and Zambia, participants from across different religious traditions and generations shared experiences of SGBV, treatment adherence, the problems with “faith only” healing messages which resulted in treatment default, and the negative impact of stigma and discrimination. Together with presentations by medical professionals, in-depth discussions on the meaning and understanding of faith healing and cure among theologians, senior church leaders, young people living with HIV, young advocates, and activists aided the shaping of the first drafts of the manuals in English and French. Discussions on faith healing and cure amplified the need for people to explore both meanings and people’s understanding from a wide variety of African languages spoken and commonly used in sub-Saharan Africa.<sup>98</sup>

The need for the training manual for religious leaders emerged out of the realization that exclusive claims of faith healing in the context of HIV and AIDS in sub-Saharan Africa are compromising adherence to ART. Therefore, the manual seeks to challenge the false dichotomy that places ART and faith healing at opposite ends of the spectrum. It recognizes that religious leaders are strategically placed to promote adherence (following through on the use of medication as suggested by a treating doctor) to ART as an integral part of God’s healing action and to challenge stigma and discrimination. Further, it enjoins religious leaders to play a critical role in promoting HIV testing, treatment uptake, and adherence in the context of HIV and AIDS.

The manual consists of practical, user-friendly units designed for use with faith communities, theological institutions, and theological education by extension. It is a living document and is adaptable to different contexts. The English Manual has been translated to Kiswahili and the French to Kinyarwanda so as to reach wider audiences.

The other task was to develop handbooks for adolescents and young people in faith communities on positive masculinities and femininities in Nigeria and (DRC. WCC-EHAIA's previous extensive work on the link between HIV and SGBV, publications on rape and biblical narratives, research studies, and theological reflections on masculinities and femininities over many years aided the development of the handbooks in Nigeria and DRC. To support this effort, interfaith national consultations were held in Nigeria and DRC. These intergenerational consultations focus on positive masculinities and femininities, HIV prevention and the reduction of stigma, and SGBV among adolescents and young people in Nigeria and DRC.

Objectives for each consultation included:

- Convene interfaith national level multi-stakeholder consultation in Nigeria and DRC;
- Scale up the engagement of faith communities in intergenerational safe space conversations on sex, sexuality, SGBV, eVT, stigma and discrimination, HIV testing, prevention, adherence to treatment as well as care and support for influential faith leaders, schoolteachers, health providers and young people
- Promote positive masculinities and femininities through curriculum and media to ensure buy in and support of the religious leadership in creating sustainable and comprehensive community HIV interventions

Following review by content experts, 1,500 copies were printed and distributed to local faith communities, youth networks, and local networks for people living with HIV. The curriculum was also translated into at least one local language in Nigeria. WCC-EHAIA promoted the curriculum through Twitter and Facebook and through interviews and feature stories on other media platforms.

The handbook is a resource designed to equip adolescents, young people, teachers and students, women and youth leaders, religious leaders, and other stakeholders with necessary tools to respond effectively to the challenge of negative masculinities and femininities that are negating our responses to HIV and SGBV among adolescents and young people.

It contains a brief introduction, purpose and objectives. The chapters provide information on various aspects of gender with a particular emphasis on the effects of negative masculinities and femininities, where such masculinities and femininities are displayed. There is also information on positive masculinities and femininities and the strategies that could be used to promote these masculin-

ties in families, faith communities, and society at large.<sup>99</sup>

After several reviews of the draft manuals on treatment adherence and faith healing went through pilot testing in Zambia, Kenya and Rwanda and the handbooks on positive masculinities and femininities were pilot tested in Nigeria and DRC. Finally, these resources were launched in the presence of staff of UNAIDS, representatives of other implementing partners of the PEPFAR/UNAIDS faith initiative, 140 church leaders, theologians, young people and other HIV stakeholders in Nairobi, Kenya. The launch event was co-hosted by the All Africa Conference of Churches and the WCC.<sup>100</sup>

These resources are available in hard and soft copies <https://seafile.ecucenter.org/d/7efde2259e564c84b38f/>

In Tanzania WCC-EHAIA was tasked with the responsibility of working with UNAIDS and the Tanzania Commission on AIDS (TACAIDS) to address stigma and discrimination in faith communities and health facilities and to scale up HIV prevention, testing, treatment, treatment adherence, care, and support. The Interfaith National Consultation for an intergenerational group of religious leaders, including some living with HIV as well as young people, focused on the following objectives:

- Review and challenge the persistence of stigma and discrimination within faith communities
- Develop or deepen skills of utilizing sacred texts (especially the Bible, the Quran, and the hadith) and African traditional religions to address stigma and discrimination
- Introduce and deepen a theology of compassion that will contribute towards minimizing stigma and discrimination within the faith communities
- Promote, widen and strengthen the sharing of resources across the different faith communities to respond to stigma and discrimination within the faith communities

The consultation was designed to:

- Increase competence of religious leaders in utilizing sacred texts to address stigma and discrimination
- Articulate a theology of compassion and minimize stigma and discrimination
- Share resources among African traditional, Muslim, and Christian leaders to join forces in addressing stigma and discrimination within the faith communities and the larger society.

During the consultation participants had the opportunity to launch the Treatment Adherence and Faith Healing Manual in Kiswahili. There was strong affirmation that faith communities need to do much more to reduce stigma and discrimination and to offer comprehensive sexuality education for adolescents and young people throughout the country. As was the case in earlier consultations, efforts to create intergenerational safe spaces and to strengthen communication skills and conversations on sex, sexuality, and sexual and reproductive health education with adolescents, young people, adults, leaders, professionals, and policy influencers and makers in churches, church-owned schools, and institutions of higher learning will go a long way in promoting an effective HIV response in the country. Similarly, there is need for in-depth theological reflections on sacred texts from the Bible and the Koran to simplify life-saving messages for congregations and to develop a theology of compassion (pastoral accompaniment) for people who are most affected by HIV epidemic.

<https://www.oikoumene.org/en/press-centre/news/tanzania-a-long-standing-issue-with-potential-for-change>

## The Vision Multiplied: Faith-Based Organizations Working on the Ground

### Expanded Church Response (ECR)

Based in Lusaka, Zambia, ECR has implemented a variety of projects to strengthen the response of local churches to the HIV crisis.<sup>101</sup> ECR is innovative in building capacity by offering seed grants to local grassroots initiatives. Prior to providing local entities with the funds, ECR conducts an initial assessment to determine the organization's needs and current capacity. To ensure that the churches or organizations will be able to adhere to ECR's principle of accountability, ECR provides the entity with an initial commodity grant (often a gift-in-kind) related to a need that was identified in their initial assessment. If the report

detailing the processes by which the organization used the commodity grant meets ECR's standards, organizations then receive a small seed grant to carry out a new project (e.g. one local group developed a home-based care program with a focus on linkage to care and ART adherence) or expand a current program. In addition to providing the funding, ECR trains local FBOs on best practice models for program administration with a focus on planning, reporting, budgeting, and administrative policies. Finally, ECR provides training to seed grant recipients on grant writing to assist them in identifying and successfully receiving grants that can support sustainability.

### Zambia Interfaith Networking Group on HIV (ZINGO)

ZINGO is an interreligious network representing the Baha'i faith, the Council of Churches in Zambia, the Evangelical Fellowship of Zambia, the Hindu Association of Zambia, the Independent Churches of Zambia, the Islamic Council of Zambia, and the Zambia Episcopal Conference of the Roman Catholic Church.<sup>102</sup> ZINGO networks, coordinates, builds competencies, and mobilizes both technical and financial resources to assist FBOs in carrying out HIV and AIDS activities that will promote quality of life and contribute to the reduction of new infections in their communities. ZINGO has a number of specific initiatives for children and adolescents living with HIV.<sup>103</sup> These include a project to improve uptake of comprehensive ANC services that include: HIV testing for expectant mothers, building stronger community engagement approaches to inform high-quality maternal and child health services that also reflect community priorities, and efforts to ensure accountability and transparency in delivery of pediatric HIV and maternal health services.<sup>104</sup> ZINGO was a coordinator for the 2016 national consultation in Zambia on faith-based partnerships in the national HIV strategic priorities sponsored by the UNAIDS/PEPFAR Faith Initiative.



## Understanding the Vision: Further Information on the Topics Discussed in this Chapter

- For further information on the **interfaith pre-conferences held in Durban and Amsterdam prior to the International AIDS Conference**, see <http://iacfaith.org>. There are numerous links to scheduled events, activities, photographs, and videos for both conferences from this site.
- Visit <http://ihpemory.org/webinars/> for further information on the **webinars developed by the Academic Consortium**, to view the webinar series, and to access content.
- **WCC-EHAIA's French language resources** can be found at: [https://www.oikoumene.org/fr/resources/documents/programmes/justice-diakonia-and-responsibility-for-creation/ehaia?set\\_language=fr](https://www.oikoumene.org/fr/resources/documents/programmes/justice-diakonia-and-responsibility-for-creation/ehaia?set_language=fr). **Spanish language resources** can be found at: [https://www.oikoumene.org/es/resources/documents/programmes/justice-diakonia-and-responsibility-for-creation/ehaia?set\\_language=es](https://www.oikoumene.org/es/resources/documents/programmes/justice-diakonia-and-responsibility-for-creation/ehaia?set_language=es)
- **WCC-EAA's French language resources** can be found at: [https://www.oikoumene.org/fr/activites/ehaia?set\\_language=fr](https://www.oikoumene.org/fr/activites/ehaia?set_language=fr)
- **WCC-EAA's German language resources** can be found at: [https://www.oikoumene.org/de/was-wir-tun/ehaia?set\\_language=de](https://www.oikoumene.org/de/was-wir-tun/ehaia?set_language=de)
- **WCC-EAA's Spanish language resources** can be found at: [https://www.oikoumene.org/es/nuestra-labor/ehaia?set\\_language=es](https://www.oikoumene.org/es/nuestra-labor/ehaia?set_language=es)
- For further information on **Expanded Church Response**, please visit: <http://www.ecrtrust.org>
- To find out more about the **Zambia Interfaith Networking Group Platform**, please visit: <http://bit.ly/zambia-interfaith-platform>. Also, visit <http://bit.ly/zingo-and-children>.
- Further information on the Global Ecumenical Health Strategy of the **WCC** can be found at: <http://bit.ly/WCC-health-strategy>.
- Copies of **WCC-EHAIA** curricula on treatment adherence and faith healing and on positive masculinities and femininities can be found at <https://seafle.ecucenter.org/d/7efde2259e564c84b38f/>

## Building the Vision: Progress on the Recommendations of *The Gap Report* and *The Lancet Series*.

This chapter has laid out the current efforts to build capacity of community FBOs, FBHPs, and religious communities to respond to HIV in a number of areas. Organizations and activities profiled in the chapter support the following priorities laid out in *The Gap Report*.

Table 3.1: *The Gap Report* program priorities addressed in this chapter

GROUPS	REASONS THIS COMMUNITY IS BEING LEFT BEHIND	PRIORITIES FOR CLOSING THE GAP
<i>People living with HIV</i>	<ul style="list-style-type: none"> <li>▪ Access to treatment and services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Meaningful participation of people living with HIV</li> <li>▪ Improve services, including community-based services</li> <li>▪ Scale up antiretroviral therapy and integrated health services</li> </ul>
<i>Adolescent girls and young women</i>	<ul style="list-style-type: none"> <li>▪ Lack of access to health services</li> <li>▪ Policies that do not translate into action</li> </ul>	<ul style="list-style-type: none"> <li>▪ Ensure access to quality health services</li> <li>▪ Empower young women and girls and challenge and change social norms</li> </ul>
<i>Members of key populations communities</i>	<ul style="list-style-type: none"> <li>▪ Absent or inadequate services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Expand prevention, treatment, and support services</li> </ul>
<i>Children and pregnant women living with HIV</i>	<ul style="list-style-type: none"> <li>▪ Limited access to sexual and reproductive health and HIV services</li> <li>▪ Limited access to HIV treatment</li> <li>▪ Poorly integrated health-care services</li> </ul>	<ul style="list-style-type: none"> <li>▪ Improve access to health and HIV services for all women and children</li> <li>▪ Ensure treatment is available for all in need</li> <li>▪ Scale up integrated, family-centered health care services and information</li> </ul>



These activities also reflect the following recommendations and priority focuses from *The Lancet* series:

Table 3.2: **Key recommendations from *The Lancet* Series addressed in this chapter**

RECOMMENDATION/SOURCE	PRIORITY FOCUSES
<p><b>Conduct research into the precise nature and implications of faith roles in HIV care and services (Karam, Clague, Marshall, and Olivier; Olivier et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ For service delivery research, move beyond simply calculating scope to include mixed method and comparative approaches that address reach, service to the poor, quality, trust, volunteer mobilization/support, and financing</li> <li>▪ Expand to traditions outside Christianity</li> <li>▪ Survey research and publish in non-Anglophone languages</li> <li>▪ Research beyond service provision to encompass religion’s social capacity to influence norms, perceptions, politics, and policies</li> </ul>
<p><b>Build on the lessons learned from the 2014-2015 Ebola outbreak (Marshall and Smith).</b></p>	<ul style="list-style-type: none"> <li>▪ Strengthen knowledge of religious demography, institutions, and relationships so that faith communities/FBOs could be readily mobilized</li> <li>▪ Strengthen approaches to community engagement carried out by public health organizations to be more systematic, multidisciplinary, and informed about/respectful of cultural norms, beliefs, and practices.</li> <li>▪ Strengthen knowledge of the religious dimensions of behavior change and highlight the value of community expertise and the need to draw on it more purposefully and systematically.</li> </ul>
<p><b>Develop research initiatives in health systems strengthening for faith-based, non-profit health providers. (Olivier, et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Identify strategies for health providers to adapt to changing financing</li> <li>▪ Build infrastructure for capacity-building, focusing on joint strengthening of programmatic and administrative capacities</li> </ul>
<p><b>Develop research initiatives on the influences of religion on cultural, social, and political norms and perspectives. (Tomkins, et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Develop platforms for identifying shared commitments between religious leaders and health policy-makers.</li> </ul>
<p><b>Strengthen multisectoral partnerships that include governmental programs, civil society organizations, FBOs/health providers, and local faith communities (Buckingham and Duff).</b></p>	<ul style="list-style-type: none"> <li>▪ Measure and improve communication of the scope, scale, distinctiveness, and results of faith-based groups’ work in health care.</li> <li>▪ Appreciate respective objectives, capacities, differences, and limitations.</li> <li>▪ Increase investments in faith-based groups, while requiring transparent fiscal management.</li> <li>▪ Exchange and build core competencies in health and faith in both secular and faith-based groups, and inspire innovation and courageous leadership.</li> </ul>



Globally, HIV exacts a disproportionate toll on women and adolescent girls. As of 2016, AIDS-related illnesses were the leading cause of death among women of reproductive age (15-49 years); new infection rates were 67% higher in young women than in young men in central and western Africa and 133% higher in eastern and southern Africa.<sup>105</sup> In many communities around the world, FBOs frame HIV prevention, treatment, and support services broadly in order to shift harmful cultural and gender norms to provide HIV information and care to both men and women. PEPFAR and UNAIDS are working with religious leaders and local faith communities to address gender inequities, encourage people to understand the social forces that underwrite such inequities and commit to challenging them; condemn SGBV; and advocate for programs that address treatment, prevention, and support programs that address women's specific needs and encourage retention in care.<sup>106</sup>

The *Start Free, Stay Free, AIDS Free* Framework supports civil society organizations, including FBOs and religious leaders as they offer these kinds of services for young women most at risk for HIV. Launched by UNAIDS and PEPFAR in collaboration with global partners, the framework has set specific targets to give children an HIV-free start by supporting PVT of HIV and to support both young women and young men to remain HIV-free as they enter adulthood. Targets for young women and young men include a reduction in the number of new HIV infections among adolescents to less than 100,000 by 2020 and services to provide voluntary medical circumcision for HIV prevention to 25 million additional men by 2020 globally, with a focus on young men ages 10-29.<sup>107</sup> To achieve these targets the initiative offers combination HIV prevention strategies which meet the HIV information and service needs of young people. Strengthening and expanding partnerships with FBOs is critical to achieving these targets because they are named most frequently as a trusted community resource, their leaders have significant social capital to shape public opinion, and the educational, health, and support services they provide are essential to national responses in many of the 21 focus countries of the *Start Free, Stay Free, AIDS Free* Framework. At the same time, some FBOs and faith communities promote messages and teachings in tension with comprehensive HIV services, not only for women adolescent girls but also for other marginalized groups. There are, however, some FBO partners who are committed to advocating for and offering comprehensive sexuality education and services and to addressing the broader social-systemic factors that create vulnerabilities for women, adolescent girls, and other marginalized communities.

In many countries however, faith-based contributions to targeted services for women and men are not well coordinated or documented. The UNAIDS/PEPFAR FBO

Initiative is working to change that. The initiative has sponsored national interfaith consultations led by national AIDS authorities in six countries. These consultations are strengthening faith action plans and coordination mechanisms to integrate contributions from the faith sector more effectively into national responses. They have also equipped religious leaders to be advocates for programs that decrease cultural and gender inequalities that affect the vulnerability of women and adolescent girls to HIV infection and engage with other faith and local community leaders to decrease stigma and discrimination. These consultations, along with other activities sponsored by the implementing partners in the FBO Initiative are described below:

### From Vision to Reality: Activities of Implementing Partners

#### WCC-EHAIA

WCC-EHAIA coordinated national-level consultations in Zambia and Kenya to strengthen collaborations among FBOs from various religious traditions to respond to HIV (as described in chapter three). These consultations specifically addressed gender issues and fed into the much larger work that is carried out in local congregations and theological institutions. Participants were introduced to the WCC-EHAIA model of CBS that re-examines passages from religious texts that have historically been used to justify violence against women; the WCC-EHAIA manuals interpret those texts from women's points of view to demonstrate women's capacity to challenge disempowering gender norms. Following the Zambia consultation, these studies were implemented in 33 communities in partnership with the Network of Zambian People Living with HIV and with Trans Bantu Zambia, a non-governmental organization advocating for human rights for transgender people and people who are intersex.

In general, the clinical markers for effective HIV treatment are worse for men than for women and they are at increased risk of death from AIDS.<sup>108</sup> Though socio-cultural and internalized gender norms may affect these gaps, the design of HIV prevention and treatment programs often focuses on women and minimizes the role of men; one unintended effect of this focus on women is that it burdens them with the responsibility not only for managing their own health but also for dealing with men's choices. WCC-EHAIA challenges this approach through its Transformative *Masculinities and Femininities* program. The program names harmful ideas around masculinity and femininity and spells out the effects of those perspectives. This lays the foundation for improved HIV prevention and treatment services for men as well as women. The program was offered by WCC-EHAIA at the national-level consultation held in Zambia and Kenya; in addition, other

faith-based partners employed the program in their own activities in collaboration with WCC-EHAIA. Similarly, INERELA+ and the Young Men's Christian Association have their own toolkits for exploring transformative masculinities and femininities that attempt to address cultural gender norms and ensure that men are included in HIV prevention, care, and treatment program.

SGBV often places people at increased risk for HIV infection (for example, by deterring them from insisting on safer sex practices with partners), while simultaneously decreasing their ability to access HIV prevention and treatment services. INERELA+ Zambia Chapter and WCC-EHAIA developed targeted initiatives in collaboration with the United Church of Zambia to educate adolescents and young adults on SGBV and offer safe spaces to those experiencing such violence. Such activities reflect a long-standing commitment of WCC-EHAIA to address SGBV through its TiB campaign.<sup>109</sup> The campaign takes as its inspiration the witness of women around the world, including the Mothers of the Disappeared in Buenos Aires, Argentina; the Women in Black in Israel and Palestine; the Black Sash movement in South Africa; and the efforts of women in Rwanda and Bosnia who protested the use of rape as a weapon of war.

WCC-EHAIA works to address SGBV in collaboration with various civil society partners. For example, in 2017 WCC-EHAIA helped coordinate a consultation in Zimbabwe with Sonke Gender Justice<sup>110</sup> on transforming gender norms that brought together civil society organizations and religious leaders to challenge harmful conceptions of masculinity. Ezra Chitando spoke on WCC-EHAIA's curriculum on transformative masculinities and femininities.<sup>111</sup>

### WCC-EAA

WCC-EAA has mobilized over 1,000 leaders from various religious traditions around the world through its *Leading By Example* initiative. These leaders promote HIV testing and challenge stigma and discrimination with messages of compassion, support, and empowerment. WCC-EAA also sponsored an event entitled *HIV, Inheritance, and Property Rights—FBOs and Religious Leaders Overcoming Barriers to Women's Economic Empowerment* that was held in conjunction with the 61st Global Session of the Commission on the Status of Women.

WCC-EAA built on the successes of its Framework for Dialogue initiative in Kenya to mobilize religious leaders and key male stakeholders in areas with high numbers of people living with HIV to advocate for sustained, comprehensive services for all people living with HIV, while also addressing the low levels of HIV testing among men in these communities. WCC-EAA worked closely with the Kenya chapter of INERELA+ and with the Kenya Male Engagement Network (MenKen) on these activities. The involvement of religious leaders and the male engagement in sensitization activities created demand for HIV services and resulted in increased uptake for HIV testing services by men across the project sites in Homa Bay and

Siaya counties. This methodology for demand creation, by mobilizing men to access services through engaging with faith communities, religious leaders and structures, provides an innovative model for replication if proven to be effective.

## The Vision Multiplied: Faith-Based Organizations Working on the Ground

### American Jewish World Service (AJWS)

AJWS is the largest Jewish organization working on global health and development initiatives and social justice issues. AJWS addresses gender inequities and SGBV through a number of programs. In eastern regions of DRC, AJWS funds *Female Solidarity for Integrated Peace and Development*, a program that provides support to women who have experienced sexual violence. AJWS provides similar support for women living in refugee camps in Myanmar where rape and sexual violence are weapons used against cultural minority groups. The program, the *Karen Women's Organization*, offers support for the immediate physical needs of women and children such as clothing, food, and shelter, as well as longer-term support that includes leadership training and education. In Guatemala, AJWS supports *Incide Joven*, a youth-led program that educates local communities about SRH including HIV prevention. Finally, AJWS supports lesbian women and transgender women in various LGBTQI initiatives around the world.<sup>112</sup>

### ABAAD-Resource Center for Gender Equality

In Lebanon, ABAAD sponsors national campaigns supporting gender equity and condemning violence against women. The "We Believe" campaign enlists Christian and Muslim religious leaders as trusted messengers of these campaigns. The success of the initial campaign led to the program's expansion across the Middle East and North Africa region.<sup>113</sup>

### Muslims for Progressive Values (MPV)

MPV is working to build a progressive global Muslim community that champions gender justice and speaks out against stigma and violence that people living with HIV experience. MPV is a strong advocate for ten principles based on Muslim teachings: hospitality to all, equality, separation of religious and state authorities, freedom of speech, human rights, gender equality, LGBTQI inclusion, critical thinking, compassion, and diversity.<sup>114</sup>

## Menengage Alliance

The Menengage Alliance is a global network of organizations that educate men on transformative masculinity and advocate for gender equity. The alliance convened an international consultation with religious leaders and FBOs in 2016. Participants represented Muslim, Baha'i, and Christian traditions as well as a variety of civil society organizations.<sup>115</sup> The Kenya chapter of Menengage is working with WCC-EAA, an implementing partner in the UNAIDS/PEPFAR FBO Initiative, to engage men in HIV prevention services through the Framework for Dialogue program.

## Circle of Concerned African Women Theologians

This continent-wide network of African feminist theologians authors a variety of materials for both local faith communities and for theological schools that promote gender justice and call religious communities to practices of justice and support for women. The Circle has developed resources on HIV that are used in churches, seminaries, and theological schools around the world. The Circle also convenes local, national, and global meetings on gender issues, including HIV and sexual health.<sup>116</sup>

## RAHMA

Rahma is a Muslim FBO based in Washington, DC that supports people living with or affected by HIV by addressing issues of stigma and discrimination and working for women's empowerment and gender equity. Rahma sponsors HIV testing campaigns, offers programs on HIV education for youth, conducts HIV workshops, and sponsors retreats for Muslim women and men living with or affected by HIV.

## Understanding the Vision: Further Information on the Topics Discussed in this Chapter

- For information on the ways that **American Jewish World Service** addresses gender equity and promotes SRH, visit: <https://ajws.org/what-we-do/sexual-health-and-rights/>
- To find out more about the ways that **ABAAD** engages men and boys to support gender equality, see: <https://www.abaadmena.org/documents/ebook.1487166563.pdf>
- The website of **Muslims for Progressive Values** describes the organization and lays out its guiding principles. See <http://www.mpvusa.org/mpv-principles>.
- The **MenEngage Alliance** worked with **Tearfund** to convene a two-day consultation on Transforming Masculinities. The report on the consultation can be found here: <http://bit.ly/transformingmasculinities-report>.
- For a comprehensive history of the first two decades of the **Circle of Concerned African Women Theologians**, see <https://muse.jhu.edu/book/56506>.
- To learn more about **Rahma**, visit the organization's website at <http://haverahma.org>.
- **WCC-EHAIA** leads a number of initiatives on gender equality. For information on the Thursdays in Black campaign, visit <http://bit.ly/thursdaysinblack>. For worship resources and study guides for contextual Bible studies, visit: <http://bit.ly/ContextualBibleStudyToolkit>. For information on the Redemptive Masculinities initiative of WCC-EHAIA, visit <http://bit.ly/redemptivemasculinity>
- **INERELA+** has authored curricula to help religious leaders teach and advocate for comprehensive sexual health education and gender equity in their faith communities and the broader community. See <http://inerela.org/wp-content/uploads/2019/01/ASRRH-Handbook.pdf>. INERELA+ offers the complete SAVE Toolkit for comprehensive HIV prevention on its website. See <http://inerela.org/resources/save-toolkit/>



## #KnowYourStatus

HIV Testing: Leading by Example



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“Giving example to check our status among religious leaders is more powerful than all interventions.”

**Anggia Ermarini**  
Chairperson of Fatayat  
Nahdlatul Ulama, Indonesia



## Building the Vision: Progress on the Recommendations of *The Gap Report* and *The Lancet Series*

This chapter has highlighted efforts by FBOs and religious leaders in support of gender equity and equality and challenge SGBV. These activities support the following priorities identified in *The Gap Report*:

Table 4.1: *The Gap Report* program priorities addressed in this chapter

GROUPS	REASONS THIS COMMUNITY IS BEING LEFT BEHIND	PRIORITIES FOR CLOSING THE GAP
<i>People living with HIV</i>	<ul style="list-style-type: none"> <li>Human rights violations, stigma and discrimination</li> <li>Gender-based inequalities</li> <li>Criminalization and exclusion</li> </ul>	<ul style="list-style-type: none"> <li>Meaningful participation of people living with HIV</li> <li>Increase treatment and rights awareness</li> </ul>
<i>Adolescent girls and young women</i>	<ul style="list-style-type: none"> <li>Gender-based violence</li> <li>Lack of access to health services</li> <li>Lack of access to education</li> <li>Policies that do not translate into action</li> </ul>	<ul style="list-style-type: none"> <li>End all forms of gender-based violence</li> <li>Ensure access to quality health services</li> <li>Keep girls in school</li> <li>Empower young women and girls and challenge and change social norms</li> </ul>
<i>Members of key populations communities</i>	<ul style="list-style-type: none"> <li>Absent or inadequate services</li> <li>Widespread societal stigma</li> <li>Violence</li> </ul>	<ul style="list-style-type: none"> <li>Expand prevention, treatment, and support services</li> <li>Address institutionalized stigma and discrimination</li> <li>Focus on those who commit violence rather than prosecuting those who experience violence. Develop protective social and legal environments.</li> </ul>
<i>Children and pregnant women living with HIV</i>	<ul style="list-style-type: none"> <li>Limited access to sexual and reproductive health and HIV services</li> <li>Limited access to HIV treatment</li> <li>Poorly integrated health-care services</li> </ul>	<ul style="list-style-type: none"> <li>Improve access to health and HIV services for all women and children</li> <li>Ensure treatment is available for all in need</li> <li>Scale up integrated, family-centered health care services and information</li> </ul>

These activities also align with the following key recommendations from articles published in the 2015 issue of *The Lancet* on faith-based healthcare.

Table 4.2: **Key recommendations from *The Lancet* Series addressed in this chapter**

RECOMMENDATION/SOURCE	PRIORITY FOCUSES
<p><b>Conduct research into the precise nature and implications of faith roles in HIV care and services (Karam, Clague, Marshall, and Olivier; Olivier et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Expand to traditions outside Christianity</li> <li>▪ Broaden focus to include areas beyond sub-Saharan Africa</li> <li>▪ Develop more robust conceptual understanding of religion</li> <li>▪ Research beyond service provision to encompass religion’s social capacity to influence norms, perceptions, politics, and policies</li> </ul>
<p><b>Build on the lessons learned from the 2014-2015 Ebola outbreak (Marshall and Smith).</b></p>	<ul style="list-style-type: none"> <li>▪ Strengthen knowledge of religious demography, institutions, and relationships so that faith communities/ FBOs could be readily mobilized</li> <li>▪ Strengthen approaches to community engagement carried out by public health organizations to be more systematic, multidisciplinary, and informed about/respectful of cultural norms, beliefs, and practices.</li> </ul>
<p><b>Develop research initiatives in health systems strengthening for faith-based, non-profit health providers. (Olivier, et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Describe similarities and differences on norms and perspectives <i>within</i> a religious tradition and <i>across</i> religious traditions.</li> <li>▪ Focus on the effects of religion’s influences on marginalized populations.</li> <li>▪ Develop platforms for identifying shared commitments between religious leaders and health policy-makers.</li> </ul>
<p><b>Strengthen multisectoral partnerships that include governmental programs, civil society organizations, FBOs/health providers, and local faith communities (Buckingham and Duff).</b></p>	<ul style="list-style-type: none"> <li>▪ Measure and improve communication of the scope, scale, distinctiveness, and results of faith-based groups’ work in health care.</li> <li>▪ Appreciate respective objectives, capacities, differences, and limitations.</li> <li>▪ Exchange and build core competencies in health and faith in both secular and faith-based groups, and inspire innovation and courageous leadership.</li> <li>▪ Refrain from using religious teachings to undermine evidence-informed public health practices; refrain from using secularist ideology to undermine effectiveness of faith-based groups’ work in health.</li> </ul>



PHOTO: USAID KENYA/Irene Angwenyi



As soon as the first AIDS cases were reported, many people who were infected or affected faced stigma based solely on their HIV status or perceived risk of infection. Not all illnesses carry this stigmatizing dimension, but HIV clearly has. Because of the power and pervasiveness of this stigma, HIV has always required not only a clinical and medical response, but a cultural response as well. However, such cultural responses could not be universal; they had to reflect nuanced understandings of the varying origins of stigma in different contexts as well as the varied social-cultural responses that could help dismantle it in such contexts. And yet, some of the early programs to address stigma were based on models that had proven effective in North America and Europe that could not account for the differing cultural production of stigma in other parts of the world and did not draw on the wisdom and insights of experts or people living with HIV from those parts of the world. This chapter and accompanying Annex III describe some of the limited conceptualizations of HIV-related stigma, describe efforts to broaden our understanding of stigma and work to dismantle it, and summarize the work carried out by religious communities and FBOs to understand and challenge the ways that religion has been used to create, justify, and magnify the stigma that people living with HIV face.

A foundational 2003 article by social scientists Richard Parker and Peter Aggleton surveyed research into and programs to address HIV-related stigma and argued that efforts to address it were limited by inadequate understandings of stigma, claiming that “our collective inability to more adequately confront stigmatization, discrimination and denial in relation to HIV and AIDS is linked to the relatively limited theoretical and methodological tools available to us.”<sup>117</sup> Their survey demonstrates that most of the work of stigma challenged stereotypical attitudes rather than addressing the social-structural forces that exclude those who experience stigma from supportive social relationships. By focusing on stereotyped assumptions, efforts to address stigma sought to generate empathy and reduce fear in those who stigmatized people living with HIV by providing information that challenged the assumed basis of their fears. While such an approach had some positive effect, it failed to address the underlying social factors that generated assumptions and fear in the first place. This had a long-term, unintended consequence: “stigma [came] to be seen as something in the person stigmatized, rather than as a designation that others attach to that individual.”<sup>118</sup>

Parker and Aggleton argued that stigmatization needed to be reframed primarily as a social process in order to understand the broader notions of power and domination involved. They believe that “stigma plays a key role in producing and reproducing relations of power and control. It causes some groups to be devalued and others to

feel that they are superior in some way. Ultimately, therefore, stigma is linked to the workings of social inequality and to properly understand issues of stigmatization and discrimination, whether in relation to HIV and AIDS or any other issue, we need to think more broadly about the forces that create and reinforce exclusion in different settings.”<sup>119</sup> This analysis provides a good explanation for shifts in the global response to HIV-related stigma and discrimination from early efforts to promote “tolerance” and help people living with HIV “cope,” to more recent work to challenge the structural and social injustices that perpetuate stigma and discrimination.

Theologian Gillian Paterson reflected this critique in her work. Working with WCC-EAA, Paterson conducted a review of the literature on stigma and articulated a Christian theological framework for understanding stigma that lays out that the ways the Christian tradition has been a source of the power, control, and social inequality described by Parker and Aggleton. Paterson developed a number of principles on stigma, summarized here<sup>120</sup>:

- Stigma is contextual and social. Paterson argues that stigma cannot be understood as an innate characteristic of a person who experiences stigma but as an effect of the social and political responses it generates: “my ethnic background, gender or age can be stigmatizing in one environment, but constitute the norm in another. It is by the way that others treat me that you form the judgement that I carry a stigma.”
- Stigma is not the same as discrimination, though they are often related. By developing new social networks that refuse the cultural norms and attitudes that drive stigma or by advocating for legislative protection against stigmatizing attitudes, stigmatized groups may be able to resist the more obvious forms of discrimination. Such efforts alone, however, challenge discrimination but will not necessarily transform the stigmatizing attitudes that produced them.
- Fear and lack of knowledge contribute to disease-related stigma. Addressing this fear requires both accurate information and access to treatment.<sup>121</sup>
- One form of stigma, symbolic stigma, relates to cultural or religious meanings and it is expressed in religious or moral judgements. This stigma is generated through different social, cognitive and emotional processes from disease-related stigma and from rational assessments of risk. As such, it requires different interventions.



- In generating and defending the social norms of a culture, religion often functions to reinforce and ritualize symbolic stigma. In the Christian tradition, the infringement of cultural and social norms may be interpreted as sin.
- When stigma is internalized, it may permeate an individual's entire self-identity with shame or self-disgust. This may lead the stigmatized individual to collaborate in their own stigmatization.
- It is possible to reduce stigma over time because cultural norms and attitudes can change. Religious teachings and practice can generate symbolic stigma by re-enforcing or ritualizing those norms; they may also reduce stigma by challenging those norms.
- Religious institutions may stigmatize and exclude members who have been named as sinners because the leaders of those institutions believe that the fear of exclusion helps preserve the institutional identity and protect the members' moral welfare. The key issue within those communities focuses on the understanding of what constitutes sin.
- Stigma serves to further root the inequalities already in place in culture. Those on the social margins tend to become scapegoats for disease or calamity. This creates a social distance from this risk for those in the social mainstream, reducing anxiety.

Reflecting the theological imperatives laid out by Paterson, a consultation with Christian theologians to examine HIV-related stigma was convened by UNAIDS in 2005. Participants laid out seven theological themes. One of them, religious responses to HIV-related stigma, is summarized here and the other six are summarized in Annex III.<sup>122</sup> Please note that this was a consultation with Christian theologians and subsequent work in other faith traditions has addressed issues of stigma and discrimination drawing on theological reflection from other faith traditions.<sup>123</sup>

### **Religious Responses to HIV-related Stigma**


Religion has not been the only driver of HIV-related stigma, but it can be a powerful contributor to stigmatizing attitudes.<sup>124</sup> On the other hand, religion can also be a powerful resource to challenge stigma. If people of faith use the teachings of their religious tradition to justify a particular moral framework that stigmatizes people who are living with HIV or who are vulnerable to infection, then other people from within that same tradition can articulate another perspective drawing on religious teachings that offers an entirely different moral framework to challenge such stigma. The UNAIDS/PEPFAR joint FBO Initiative has sponsored a number of activities to address HIV-related stigma. These activities fall into two general categories: 1) challenging stigmatizing attitudes, and 2) articulating a different framework. Activities that challenge stigmatizing attitudes focus on the message that all people living with or affected by HIV should be treated

with respect and compassion.

These activities do not address the underlying structures and assumptions that generate stigma but argue that such assumptions should be secondary to treating all human beings compassionately, regardless of perceptions and beliefs about the morality of their actions. Such activities can generate broad-based support from religious communities and religious leaders and directly challenge discriminatory attitudes, practices, or policies.


Activities that articulate a different framework may employ religious messages, develop a theological argument, or call on the social authority of religious leaders to support an aspect of the HIV response often seen to be at odds with existing religious frameworks and interpretations. Examples would include advocating for evidence-based public health approaches in working with people who inject drugs rather than mandating abstinence or affirming some forms of sexual expression outside of monogamous heterosexual marriage. In doing so, these kinds of activities create a distinctly new and different framework.

The first kind of activities can be an effective tool for challenging HIV-related discrimination by arguing that the appropriate religious response to HIV is not to render moral judgements but to offer support to those in need. The second kind of activities can be powerful resources for specific initiatives designed to address stigma and barriers to care that members of key population groups face. Globally, members of key populations and their partners account for over 50 percent of new HIV infections each year, even though they make up a much smaller proportion of the total population.<sup>125</sup>



## #KnowYourStatus


HIV Testing: Leading by Example



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“I encourage everybody to get tested as we work towards the end of AIDS by 2030.”

**Rev. Fr. Joseph Mutie**  
 General Secretary  
 Organization of African Instituted  
 Churches in Kenya



## From Vision to Reality: Activities of Implementing Partners

This section describes various activities carried out by the implementing partners in the FBO Initiative. Some of the activities fit into first category of challenging stigmatizing attitudes and others fit into the second category of articulating a different framework. Work described here includes different ways of addressing stigma and discrimination by working together with FBOs and key populations.

### *The Academic Consortium*

Researchers from St. Paul's University and Emory University, both members of the Academic Consortium, conducted interviews and focus group discussions in Kenya to better understand the influence of religion on the stigma that members of key population groups face and how FBOs can work effectively key populations living with HIV and AIDS. 190 people representing various key population groups (including men who have sex with men, sex workers, people who inject drugs, and young women) or staff of FBOs that offer specific services for key population groups participated in focus groups or agreed to a key informant interview. Participants were chosen to assure geographic representation of the western region (Kisumu, Uasin Gishu counties), the central region (Kiambu and Nairobi counties), and the coastal region (Mombasa and Kilifi counties). 77% of participants identified as Christian, with 20% identifying as Muslim, the remaining 3% not identifying, and <1% (n=1) identifying as atheist.

The staff of FBOs committed to working with key population groups acknowledged that religious beliefs in the broader society were sources of discriminatory attitudes but they articulated different religious frameworks. The two most common frameworks were "only God can pass judgement" and "everyone is created in the image of God." For members of key population groups, religion's effects were varied and complex. Participants described experiences in which religion contributed to stigma and discrimination and in which it served as a powerful rationale for challenging and reducing stigma. Members of key population groups recounted the ways in which religious commitments of some friendly FBOs motivated staff to offer essential services, but they also described experiences of stigma and discrimination, denial of services, forced disclosure of their status, and a lack of confidentiality in other FBOs where they had bad experiences. Participants stated that such negative or positive experiences were not limited to FBOs and that religion could be a contributing factor to positive attitudes or negative judgements by staff in various types of facilities.

Religious belief and practice remained important for the great majority of participants. 185 out of 190 (97%) indicated that they were believers of either Christian or Muslim traditions and only one participant self-identified as atheist. Participants who described themselves as reli-

gious noted that their faith was an important resource for coping with stigma and most had worked to reframe or re-interpret condemning religious messages into theological viewpoints that focused on God's love for them.

Findings from this research have served as core content for a curriculum to train FBOs and religious leaders on models of HIV care and support programs that reflect the needs and priorities of key populations communities and reflect the attitudes of FBOs programs and leaders that offer compassionate, high-quality services.

The Academic Consortium also worked with other implementing partners and the UNAIDS Country Office in Nigeria to develop and pilot a national curriculum for addressing stigma. Two consortium members, the University of Jos and Emory University, worked with leadership from Caritas Nigeria, the Christian Health Association of Nigeria and representatives from the National Agency for the Control of AIDS, the multi-sectoral body in Nigeria responsible for setting HIV priorities. The curriculum challenged general stigmatizing attitudes and specifically addressed religiously motivated stigma with specific modules for Muslim and Christian religious communities in Nigeria.

### *ACHAP*

Working with the Academic Consortium, ACHAP co-sponsored a needs assessment on the clinical knowledge and skills of HIV primary care providers working in health facilities in the CHAK to provide best-practice models of HIV care to members of key population groups. One hundred twelve HIV care providers from CHAK facilities in 12 counties participated. Findings from the needs assessment are informing a clinical training initiative for CHAK staff to improve knowledge and skills. While this will build capacity for CHAK's HIV programs, it will do so in a way that directly improves access to care for communities who disproportionately face barriers to services, helping to counteract one of the effects of stigma and discrimination faced by key populations.

### *WCC-EAA*

Addressing stigma and discrimination and promoting human rights are key priorities of the WCC-EAA "Faith on the Fast Track" campaign which seeks to create a coordinated interfaith voice and mobilize action to generate change in attitudes in communities of faith and policy change in countries. WCC-EAA recruited over 1,000 faith leaders from around the world to participate in its "Leading by Example: Religious Leaders and HIV Testing" campaign to promote HIV testing in faith communities as a way to challenge the stigma that often accompanies access to HIV services. Launched in 2016, the campaign is engaging leaders from different faith traditions to promote testing and linkage to services by increasing awareness of HIV and by creating faith communities free of stigma and discrimination.

Through the campaign, religious leaders are tested and come to know their HIV status; this encourages others to do the same. The religious leaders who are part of the campaign share information about HIV in their places of worship. They invite people to know their status when exposed to HIV, and when necessary, encourage mothers to bring their babies and infants for testing along with other family members. This initiative promotes a strong linkage among faith communities and health-care facilities. It provides an excellent basis to speak out to get more people who need to be tested to know their status, linked to services, and retained in care. The social-media component<sup>126</sup> of the campaign displays posters of religious leaders and people who have undergone an HIV test to inspire others to be tested as well (without the need to disclose the HIV test result). Increasing the number of people receiving HIV testing is vitally important in the effort to end AIDS as a public health threat by 2030. The aims of this interfaith campaign are to: overcome the stigma of HIV testing by showing that having an HIV test is not a statement about morality but a health practice that those at risk of infection should adopt; increase the number of HIV-positive people who know their status; and link them to treatment and support services. Religious leaders who join the campaign commit themselves to:

- Promote testing in their faith community. They do so by setting an example of getting tested themselves and by allowing their photo to be taken for the social media poster series on ["Leading by Example: Religious Leaders and HIV Testing"](#).
- Encourage people to know their status when exposed to HIV. They do so by sharing this message through sermons; sharing accurate information about HIV testing and treatment; promoting a non-discriminatory community, and encouraging community outreach groups (e.g. women and youth groups) to support HIV testing and treatment adherence. In some communities, a mobile HIV testing unit has been organized through the local government or health service.
- Set a specific HIV testing day each month, or an HIV testing week or month each year.
- Share with media the importance of HIV testing and the example being set both by the religious leader and the faith community. They do this by writing a letter to the editor of a local newspaper or encouraging letter-writing campaigns to government officials to advocate for strong HIV funding and services.
- Share their sermons with the WCC-EAA. They do so by sending the sermons they are using to raise awareness on HIV so that they can be shared with other leaders and faith communities.

Another tool implemented by the WCC-EAA to tackle stigma and discrimination is the "Framework for Dialogue process. The Framework for Dialogue between religious leaders and networks of people living with HIV is an interfaith collaborative initiative developed and led by the WCC-EAA, in collaboration with UNAIDS, GNP+ and INERELA+. This collaborative effort creates opportunities for dialogue and joint actions for stigma reduction among faith-based and non-faith-based actors. Dialogue processes have been implemented in Uganda, Malawi, Ethiopia, and Nigeria. They are ongoing in Kenya at national and local levels and they are launching in DRC, Ukraine and the United States. In Ethiopia, a Sermon Guide for the Orthodox Church on GBV, eVT of HIV, and HIV-related stigma has been developed, and communities are being instructed in its use. In Uganda, participants have committed to further dialogue on critical issues related to families and HIV such as marriage and discordant relationships, and faith healing in relation to ART. In each instance, strategies have been identified to overcome each challenge. In Malawi, some faith leaders became champions against homophobia and a work policy prohibiting LGBTQI discrimination in churches was developed. WCC-EAA sponsored "Framework for Dialogue" meetings across Kenya in collaboration with UNAIDS Kenya, INERELA+ Kenya, and MenKen. The meetings generated community action plans, many of which focused on sensitizing male religious and community leaders to challenge stigma and discrimination and to encourage young men to seek HIV testing. The collaborative structure of the Framework for Dialogue provides an effective tool to be implemented at both national and local levels that increases mutually beneficial, systematic, inclusive and sustained joint action among people living with HIV and faith communities, governments, and international and civil society organizations. It can also contribute to efforts to address the stigma and discrimination faced by people living with HIV. Finally, it provides a way for communities to identify and tackle the factors that increase vulnerability to HIV infection and to develop strategies for improving adherence and retention.

A 2017 "Framework for Dialogue" impact assessment in Kenya showed that local community members and leaders had maintained efforts to continue carrying out action plans to offer additional support to people living with HIV that had been developed years earlier. Many of the community leaders involved in these plans committed to the WCC-EAA campaign, "Leading by Example", to challenge stigma and offer support to people living with or affected by HIV.<sup>127</sup> Through this campaign, several religious leaders in Kenya became Faith Pediatric AIDS Champions. In June 2017, these leaders launched pediatric HIV efforts that included advocacy in support of the 2018 UN treatment targets for children and adolescents, HIV testing in local faith communities and religious schools, and social media campaigns to provide positive messages of strength and compassion.<sup>128</sup>

At an international level, WCC-EAA convened the Interfaith Pre-Conference to the 2018 International AIDS Conference in Amsterdam. The conference theme, *Faith Building Bridges*, explored ways that FBOs and faith communities could build bridges of dialogue, exchange, mutual understanding, respect, and collaboration. Various sessions addressed efforts to combat stigma and discrimination and plenary sessions as well as various conference tracks focused on the specific issue of stigma, highlighting religious responses to stigma, including responses built in partnership with key populations.

### **WCC-EHAIA**

In Zambia, WCC-EHAIA worked with Trans Bantu Zambia, a national LGBTQI advocacy organization, to help implement a CBS program and establish a safe spaces initiative. The CBS model re-examines religious texts that have been used to justify violence and discrimination toward members of key population communities by listening to the concerns and points of view of people from those communities.

In the FBO Initiative, WCC-EHAIA and WCC-EAA have both worked with the INERELA+ to ensure that the perspectives of people living with HIV guide their activities and also serve to inform broader HIV initiatives and advocacy efforts. The WCC-EAA collaborates with the Global Network of People Living with HIV (GNP+) and with national networks of people living with HIV on joint interventions to address stigma and discrimination identified through the Framework for Dialogue process; it collaborates with migrants living with HIV on advocacy around HIV prevention, access to services, and tackling stigma and discrimination in the migration contest, and with members of the NGO Delegation to the UNAIDS Programme Coordinating Board on advocacy at global level. These efforts reflect one of the key priorities in *The Gap Report*—the meaningful participation of people living with HIV.

## **The Vision Multiplied: Faith-Based Organizations Working on the Ground**

### **The Inner Circle**

Founded in 1996, The Inner Circle is a long-standing human rights organization that addresses gender and sexual diversity from an Islamic theological perspective. Located in Cape Town, South Africa, the organization works within its local community and across the country of South Africa. It also partners with other international organizations to address issues of gender and sexual diversity within the framework of Islam. The Inner Circle works with Muslims to help them reconcile their faith and their sexuality.

Initially, the organization operated largely as an underground support system, with study circles offered in the home of Imam Muhsin Hendricks, the founder of The Inner Circle. These study circles have continued into the present, growing to offer a vital context for helping

LGBTQI Muslims reconcile Islam with their sexuality.

Today, Imam Hendricks coordinates the various activities of The Inner Circle. These include a personal empowerment initiative, an International Retreat for Queer Muslims, and an International Conference for the Empowerment of Women. He also writes theological, sociological, and public policy papers, including a policy brief on HIV health services for queer Muslims entitled *Islam, Sexual Diversity, and Access to Health Services*.<sup>129</sup>

### **INERELA+**

INERELA+ is the only global interfaith FBOs led by people living with HIV to address HIV in different contexts.<sup>130</sup> Through its headquarters staff and the various country chapters of INERELA+, the organization carries out a number of stigma reduction initiatives. INERELA+ has developed an innovative, comprehensive HIV education and stigma reduction approach called SAVE>SSDDIM. The SAVE Toolkit provides a number of resources to teach people about **S** safer practices, encourage **A**ccess to antiretroviral treatment and medical care, support **V**oluntary testing and counselling so that individuals know their HIV status, and **E**mpower people living with or affected by HIV to challenge stigma and apathy. Together, these SAVE principles will challenge SSDDIM: **S**hame, **S**tigma, **D**enial, **D**iscrimination, **I**naction, and **M**isaction. SAVE principles inform INERELA+ educational, advocacy, and support programs and INERELA+ explicitly involves LGBTQI individuals and communities in its activities.

### **Church World Service**

Church World Service works to create a safe space for LGBTQI persons, providing both resettlement for LGBTQI refugees and protection to those still facing the fear of persecution. CWS operates centers in Nairobi, Kenya and Johannesburg, South Africa to serve refugees and those seeking asylum. The center has served LGBTQI people, among others. CWS has developed linkages between faith communities and LGBTQI rights organizations in both Kenya and South Africa with the aims of improving protection for LGBTQI refugees and creating a network of advocates for LGBTQI rights at the local community level. As part of this network, CWS conducts outreach in LGBTQI communities and sponsors a peer support program for queer youth. Starting in 2017, CWS began offering HIV prevention and treatment to LGBTQI refugees in Kenya in partnership with the Liverpool VCT Centre with funding support from the Elton John AIDS Foundation. In addition to these activities, CWS has offered Safe Space trainings to hundreds of religious leaders in Kenya and South Africa. The trainings encourage leaders to extend hospitality to LGBTQI people. CWS recognizes that the psychosocial, spiritual, and health needs of those seeking asylum can be exceptionally challenging. They work together with caring churches, organizations, and individuals to provide help and homes to refugees.

Through addressing psychosocial and physical trauma, CWS works to build a welcoming community for uprooted people so that they can fashion a better future.

### **AJWS**

AJWS is an FBO that supports a number of health, development, and social justice initiatives around the world. The organization is the fourth largest funder of programs for LGBTQI people and supports 51 organizations working in 14 countries in Africa, Latin America, and Asia.<sup>131</sup> AJWS also funds 17 organizations working in eight different countries on sex workers rights.<sup>132</sup> These programs specifically address stigma in relation to cultural, policy, and legal issues; they also provide HIV services, helping lower the barriers to care that are an effect of stigma and discrimination.

### **MEWA**

MEWA is a Muslim FBO in Mombasa, Kenya that was founded in 1986 to help improve the educational, economic, and social welfare of Muslims. Funded by the contributions of individual Muslims and Muslim organizations, MEWA has now built a hospital, drug treatment center, library, and computer center.

The organization also provides services to those who are not Muslim; MEWA does not discriminate in the provision of its services in regard to race or ethnicity, gender, or religion.

MEWA offers extensive services to people who inject drugs. In 1993, MEWA began to focus on drug treatment in response to the growing addiction problem in the coast province, particularly among youth using heroin. Many of those with whom MEWA works are also HIV positive.

The MEWA Drug Treatment Centre offers services<sup>133</sup> using treatment models adapted from Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), using the Milati Islami (Path to Peace) model that re-interprets AA and NA principles in light of Muslim religious teaching.

MEWA not only offers treatment services; its volunteers and staff provide street outreach programs in locations where drug users meet and use drugs. Equipped with alcohol swabs, water, condoms, clean needles, and educational materials, MEWA staff offer low-threshold services to meet immediate needs and use these encounters as a basis to establish trust in order to explore with program participants the various options for drug treatment services. MEWA also provides important psychosocial support to family members of treatment participants.

MEWA currently has five different centers that have seen over 10,000 patients for clinical detox. With over 26,000 drug users in the Coast Province alone, MEWA currently has over 5,000 clients in Mombasa and is actively reaching out to younger IDUs in villages. This CBO is providing “health, hope, and healing” to drug users, their families, and the broader community, all important elements in

addressing stigma and discrimination in communities.

### **Inclusive and Affirming Ministries (I AM)**

I AM is an FBO in South Africa that works at the intersection of religion, gender and sexual orientation, and public health and focuses on LGBTQI programs, HIV services, and youth-specific services.<sup>134</sup> Since its founding in 1995, I AM has expanded to support programs in Botswana, Namibia, Malawi, Tanzania, Zimbabwe, and Uganda. A distinctive service of I AM is a safe house in Cape Town where LGBTQI people from other regions of Africa who have left their homes after fearing violence or experiencing violence can receive safe housing and emergency support.

**The People Living With HIV Stigma Index** was begun by networks of people living with HIV, including GNP+ and the International Community of Women Living with HIV (ICW) in 2008 with the support of civil society organizations and UNAIDS. The index has since been translated into 55 languages and implemented in over 100 countries; over 100,000 people living with HIV have been interviewed.<sup>135</sup> While the method anchoring the process is standardized, the findings generated are country-specific and have been used to provide evidence of successful (or unsuccessful) stigma reduction initiatives, identify processes of stigmatization that have been overlooked and require a response, influence workplace policies, inform legal viewpoints regarding the criminalization of HIV transmission, and champion human rights. Today, the index is supported by ICW and GNP+.

Using findings from the Stigma Index, WCC-EAA has partnered with INERELA+, GNP+, and UNAIDS to carry out new phases of the “Framework for Dialogue” workshops and has produced a companion volume called *Dignity, Freedom, and Grace*, including specific chapters addressing the intersection of religion and stigma.<sup>136</sup>

### **National Council of Churches of India (NCCI)**

In 2008, NCCI launched the Ecumenical Solidarity on HIV and AIDS (ESHA) initiative, with activities carried out in local congregations and theological colleges. In partnership with Kerke in Actie, the public ministries program of the Protestant Church of the Netherlands<sup>137</sup>, ESHA has developed initiatives to equip churches to speak out against stigma and discrimination against LGBTQI people in local churches and extend hospitality to LGBTQI people. In addition, ESHA is training seminarians through theological reflection, interpretation of Biblical passages, and training in pastoral care.<sup>138</sup>

## **MPV**

MPV is an advocacy organization that champions progressive values and policies in society and in Islam.<sup>139</sup> MPV's statement of principles supports universal human rights, gender equality, and LGBTQI inclusion. Through policy papers and research fellows, MPV is a strong voice for programs and policies that address stigma and discrimination. MPV is also part of the Alliance of Inclusive Muslims<sup>140</sup>, a global network of fourteen member organizations that challenges violent extremism, authors progressive Islamic scholarship, and advocates for gender rights and equality.

## **Metropolitan Interdenominational Church**

Metropolitan Interdenominational Church was founded in 1981 in Nashville, TN, USA. Reverend Edwin Sanders was the founding pastor and continues to serve in that role today. From its beginning, Metropolitan had openly out LGBTQI members and began offering ministries of care and support to people living with HIV in the earliest days of the epidemic. In 1994, the congregation opened the First Response Center, an HIV program providing support services, HIV primary care programs, and a Wellness Center that supports outreach services to active drug users as well as intensive day-treatment programs for people who use drugs. The First Response Center combines a harm reduction model with treatment services to support people who are working to achieve and maintain abstinence. The HIV program provides support services to help people experiencing homelessness and actively using drugs to maintain ART medication regimens. Reverend Sanders is a national leader on HIV issues in the United States, having served on the U.S. President's Advisory Council on HIV/AIDS and the CDC Advisory Committee on HIV and STD Prevention. He is National Director of Religious Leaders for a More Just and Compassionate Drug Policy and is a member of the Scientific Advisory Board for PEPFAR. He uses these platforms to challenge stigma and discrimination towards people living with and at increased risk of HIV infection and its impact.

## **Office of Health and Healing of the WCC**

This office, formerly known as the Christian Medical Commission, played a formative role in the development of the primary health care movement.<sup>141</sup> The movement represented a revolutionary change in the development of health programs and organizations in the 1970s. At that time, health initiatives tended to focus exclusively on siloed programs managed by outside technical experts with scientific or clinical knowledge but little or no knowledge of local community priorities or interests. The primary health care movement sought to democratize health service delivery and the platforms for public health and social development in low and middle-income countries. In the 1970s, WHO adopted the primary health care model as its primary strategy. UNAIDS has identified the principles and priorities of the primary health care movement as key contributors to the global strategy for addressing HIV at local, regional, national, and global

levels. "When well resourced, primary care, with its emphasis on comprehensive, coordinated, continuous and people-centered care, is particularly well suited among service delivery platforms to provide care for people facing chronic illness and multi-morbidity. In some countries, the AIDS response has charted a new path, representing the first large-scale, chronic care programs to support HIV as a chronic communicable disease and thus, potentially able to support large scale-up of [other health] programs."<sup>142</sup> While the primary health care movement is once again generating attention in relation to capacity-building to address pressing health needs including HIV, the role of the Office of Health and Healing at the WCC has the opportunity to engage proactively, drawing on its important history.

The Office of Health and Healing is developing a new strategy on health for the WCC called the Ecumenical Health Strategy, with primary health care as a foundation.<sup>143</sup>

## **The Global Interfaith Network for people of all Sexes, Sexual Orientations, Gender Identities and Expressions (GIN)**

GIN is a Global network of Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI) communities who are organizing themselves to demand protection under the law and to demand an end continued criminalization of LGBTQI identities. This kind of discrimination is often justified with religious rhetoric, cultural claims and customary laws, which lead to religious persecution and violence against LGBTQI people, especially in the Global South. While HIV is not the central focus of this network, the criminalization of LGBTQI identities is closely linked to HIV because this discrimination increases the risk and impact of HIV. The network has strong links with INERELA+ and people of faith living with HIV are part of the network's leadership. GIN was an active member of the Global Organizing Committee for the WCC-EAA Interfaith Pre-Conference to the 22nd International AIDS conference, held in 2018 in Amsterdam. GIN shared their work and resources, offering a session on dialogue with religious leaders, participating in a panel discussion on queer engagement with faith traditions and offering an SGBV workshop. Engagement with religious leaders from the Buddhist and Hindu traditions is a strong feature of the network.<sup>144</sup>

## Understanding the Vision: Further Information on the Topics Discussed in this Chapter

- For further information on the **People Living with HIV Stigma Index**, see <http://www.stigmaindex.org>. Program partners are collaborating on the index. For information on the **International Community of Women Living with HIV**, see <http://www.icwglobal.org>. For information on the **Global Network of People Living with HIV (GNP+)**, see <https://www.gnpplus.net>. For information on the *Grace, Freedom, and Dignity* publication published by WCC-EAA as part of the partnership with GNP+ and INERELA+ using findings from the stigma index, see <http://bit.ly/Dignityfreedomandgrace1>. For an excerpt of the book, see <http://bit.ly/dignityfreedomandgrace2>.
- A copy of the theological reflection by Gillian entitled *AIDS Related Stigma. Thinking Outside the Box: The Theological Challenge* can be found at <http://bit.ly/aidsrelatedstigma>.
- A copy of the report from the 2005 theological consultation convened by UNAIDS can be found at [http://data.unaids.org/publications/irc-pub06/jc11119-theological\\_en.pdf](http://data.unaids.org/publications/irc-pub06/jc11119-theological_en.pdf)
- Further information on the **Ecumenical Solidarity on HIV/AIDS Initiative** of the National Council of Churches of India can be found at <http://www.eshancci.org>. The initiative is supported by the Protestant Church in the Netherlands. See <https://www.kerkinactie.nl>
- Information on **The Inner Circle** can be found at <http://al-fitrah.org.za>. The report on *Islam, Sexual Diversity, and Access to Health Services* authored by Imam Hendrix from The Inner Circle can be found at <http://bit.ly/Islam-sexual-diversity>.
- For further information on **INERELA+**, see <http://inerela.org>
- For further information on **American Jewish World Service**, please visit <https://ajws.org>. For a summary of AJWS' work on LGBT rights, see <http://bit.ly/AJWS-LGBT>. For a summary of their work on sex workers' rights, see <https://ajws.org/what-we-do/sexual-health-and-rights/sex-worker-rights/>
- Further information on **Inclusive and Affirming Ministries** can be found at <http://iam.org.za>
- To find out more about **Muslims for Progressive Values**, please visit <http://www.mpvusa.org>. Muslims for Progressive Values is part of the **Alliance for Inclusive Muslims**. Please visit <https://www.aim.ngo> for further information.
- For further information on **Metropolitan Interdenominational Church**, please visit <http://www.micwhosoever.org>. For information on their HIV and drug treatment programs, please visit <http://metropolitanfrc.com>
- Further information about the **Muslim Education and Welfare Association** can be found at <https://www.mewa.or.ke>
- Further information on the work of **Church World Service** to support LGBT refugees can be found at <http://bit.ly/cws-lgbti>.
- **UNAIDS** has published a report describing the relationship between the primary health care movement and the global response to HIV. It can be found at: <http://bit.ly/UNAIDS-primary-care>.
- For further information on the **Global Interfaith Network for people of all Sexes, Sexual Orientations, Gender Identities and Expressions**, see <http://www.gin-ssogie.org/about-us/>. For further information on their work on HIV: <http://www.gin-ssogie.org/news/22nd-international-aids-conference-july-2018/>. For information on their Manifesto from the Asia/South-East Asia consultation including dialogue with Buddhist and Hindu leaders: <http://www.gin-ssogie.org/family-and-traditional-values-regional-joint-declarations/silom-manifesto/>

## Building the Vision: Progress on the Recommendations of *The Gap Report* and *The Lancet Series*

The chapter has laid out activities of FBOs and religious leaders to challenge stigma and discrimination, focusing on activities that challenge contagious stigma and activities that seek to address the fear of moral contagion. The organizations and activities profiled in the chapter support the following priorities laid out in *The Gap Report*.

Table 5.1: *The Gap Report* program priorities addressed in this chapter

GROUPS	REASONS THIS COMMUNITY IS BEING LEFT BEHIND	PRIORITIES FOR CLOSING THE GAP
<b>People living with HIV</b>	<ul style="list-style-type: none"> <li>Human rights violations, stigma and discrimination</li> <li>Access to treatment and services</li> <li>Gender-based inequalities</li> <li>Criminalization and exclusion</li> </ul>	<ul style="list-style-type: none"> <li>Meaningful participation of people living with HIV</li> <li>Improve services, including community-based services</li> <li>Scale up antiretroviral therapy and integrated health services</li> <li>Increase treatment and rights awareness</li> </ul>
<b>Adolescent girls and young women</b>	<ul style="list-style-type: none"> <li>GBV</li> <li>Lack of access to health services</li> <li>Policies that do not translate into action</li> </ul>	<ul style="list-style-type: none"> <li>End all forms of GBV</li> <li>Ensure access to quality health services</li> <li>Empower young women and girls and challenge and change social norms</li> </ul>
<b>Members of key populations communities</b>	<ul style="list-style-type: none"> <li>Criminalization and punitive laws</li> <li>Absent or inadequate services</li> <li>Widespread societal stigma</li> <li>Violence</li> </ul>	<ul style="list-style-type: none"> <li>Decriminalize sex work and sex between consenting men, change focus of laws on drug use from incarceration to treatment</li> <li>Expand prevention, treatment, and support services</li> <li>Address institutionalized stigma and discrimination, empower key populations communities</li> <li>Focus on those who commit violence rather than charging those who experience violence. Develop protective social and legal environments.</li> </ul>



PHOTOS: WCC/Albin Hillert; WCC-EAA/Paul Jeffrey



The activities to address stigma and discrimination also support the following key recommendations from various articles in *The Lancet Series* on faith-based health care.

Table 5.2: **Key recommendations from *The Lancet Series* addressed in this chapter**

RECOMMENDATION/SOURCE	PRIORITY FOCUSES
<p><b>Conduct research into the precise nature and implications of faith roles in HIV care and services (Karam, Clague, Marshall, and Olivier; Olivier et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ For service delivery research, move beyond simply calculating scope to include mixed method and comparative approaches that address reach, service to the poor, quality, trust, volunteer mobilization/support, and financing</li> <li>▪ Expand to traditions outside Christianity</li> <li>▪ Broaden focus to include areas beyond sub-Saharan Africa</li> <li>▪ Develop more robust conceptual understanding of religion</li> <li>▪ Research beyond service provision to encompass religion’s social capacity to influence norms, perceptions, politics, and policies</li> </ul>
<p><b>Build on the lessons learned from the 2014-2015 Ebola outbreak (Marshall and Smith).</b></p>	<ul style="list-style-type: none"> <li>▪ Strengthen knowledge of religious demography, institutions, and relationships so that faith communities/ FBOs could be readily mobilized</li> <li>▪ Strengthen approaches to community engagement carried out by public health organizations to be more systematic, multidisciplinary, and informed about/respectful of cultural norms, beliefs, and practices</li> <li>▪ Strengthen knowledge of the religious dimensions of behavior change and highlight the value of community expertise and the need to draw on it more purposefully and systematically</li> </ul>
<p><b>Develop research initiatives on the influences of religion on cultural, social, and political norms and perspectives. (Tomkins, et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Describe similarities and differences on norms and perspectives <i>within</i> a religious tradition and <i>across</i> religious traditions</li> <li>▪ Focus on the effects of religion’s influences on marginalized populations</li> <li>▪ Develop platforms for identifying shared commitments between religious leaders and health policy-makers</li> </ul>
<p><b>Strengthen multisectoral partnerships that include governmental programs, civil society organizations, FBOs/health providers, and local faith communities (Buckingham and Duff).</b></p>	<ul style="list-style-type: none"> <li>▪ Measure and improve communication of the scope, scale, distinctiveness, and results of faith-based groups’ work in health care</li> <li>▪ Appreciate respective objectives, capacities, differences, and limitations</li> <li>▪ Increase investments in faith-based groups, while requiring transparent fiscal management</li> <li>▪ Exchange and build core competencies in health and faith in both secular and faith-based groups, and inspire innovation and courageous leadership</li> <li>▪ Refrain from using religious teachings to undermine evidence-informed public health practices; refrain from using secularist ideology to undermine effectiveness of faith-based groups’ work in health</li> </ul>



The previous five chapters have detailed activities across many different contexts and priority areas that demonstrate the contributions of faith-based partners toward the vision of a world without AIDS. That vision is before us; the challenge comes in summoning the will to make it a reality. This must include the prophetic voice of political, technical, and religious leadership to advance a positive agenda in an environment of complacency and a time of division. Doing so will require strong voices to make clear the demands required and to inspire local communities, governmental authorities, and global bodies to continue their support for programs and services. Religious leaders and FBOs possess powerful voices for making this case and the UNAIDS/PEPFAR FBO Initiative is supporting advocacy activities that focus on three priorities: 1) offer compassion and support for people living with HIV or at risk for HIV infection in local religious communities, 2) call governments at local, regional, and national levels to strengthen their response to HIV and increase funding while also calling for transparency in funding and programming, and 3) build new and strengthen existing platforms to advocate for continued or increased funding to global bi-lateral and multi-lateral mechanisms for HIV funding. These priorities build on the roles and responsibilities of FBOs and UNAIDS set out in the UNAIDS Strategic Framework for Partnership with FBOs, agreed on in 2009.<sup>145</sup> Activities that support advocacy for these priorities in global and international arenas are described below.

### From Vision to Reality: Activities of Implementing Partners

#### WCC

WCC manages two HIV related initiatives. However, WCC itself is also a body that brings together over 350 member denominations and church bodies and has been an early, courageous, and constant advocate for compassionate Christian responses to HIV. Since the earliest days of the epidemic, WCC has set out a powerful and progressive advocacy agenda on HIV. Early resolutions of the WCC were ground-breaking and have formed the foundation for the work of the two projects through the UNAIDS/PEPFAR FBO Initiative today.<sup>146</sup>

#### WCC-EHAIA

WCC-EHAIA is one of the faith initiatives working with churches in sub-Saharan Africa on local and national advocacy and activism on HIV as a social justice, human dignity and rights issue and prevention of sexual-gender-based-violence, and reduction of stigma and discrimination through CBS. WCC-EHAIA has developed a number of resources to study positive masculinities, femininities, and HIV life-affirming theology and literature

in theological institutions. In its endeavor to advocate for and promote gender justice and positive masculinities and femininities, WCC-EHAIA has worked to listen to and learn from people who share their experiences as LGBTQI people.

These encounters with LGBTQI individuals have encouraged WCC-EHAIA to host dialogues between LGBTQI individuals and religious leaders, which create safe spaces for examining cultural beliefs, scriptures, and African ways of socialization. At the congregational level, WCC-EHAIA facilitates theological reflections on pastoral accompaniment with people living with or affected by HIV and survivors of SGBV, as well as developing resilience and support for learners and teachers (especially those living with HIV) in church-owned schools. In addition, WCC-EHAIA promotes intergenerational communication that helps to build the skills to discuss sex, sexuality, and SRHR in mixed groups of adolescents and young people. These discussions are carried out with leaders, professionals, social influencers, and policy-makers in churches, church-owned schools, and institutions of higher learning. WCC-EHAIA has extensive global influence through its biblical, theological, ethical, and liturgical literature and manuals. The publications are in high demand and are widely read and cited in academic publications.

#### WCC-EAA

WCC-EAA is the largest faith-based advocacy platform on ecumenical solidarity and social justice in the world, drawing on a Christian membership broader than that of the WCC itself and convening interfaith partners on HIV-related issues. The WCC-EAA understands advocacy to encompass awareness raising, capacity building, campaigning, and policy engagement.

Awareness raising is directed at the public more than at decision makers. It seeks to educate and make people aware of issues of injustice and it is not necessarily intended to accomplish immediate or direct change. Rather it lays a foundation on which further advocacy can be built. Capacity building aims to strengthen the capacity and engagement of churches and FBOs to be more effective in speaking out and acting for universal access to prevention, testing, treatment, care, and support, and against stigma and discrimination. This may include trainings, workshops, and documentation support. Campaigning happens in public and involves mobilization. In some cases, campaigning may be focused on convincing decision-makers at all levels, including in the church, to take certain actions. In others the focus may be on the general public in order to encourage attitudinal, behavioral, and social change.

Policy engagement entails working with decision makers at international, national, and local levels, and often seeks to bring about change by offering expertise or proposing solutions rather than through overt pressure.

Examples of the interfaith advocacy led by WCC-EAA are the Interfaith HIV Prayer Breakfast in coordination with the opening of the United Nations General Assembly in New York; the “Leading by Example” campaign on testing; the children letter-writing action on pediatric HIV; and advocacy efforts on Migration and HIV.

The 2016 Interfaith HIV Prayer Breakfast was aimed at generating concrete actions and at fostering partnerships for achieving the time-bound targets of the UN Political Declaration on Ending AIDS adopted by all UN member states in June 2016. A concrete outcome of the 2016 breakfast was the renewed commitment by FBOs and religious leaders to promote uptake of testing and linkage to services in faith communities with the launch of the “Leading by Example: Religious Leaders and HIV Testing” campaign.

The 2017 breakfast focused on promoting action by faith leaders and communities to reach the 2018 and 2020 prevention, testing, and treatment targets for children and adolescents. Participants committed to raise awareness on pediatric HIV and to engage children and adolescents in advocacy on HIV. As a concrete outcome, the WCC-EAA launched the guide for teachers and religious leaders: Faith communities take action with children living with HIV.<sup>147</sup> Working through faith communities and religious schools to reach children, adolescents, and young people, aged 11 to 24, this letter-writing action encouraged young people to write letters to government ministries, First Ladies, and specific pharmaceutical and diagnostic companies, asking them to improve access to age-appropriate HIV information, testing, and treatment for children and adolescents. The guide also offers ideas to students and youth groups to use in raising awareness of these issues in local newspapers and other media forums. Young people are therefore encouraged to become advocates for better diagnostics and treatment for their peers living with HIV. Finally, the guide also provides an opportunity to share age-appropriate prevention information on HIV and to empower youths to take action on behalf of, and in solidarity with, others who live with HIV. WCC-EAA sponsors other activities in South Africa and Kenya, which include dialogues between adolescents, youth and faith leaders.

In 2018, the Interfaith HIV Prayer Breakfast highlighted the urgent need for coordinated and effective advocacy for HIV and tuberculosis (TB) preventive therapy, diagnosis, and treatment, detailing the consequences of untreated TB for people living with HIV. Speakers and table discussions focused on the outcomes of the United Nations High-Level Meeting on Tuberculosis and examined how the longstanding experience of FBOs in responding to TB and HIV can support the new declaration. The participants renewed their call to national governments, donors, UN agencies and faith groups to not only maintain but in-

crease support in order to end AIDS and TB. In the group discussions, participants brainstormed ways to scale up case findings and treatment for children and adolescents with TB and HIV; discussed prevention interventions by FBOs and faith leaders; and learned about partnerships for change. They called for stronger follow-up actions, recommendations, and financial commitments. As a concrete outcome, the WCC-EAA included TB in its advocacy strategy and organized a series of workshops on HIV and TB for faith leaders and representatives of FBOs.

More recently, WCC-EAA partnered with the International Catholic Migration Commission, the International Organization for Migration, the UN Refugees Agency (UNHCR), UNAIDS, and others to call for greater attention to issues related to migration and HIV. Seventy individuals from 40 organizations, representing 36 countries gathered in the Ecumenical Centre in Geneva in February 2019 to develop a road map for strengthening collaboration among FBOs, multi-lateral organizations, governments, and civil society to address HIV risk, provision of services, and advocacy among migrants and those displaced by war, violence, and civil unrest. The road map provides a way forward in four areas: HIV prevention; testing, treatment, care and support; violence and HIV; and eliminating stigma and discrimination. Each organization represented at the meeting was encouraged to identify three actions they could undertake to support the implementation of the road map, and they agreed to regularly share their achievements with the WCC-EAA.

The WCC-EAA has become a platform for bringing the voices of various faith traditions into policy documents, strategies, and declarations, as well as into international forums. The International AIDS Conference, held every two years, draws thousands of participants, including health workers, scientists, government representatives, journalists, activists, corporate leaders, people living with HIV, religious leaders, and representatives of FBOs. The Conference and the WCC-EAA Interfaith Pre-Conference provide extensive opportunities for sharing and networking across all levels of care and response to the epidemic. The WCC-EAA provides a space for networking, learning, and advocacy among people of faith responding to HIV and AIDS at each International AIDS Conference. This is also an opportunity to further strengthen the engagement of faith communities in the comprehensive responses to HIV.

In addition, the WCC-EAA is an important convener in ecumenical efforts in advocacy to promote access to testing and treatment for all, targeting diagnostic and pharmaceutical companies; supporting initiatives to reduce the prices of medicines, specifically the collective voluntary licensing instrument of the Medicines Patent Pool and the Global Accelerator for Pediatric Formulations; promoting the *Start Free, Stay Free and AIDS Free* Framework, in particular by mobilizing faith pediatric champions and action to ensure that children and adolescents are on treatment; and serving as a key member of the monitoring team of the Rome Pediatric HIV Action Plan.<sup>148</sup>

## **The Black AIDS Institute (BAI)**

BAI had a strong advocacy leadership role at the 2016 International AIDS Conference in Durban, South Africa. With support from the UNAIDS/PEPFAR FBO Initiative, BAI sponsored conference sessions, including sessions in the Global Village adjacent to the conference center, that were open to the general public at no charge. In one session, BAI hosted members of the Congressional Black Caucus of the US Congress; these members spoke about the state of the HIV epidemic in African-American communities in the United States today.

Bridging the activities related to the International AIDS Conference and its leadership role on HIV advocacy in the United States, BAI co-sponsored the Interfaith Pre-Conference to the US Conference on AIDS. In addition, it convened local meetings in ten cities across the United States (Atlanta, GA; Oakland, CA; Charlotte, NC; Los Angeles, CA; Melbourne, FL; Fort Lauderdale, FL; Baltimore, MD; Chicago, IL; Jackson, MS; and Baton Rouge, LA) to share key findings from the International AIDS Conference and launch advocacy initiatives. Finally, BAI sponsored a special session at the 2016 Congressional Black Caucus Annual Legislative Conference.

Through these activities, BAI contributed to global faith-based advocacy efforts and was a national leader of such efforts in the United States, where Black Churches have a long history of advocacy for social justice and can build on partnerships with churches in various parts of Africa.

## **Caritas Internationalis**

Caritas Internationalis has been a strong advocate for pediatric HIV programs, highlighted in chapter two. In addition to this work, Caritas Internationalis helped convene the regional faith-based consultation in Nigeria sponsored by the UNAIDS/PEPFAR FBO Initiative; this consultation, like all the national consultations sponsored by the FBO Initiative, laid out priorities for the national HIV policy agenda for pediatric HIV treatment in each country.

In addition to its advocacy efforts on pediatric HIV care, Caritas Internationalis has worked with WCC-EAA and other partners, including WHO, UNAIDS, PEPFAR and EG-PAF, to support the Dicastery for the Promotion of Integral Human Development of the Holy See. Through this support, these partners are leading advocacy efforts to global pharmaceutical and diagnostic companies to facilitate and expedite the research, development, approval, introduction, and uptake of optimal drugs and formulations for infants, children, and adolescents. Proposals have included both steps to make priority drugs in the pipeline quickly available in the short term as well as innovative mechanisms that could be put in place to facilitate and accelerate the development of pediatric formulations of drugs for HIV and other life-threatening diseases over the longer term. A series of High-Level Dialogues provided an opportunity for stakeholders to build on those conversations by putting forward a set of concrete actions they could take to better support mechanisms for research, de-

velopment, and medication distribution. Those commitments, which also built on work within the Global Accelerator for Pediatric Formulations and the *Start Free, Stay Free, AIDS Free* Framework, formed the basis of the Rome Action Plan, which contains 41 good-faith commitments to focus, accelerate, and collaborate on the development, registration, introduction, and roll-out of the most optimal pediatric formulations and diagnostics.

## **The Vision Multiplied: Faith-Based Organizations Working on the Ground**

### **Religions for Peace (RFP)**

For a number of years, RFP has supported inter-religious dialogue and advocacy to address a number of pressing challenges around the world. RFP has been a leader for religious advocacy on HIV, publishing a handbook on HIV Advocacy and Media Relations<sup>149</sup> and leading a number of initiatives to equip religious leaders to speak out against GBV.<sup>150</sup>

### **The Common Voice Initiative**

The Common Voice is an inter-religious advocacy initiative to develop and articulate a common advocacy platform for continued support to end AIDS. In collaboration with WCC-EAA, the initiative is developing a number of projects, grounded in the principles laid out in the Common Voice Pledge. For more information on the Common Voice initiative and to add your voice to the pledge, go to <https://www.commonvoiceaids.org>

### **Islamic Relief**

Through various programs, Islamic Relief advocates for people living with or affected by AIDS. In 2007 with support from UNAIDS, Islamic Relief hosted a global conference on Islam and HIV in collaboration with Positive Muslims—a network of Muslim people living with HIV. The conference produced an important theological text on Islam and HIV, *Islam and AIDS: Between Pity, Scorn, and Justice*. In 2019, Islamic Relief is focusing its advocacy efforts on gender justice.<sup>151</sup> In February it convened global leaders to draft a first-ever Islamic Declaration on Gender Justice, which was launched in June 2019 following input from key stakeholders. It hosted a number of inter-religious events in conjunction with the United Nations Commission for the Status of Women in March.<sup>152</sup>

## Understanding the Vision: Further Information on the Topics Discussed in this Chapter

- For information on the HIV media toolkit developed by **Religions for Peace**, see <http://bit.ly/rfp-hiv-advocacy>. For further information on their efforts to address GBV, see <http://bit.ly/rfp-gbv>.
- **Islamic Relief** is focusing on gender justice in 2019. For information on their consultation on gender justice and the forthcoming gender justice declaration, see <https://www.islamic-relief.org/landmark-final-consultation-on-gender-justice-declaration/>. For information on their efforts advocating on gender justice at the 2019 UN meeting of the Commission on the Status of Women, see <https://www.islamic-relief.org/islamic-relief-at-csw-2019/>. Farid Esack, one of the conveners of the 2007 conference coordinated by Islamic Relief and Positive Muslims, has made a number of documents from the conference available, including *HIV, AIDS, and Islam* ([https://www.academia.edu/33686396/HIV\\_Aids\\_and\\_Islam.pdf](https://www.academia.edu/33686396/HIV_Aids_and_Islam.pdf)), and the complete text of *Islam and AIDS: Between Scorn, Pity, and Justice* (<http://bit.ly/islam-and-aids>).
- **WCC-EAA's** history of advocacy can be found at the organization's earlier website, which is still running at <http://www.e-alliance.ch>. Their work as a program of the WCC is described here: <https://www.oikoumene.org/en/what-we-do/ea>.
- **Caritas Internationalis** has been part of numerous HIV advocacy efforts. For information on their work, including the co-sponsorship of various high-level dialogues in collaboration with other implementing partners and support from UNAIDS and PEPFAR, see <https://www.caritas.org/category/health/hiv-aids/>. In 2006, UNAIDS worked with Caritas Internationalis to publish *A Faith-Based Response to HIV in Southern Africa: The Choose to Care Initiative*. The report highlights various best practice models and calls faith communities to comprehensive and sustained action. See [https://www.unaids.org/sites/default/files/media\\_asset/jc1281-choosetocare\\_en\\_0.pdf](https://www.unaids.org/sites/default/files/media_asset/jc1281-choosetocare_en_0.pdf). In 2016, Caritas Internationalis worked with UNAIDS, PEPFAR, and a host of FBOs including many implementing partners to publish a report detailing the key steps that must be taken and sustained by faith communities and FBOs to further the hard-won gains in pediatric HIV care. See <https://www.caritas.org/2016/04/caritas-unaids-pepfar-and-faith-organisations-make-roadmap-to-end-child-hiv-infection/>.
- For a description of the advocacy and education efforts of the **Black AIDS Institute** at the 2016 International AIDS Conference, see <http://iacfaith.org/faith-at-aids-2018/BlackAIDS2016CSEPBooklet.pdf>

In 2010 WCC-EAA, UNAIDS, GNP+, INERELA+ and the government of the Netherlands convened the first global High-Level Summit of Religious Leaders on HIV in Den Dolder, The Netherlands.

Forty Baha'i, Buddhist, Christian, Hindu, Jewish, Muslim, and Sikh leaders met together, with the Executive Directors of UNAIDS and UNFPA, the AIDS Ambassadors of The Netherlands and Sweden, leaders and representatives of networks of people living with HIV, and other organizations active in the response to HIV. This Summit led to a commitment to action signed by over 400 religious leaders over the subsequent two years. For more information see: <http://e-alliance.ch/en/s/hivaids/summit-of-high-level-religious/> <http://www.hivcommitment.net/>

- Information on the **Common Voice Initiative** can be found at <https://www.commonvoiceaids.org>.



### #KnowYourStatus

HIV Testing: Leading by Example



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“Religious leaders preach in a temple, in a mosque, and in a church; they are a role model for others, such as students. I recommend people to go for a test. As a religious leader you should talk about it more. As Hindus, we are silent about it, but you should come out of it. When you are preaching, you should talk also about testing. I recommend everyone to have a test done.”

**Kamla Fatania**  
Hindu Council of Kenya


 **World Council of Churches**

## Building the Vision: Progress on the Recommendations of *The Gap Report* and *The Lancet Series*

This chapter has examined the important HIV advocacy initiatives by FBOs and religious leaders around the world. These efforts support the following priorities laid out in *The Gap Report*.


Table 6.1: *The Gap Report* program priorities addressed in this chapter

GROUPS	REASONS THIS COMMUNITY IS BEING LEFT BEHIND	PRIORITIES FOR CLOSING THE GAP
<i>People living with HIV</i>	<ul style="list-style-type: none"> <li>Human rights violations, stigma and discrimination</li> <li>Access to treatment and services</li> <li>Gender-based inequalities</li> </ul>	<ul style="list-style-type: none"> <li>Meaningful participation of people living with HIV</li> <li>Improve services, including community-based services</li> <li>Scale up antiretroviral therapy and integrated health services</li> <li>Increase treatment and rights awareness</li> </ul>
<i>Adolescent girls and young women</i>	<ul style="list-style-type: none"> <li>GBV</li> <li>Lack of access to health services</li> <li>Lack of access to education</li> <li>Policies that do not translate into action</li> </ul>	<ul style="list-style-type: none"> <li>End all forms of GBV</li> <li>Ensure access to quality health services</li> <li>Keep girls in school</li> <li>Empower young women and girls and challenge and change social norms</li> </ul>
<i>Children and pregnant women living with HIV</i>	<ul style="list-style-type: none"> <li>Limited access to sexual and reproductive health and HIV services</li> <li>Limited access to HIV treatment</li> <li>Failure to prioritize children</li> <li>Poorly integrated health-care services</li> </ul>	<ul style="list-style-type: none"> <li>Improve access to health and HIV services for all women and children</li> <li>Ensure treatment is available for all in need</li> <li>Invest in pediatric commodities and approaches</li> <li>Scale up integrated, family-centered health care services and information</li> </ul>



### #KnowYourStatus


HIV Testing: Leading by Example



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“A leader should lead in everything. An imam should walk the talk. Don’t just talk. You encourage people to do likewise. If people know their status, and you as a leader, you explain, they know you have done that. They follow you. People have trust.”

*Sheikh Abdul L. Phiri*  
Tagwa Mosque  
Zambia



In addition, these advocacy efforts reflect the key recommendations articulated in the articles in the 2015 *The Lancet* Series on faith-based health care.

Table 6.2: **Key recommendations from *The Lancet* Series addressed in this chapter**

RECOMMENDATION/SOURCE	PRIORITY FOCUSES
<p><b>Conduct research into the precise nature and implications of faith roles in HIV care and services (Karam, Clague, Marshall, and Olivier; Olivier et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ For service delivery research, move beyond simply calculating scope to include mixed method and comparative approaches that address reach, service to the poor, quality, trust, volunteer mobilization/support, and financing</li> <li>▪ Expand to traditions outside Christianity</li> <li>▪ Broaden focus to include areas beyond sub-Saharan Africa</li> <li>▪ Develop more robust conceptual understanding of religion</li> <li>▪ Research beyond service provision to encompass religion’s social capacity to influence norms, perceptions, politics, and policies</li> </ul>
<p><b>Develop research initiatives on the influences of religion on cultural, social, and political norms and perspectives. (Tomkins, et. al.).</b></p>	<ul style="list-style-type: none"> <li>▪ Describe similarities and differences on norms and perspectives within a religious tradition and across religious traditions.</li> <li>▪ Focus on the effects of religion’s influences on marginalized populations</li> <li>▪ Develop platforms for identifying shared commitments between religious leaders and health policy-makers</li> </ul>
<p><b>Strengthen multisectoral partnerships that include governmental programs, civil society organizations, FBOs/health providers, and local faith communities (Buckingham and Duff).</b></p>	<ul style="list-style-type: none"> <li>▪ Measure and improve communication of the scope, scale, distinctiveness, and results of faith-based groups’ work in health care</li> <li>▪ Appreciate respective objectives, capacities, differences, and limitations</li> <li>▪ Increase investments in faith-based groups, while requiring transparent fiscal management</li> <li>▪ Exchange and build core competencies in health and faith in both secular and faith-based groups, and inspire innovation and courageous leadership</li> <li>▪ Refrain from using religious teachings to undermine evidence-informed public health practices; refrain from using secularist ideology to undermine effectiveness of faith-based groups’ work in health</li> </ul>

## CONCLUSION. A VISION IN SHARPER FOCUS: WORKING TO FURTHER PROGRESS AGAINST HIV



This report has described the work of FBOs and religious communities in the global response to HIV. Partnerships with a wide range of civil society and community groups will be needed to build on the hard-won progress made toward ending the epidemic. Religious partners are one important group in the HIV response, given their scale, scope, reach, and influence on social norms and practices within communities.

The UNAIDS/PEPFAR FBO Initiative set out to respond to the challenges laid out in *The Lancet Series* and *The Gap Report*. It has provided a platform for research, building capacity, and mobilizing faith-based partners for advocacy on HIV. The implementing partners of the initiative have developed programs and models in six areas: 1) documenting the contributions of faith-based partners, 2) sustaining and strengthening faith-based pediatric and adolescent HIV responses; 3) building the capacity of local, regional, and national FBOs alongside local religious communities to offer compassionate and evidence-based HIV services; 4) challenging gender inequities and SGBV; 5) reducing stigma by articulating a model of justice and inclusion through religious structures and offering services to marginalized communities; and 6) advocating for strong, sustained HIV programs in local, national, contexts.

### Significant Achievements

Recognizing that this initiative had a number of constraints (see footnote 10), some of the achievements are significant. For example:

- The scale, and scope of FBO contributions to a national HIV response were documented down to county level in Kenya, and the findings made available on an interactive website.
- Through consultations held at the Vatican and in a number of countries, sustained advocacy contributed significantly to strengthened targets for pediatric HIV treatment in the Political Declaration on HIV and AIDS of 2016. Additionally, pharmaceutical companies, regulators, and other partners made over 40 specific commitments to scale up the availability of pediatric medication and progress toward those commitments was also made publicly available on a web platform.
- Capacity-building tools and training manuals for religious leaders, faith communities, and health workers have been developed that draw on supportive teachings from various faith traditions while also integrating approaches to HIV that are informed by human rights and social justice, gender equity, and scientific evidence.

- Interfaith and intergenerational dialogues at country and regional levels, combined with global advocacy initiatives, have provided safe spaces and expanded methodologies that can be replicated elsewhere to challenge gender inequality and address SGBV. For example, the *Thursdays in Black Campaign* highlights this critical issue and opens up opportunities for discussion, education, and action.
- Initiatives such as the *Framework for Dialogue and Leading by Example: Religious Leaders HIV Testing Campaign* have been launched and expanded in new countries and down to district levels to address stigma and discrimination. In addition, a national training curriculum on stigma and discrimination for health care workers in faith-based health care settings has been developed in Kenya. In Nigeria, this process was adapted and expanded to serve as a standard curriculum on stigma and discrimination to be implemented by the National Agency for the Control of AIDS and its partners across various sectors.
- Consultations, led by national AIDS authorities to strengthen the engagement of faith based organizations and health care providers in national AIDS responses, have been held in five countries, building on a model developed by the NACC and national partners in Kenya. New action plans to identify faith-based contributions to national AIDS plans have been developed and are at various stages of implementation in these five countries.

Reflections at the end of each chapter have also pointed to some of the other areas where this work has responded to the challenges and recommendations of *The Lancet Series* and *The Gap Report*.

Some important lessons have been learned or reinforced through this initiative. For example, the FBO Initiative demonstrated innovative ways to build collaboration between activities at a global level and those at national and regional level. Strong partnerships among religious leaders, governmental authorities, and civil society organizations have led to the development of national faith action plans to support countries' broader national strategic AIDS plans; these have been critical to the success of those national responses. Such initiatives have provided a solid structure for capacity building supported by global partners to support sustainability. Similarly, global advocacy efforts have been successful, due in part to the strong connection between these efforts and national programs, initiatives and partners, especially when they provide an avenue for the voices of PLHIV, key populations, and young people to be heard in the international policy making arena.



This work has reinforced the importance of working closely with people who might be invisible in their national context because of criminalization, stigma, and discrimination to provide a forum for talking about sensitive issues in safety and helping them to decide when and if they feel safe to take those discussions into the public arena. It has also highlighted the importance of working in collaboration with opinion leaders and change agents because they can sensitively challenge the status quo and bring about change from the inside. This approach can be more effective than efforts to impose change from the outside to address controversial topics, when such efforts can damage or halt programs that are working with vulnerable communities with high rates of HIV infection or increased risk for infection.

## Recommendations and Next Steps

And so what next? Building on the achievements and lessons learned from this initiative over four years, this report concludes with six recommendations to support and augment to those already articulated by *The Lancet Series* and the *The Gap Report*.

1. Ensure that people living with HIV are at the forefront of decision making, leadership processes, implementation, and monitoring and evaluation of future and ongoing faith-based initiatives and work.
2. Continue to support work with faith leaders, FBOs, faith communities, and faith-based health care facilities that are in line with human rights and social justice, gender equity, and the best scientific evidence, drawing on supportive teachings from faith traditions.
3. Strive to ensure that investment flows to strengthen national interfaith partnerships that support the national AIDS responses that are led by national AIDS authorities. Replicate or adapt successful national faith-based action plans in other countries.
4. Strengthen collaboration within and across different faith traditions in line with the roles and responsibilities outlined in the UNAIDS strategic framework for partnership with FBOs in the HIV response and the IATF guidelines for working with FBOs in health and development.
5. Invest in strengthening collaboration for advocacy between international FBOs and national faith-based partners
6. Invest in replicating, consolidating, and implementing what has been already been developed through this initiative and has been demonstrated to work, before moving into new initiatives and countries.



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## **UNAIDS Strategic framework for Partnership with FBOs**

### ***Challenges and the way forward***

Many religious communities have found HIV-related issues challenging, particularly HIV prevention, as it touches on sensitive areas such as morality and religious standards for “holy living.” There have also been polarized public debates over issues such as condom promotion, which have exacerbated tensions and prejudices.

World religions share many common values, for example compassion for the sick and vulnerable, belief in the importance of faithfulness in marriage, and the rights of the most marginalized. At the same time, prejudice is common among FBOs and between FBOs, governments, international organizations, and other AIDS actors.

Public positions, statements, and responses of some FBOs have ranged, on occasion, from the unhelpful to the deeply harmful or hurtful, increasing rather than diminishing HIV-related stigma.

Responses from other organizations, however, have at times been equally negative, reactively dismissing much of the good work done by FBOs. Some decision-makers may fear that FBOs may use HIV work as an opportunity to promote their own faith or will be judgmental; others worry that FBOs may lack the capacity or skill to run high-quality programs. However, the evidence shows that many FBOs run high-quality HIV programs.

It is time to move beyond these prejudices and positions of mistrust to create partnerships based on mutual trust and respect and with joint commitments to achieving universal access targets. There is a lot of common ground between how other organizations and FBOs respond to AIDS; for example, service delivery is often similar. With education and dialogue, attitudes are changing, and there is a new openness among other actors to engage with FBOs. Sharing goals and activities will help to build mutual trust. This process of dialogue is also helping FBOs to move towards agreed-upon “do no harm” standards of practice. In all these processes, the work of FBOs must be documented and be promoted as examples of good practice.

The issue of funding has been of concern to FBOs. Public funding of other organizations and FBOs should be transparent, with consistent criteria applied. It is important to ensure that there is no bias for or against FBOs in funding, which can be monitored by funding decision patterns and through partnership agreements.

In the context of universal access, strengthened UNAIDS-FBO partnerships will: increase community mobilization; support more people to come forward for HIV testing; increase access to HIV prevention and treatment, including prevention of mother-to-child transmission and tuberculosis/HIV services; improve the quality of life for people living with HIV; increase the level of support for women and orphans and other vulnerable children; address violence against women and girls; strengthen social protection, care, and support for families and key populations at higher risk of HIV infection; and reduce stigma, ignorance, and fear through building trust. Partnerships will also assist in integrating the activities of FBOs into national AIDS programs and strategies, thus strengthening the national AIDS response.

## **UNAIDS Strategic Framework for Partnership with FBOs Roles and Responsibilities**

### ***Roles of faith-based organizations***

#### **The roles of FBOs in HIV-related partnerships with UNAIDS include:**

- Working to end marginalization and HIV-related stigma and discrimination
- Including people living with HIV in the design, programming, implementation, research, and monitoring and evaluation of programs, and in decision-making processes
- Advocating for universal access to HIV prevention, treatment, care, and support services
- Respecting all human beings as equally worthy of health, dignity, and care, regardless of whether they share the same faith, values, or lifestyle choices as people of any particular faith
- Providing services in an open and transparent manner, according to agreed-upon criteria for the handling of finances, serving the community, and monitoring and evaluation
- Providing services based on evidence-informed practices consistent with the FBO’s own faith and values
- Refraining from attempts to discredit or undermine evidence-informed practices of other actors in the AIDS response

## ***Roles of UNAIDS***

### **The roles of UNAIDS in HIV-related partnerships with FBOs include:**

1. Working to end stigma, prejudice, and discrimination in the AIDS response, including a reluctance to partner with FBOs
2. Involving different FBOs in the development of strategy and policy guidelines
3. Involving different FBOs in major decision-making processes and reference groups
4. Advocating for the integration of FBOs in national AIDS responses.
5. Advocating, with donors and governments, for planning, implementation, and funding decisions to be made in an open and transparent way according to published criteria
6. Advocating for FBOs and other organizations to be appropriately funded so that they can play a role commensurate with their capacities in supporting the development, implementation, and monitoring and evaluation of national AIDS plans
7. Partnering with FBOs in an open and transparent way, respecting their faith as fundamental to their values and activities
8. Monitoring and evaluating civil society programs in accordance with previously agreed criteria, respecting scientific evidence and the faith and values of FBOs
9. Promoting local community ownership of HIV-related prevention, treatment access, care, and support initiatives
10. Leveraging partnerships with other actors in the context of UN reform
11. Refraining from attempting to discredit or undermine religious belief

## ***Responsibilities of UNAIDS and FBOs***

### **The responsibilities of UNAIDS and FBOs include:**

- Defining the aims and objectives of the partnership
  - Ongoing communication
  - The inclusion of partners in decision-making processes
  - Identifying and implementing activities
  - Monitoring and evaluating activities, including collecting baseline data, where applicable and disseminating the outcomes of activities
  - Establishing a clear exit strategy for terminating the partnership, when appropriate
- Promoting the value of the partnership to others

## **UN Task Force Criteria of Engagement with Faith-Based Actors**

The following criteria are culled from the record of respective UN offices and agencies engagements and outreach with faith actors for any event, initiative, (joint) programming and/or project-based deliverable. These criteria are required to guide the outreach to faith actors across the UN system around efforts taking place at the global level, and are in line with UN values and principles which support the realization of its mandates in human rights, sustainable development, and peace and security.

**Balance must be sought in regard to:**

- Representation of all faiths and denominations: Religious representation should use the UN framework lines (i.e., per number of global adherents) to be inclusive of all faith traditions, including diversity within the largest faith traditions. Traditional and indigenous faiths should also be included.
- Regional representation: All geographic regions of the world should be represented and a balance between those who work at global, regional and national levels should be displayed.
- Gender representation: All genders should be present at the meetings and initiatives. Sensitivity to the specific gendered needs and expertise of the beneficiaries of the intended project is necessary.
- Priority themes: All aspects of the thematic area(s) are examined and cross-cutting concerns covered. A diverse range of thematic expertise should be brought to the specific agenda.
- Religious registration: Non-governmental religious actors should be legally registered in at least one Member State of the UN.
- Programmatic preference: Preference can be given to organizations actively working to provide the services and/or advocacy and/or capacity under discussion (i.e. to complement the representation of religious or faith leaders).
- Criminality: There must be no objection raised by relevant UN country offices regarding a possible criminal case against the partnering organization or individual.
- Conformity to UN principles: Actors should have a track record of acting in conformity with UN values and principles.
- Affiliation: FBO partners should not be listed as a terrorist organization according to UN terrorist list(s).

## ANNEX II: A Description of the Implementing Partners in the UNAIDS/PEPFAR FBO Initiative

The UNAIDS/PEPFAR FBO Initiative supports a variety of activities carried out by the following implementing partners:

**The African Christian Health Association Platform (ACHAP)** is a network of Christian health associations (CHAs) across the sub-Saharan region of Africa. These CHAs are national-level faith-based health systems, providing a substantial proportion of health services in the countries in which they operate. ACHAP represents 44 CHAs operating in 32 countries across the region.<sup>154</sup>

**Black AIDS Institute (BAI)** is a U.S.-based non-governmental organization that promotes awareness and works to prevent HIV infections in African-American communities by engaging Black leaders, institutions, and individuals.<sup>155</sup>

**Caritas Internationalis** is a Confederation of 168 Roman Catholic relief, development, and social service organizations operating in over 200 countries and territories worldwide. As essential participants in the Roman Catholic Church's socio-pastoral mission, a significant number of Caritas organizations at all levels (global, regional, national, diocesan, and parish) are engaged in the delivery of health care to all in need, but particularly to those who are poor, marginalized, migrants, or otherwise deprived of access to such vital care.<sup>156</sup>

**The World Council of Churches (WCC)** is a global ecumenical body that brings together 350 Christian denominations and traditions in over 110 countries representing over 500 million people. Two different WCC initiatives serve as implementing partners:

- **The Ecumenical Advocacy Alliance (WCC-EAA).** The WCC-EAA is a global network of churches and related organizations that campaign on common concerns for justice and human dignity. The WCC-EAA seeks to harness the collective energies of churches, Christian organizations, and non-Christian FBOs by focusing their advocacy efforts on long-term campaigns in two selected priority issues: HIV and AIDS (the "Faith on the Fast Track" campaign) and food security and sustainable agriculture (the "Food for Life" campaign). WCC-EAA seeks to create a coordinated faith voice against injustices, strengthening the churches' and faith organizations' witness for peace, security, and dignity to end AIDS as a public health threat by 2030.<sup>157</sup>
- **Ecumenical HIV and AIDS Initiatives and Advocacy (WCC-EHAIA).** WCC-EHAIA promotes and stimulates a holistic ecumenical HIV response to ensure compassionate, faith inspired HIV interventions and engagement among churches, theological institutions, and networks of people living with HIV to address the root causes and social determinants of the pandemic. Established in 2002, WCC-EHAIA seeks to be among the most dynamic faith initiatives working in sub-Saharan Africa with extensive global influence through its biblical, theological, ethical, and liturgical literature and manuals.

**World Young Women's Christian Association (WYWCA).** WYWCA is a global network of local YWCA chapters in over 100 countries with a host of programs to empower girls, adolescents, and women and to create safe spaces where women can build effective initiatives on sexual and reproductive health (SRH) and rights, HIV, and GBV.<sup>158,159,160</sup>

**An Academic Consortium** of five universities supports the implementing partners with applied research initiatives, data analysis, capacity-building, needs assessment, and monitoring and evaluation. The consortium is comprised of Emory University (United States)<sup>161</sup>, Muhimbili University of Health and Allied Sciences (Tanzania)<sup>162</sup>, St. Paul's University (Kenya)<sup>163</sup>, University of Cape Town (South Africa)<sup>164</sup>, and University of Jos (Nigeria)<sup>165</sup>.



## ANNEX III. Stigma and Discrimination.

This annex provides context and theological perspectives on faith-based responses to HIV-related stigma and discrimination.

As was briefly summarized in chapter five, Gillian Paterson describes the social challenges and theological imperatives for confronting stigma and discrimination. She argues that stigma is difficult to address because it is woven into the fabric of society and is related to taboo. The power and consequences of disease-related stigma or symbolic stigma grow when they address individuals' behaviors that violate social norms and taboos. HIV has been wrapped in these forms of stigma because it exposes the secret that some respected members of a faith community are not actually following those social norms. Paterson describes such exposure in this way: "Let us say that it is generally assumed in your peer group of culture that a man will have several sexual partners or more than one wife. This is the Real Code. This is what it means to belong. Even if you choose not to follow the 'code,' you know that it is somehow connected with being judged a 'real man' in your society or your peer group. On the other hand, as a Christian, it may be assumed that you obey the Official Code, which says that Christian men abstain sexually until marriage and remain monogamous thereafter. When HIV appears among members of a particular church or parish, it exposes the truth, which is the likelihood that a good many people, clergy included, are not following this Official Code."<sup>166</sup>

In such instances, stigmatization seems to preserve the order of the community threatened by the transgression. Even those who continue to live by the rule of the Official Code are stigmatized if they have HIV. This is why women who have never had sex outside of their marriage but were infected through their husbands who did also face HIV-related stigma. Paterson argues that such stigma and exclusion lead to denial and prevent those at risk of infection from being tested or accessing treatment if they contract the virus. Because prevention programs cannot be built on the fiction of the Official Code being universally followed, theological reflection has to be informed by both the Real Code and the Official Code: "a process of theological reflection must allow for negotiation between the Real Code (which reigns in the marketplace and the bar, the classroom, the hospital, and the village square) and the Official Code (which takes precedence in the church). For the virus makes no distinction between the two: if you're living with HIV in the bar, then you're living with it in the church as well."<sup>167</sup>

The following principles were articulated in the 2005 UNAIDS Consultation with Christian theologians:

### ***God and creation***

God created human beings as unique persons and delights in our differences. God also desires that we share in that delight and affirm human diversity. These differences are reflected in our human sexuality. God created us to enjoy one another as sexual beings in responsible ways and we have squandered this gift through sin. We do this in a variety of ways, including the sexual and physical abuse of women by men. Theologies, images of God, and interpretations of sacred texts have contributed to the stigmatization of sexuality, with women bearing the brunt of that stigma. This misuse of the tradition has hampered the church's attempts to challenge stigma and its HIV prevention programs.

### ***Interpreting the bible***

The Bible has often been read and interpreted to encourage stigmatizing attitudes and practices within the church and increase the stigmatization of the vulnerable and marginalized. To challenge this misuse of the Bible, it is important to remember that the Scriptures were written in particular social contexts across different times, reflecting the social worldviews of the authors. Using the Bible to justify stigma refuses to account for our own social context and culture. Rather, we must take advantage of the insights available to us, including the insights of modern Biblical scholarship, sociological and anthropological research, insights from contextual theologies, and deeper understandings of social justice. God's love and God's justice, by which God seeks to redeem creation and humanity, are the two consistent, primary themes of Scripture. As such, the Bible should never be used to diminish either our well-being or the fullness of life in any other human being.

### ***Sin***

Sin is fundamentally the breaking of our essential relatedness to God, to one another, and to the rest of creation. Stigmatizing individuals is a sin against the Creator God, in whose image all human beings are made, because it rejects the image of God in the other and seeks to deny the one stigmatized the hope of life in all its fullness. This is not just a sin against a neighbor, but also a sin against God. This stigmatization often focuses on sexuality, reiterating the widely held assumption that HIV is always contracted as the result of sinful sexual relations, which are often seen as the gravest of sins. Within the context of faith today, we need to denounce the uncritical identification of sin with sex, as well as the stigmatization and the debased theology of sin that results from it. HIV is not God's punishment for sin. Claiming that it is a punishment is damaging, because resulting judgmental attitudes undermine the church's efforts at care and prevention.

The threat posed by the HIV pandemic requires that human beings should act responsibly. Failure to do so is a sin. For example, we have a responsibility to be faithful in our sexual relationships. Those with HIV or AIDS have a special responsibility not to risk infecting others. Willfully refusing such responsibilities in any of these areas is dangerous to other people and, on that account, sinful.

### ***Suffering and lamentation***

Christian theology needs to emphasize the redemptive possibilities of suffering, and to challenge those social structures that cause undue suffering and stigma. In the Cross of Jesus, God enters suffering creation to heal it from within. Jesus showed solidarity with us, and offered us God's compassion. To understand the nature of suffering and our response to it, we can seek to recover Biblical texts on suffering and draw on the rich biblical tradition of lament. Lament offers us language to name suffering, question power, and call for justice. Lament also expresses hope and trust in God's compassion to stand with us in suffering and work to deliver us from it. Thus, lament can enrich church liturgies and pastoral care, and contribute to a more truthful and intimate relationship with God by naming the 'un-nameable' to God.

### ***Covenantal justice***

A covenant is a reciprocal, binding relationship between God and human beings. This covenant serves as the foundation for just societies. While we can justly ask certain things of the societies of which we are a part, the needs of the powerless are easily overlooked, especially if they carry the double stigma of poverty and HIV. HIV stretches poor nations' already limited resources to the breaking point and thwarts prevention and care. We must identify the root causes of impoverishment, causes found in political, social, and economic policies. Unfortunately, rulers at local and national levels are often in authority over relatively powerless macro-economic and political structures. Nevertheless, we should challenge such political leaders about the misuse of public resources, including disproportionate funding of armaments, rather than allocating them to health, education, and basic services for the poor. In a world disfigured by AIDS, we especially need to address political corruption. As theologians, we have not sufficiently promoted the church's social teaching or challenged the church to rediscover its prophetic voice and ministry. While some churches in the Global North have responded to the needs of their sisters and brothers in Christ in the South, we lack global solidarity. If we truly believe that HIV is in the church, then no part of the Body of Christ is left unaffected, regardless of geography, culture, or tradition. We must, therefore, re-examine our ministerial and budgetary priorities.

### ***Truth and truth-telling***

Stigma feeds on silence and denial. This raises a number of theological challenges: What should we teach or not teach about HIV, particularly to young people? What should we say or not say about individual members? What should individuals disclose or keep secret about themselves? The truth sometimes exposes the gap between what leaders and members preach and what they actually do. In relation to HIV and AIDS, experience has shown that the best form of prevention is truthful education. This applies to 'truths of fact' (what HIV is, how it is transmitted, how it can be prevented, and what will happen if a person becomes infected); but it also applies to 'truth of meaning'. This relates to the meaning of suffering, the nature of sin, the relationship between life and death, and the search for the mind of God. Truth-telling may call us to acknowledge that we supported stigmatization or failed to challenge it. We may have condoned silence and denial at an institutional level, diluted or misrepresented the facts in our education, and failed to provide prophetic leadership.

### ***The church as a healing, inclusive and accompanying community***

In light of HIV-related stigma, what does it mean, in our time, to be the inclusive community that Jesus proclaimed? The church should be a sanctuary, a safe place, a refuge, and a shelter for the stigmatized and the excluded. Appropriate resources will enable clergy and laity (particularly young people) to respond. This role needs to be explored at the level of theological education, so that clergy and lay leaders go into parishes understanding the dynamics of accompanying stigmatized and suffering people, of praying with them and their families, of standing and waiting alongside them, and of loving them. In addressing stigma, people living with HIV are the churches' most precious resource. Their full inclusion in all aspects of the church's life is the best possible strategy for changing attitudes and removing fear. In our reflections on a church that says 'no' to stigma, we need constantly to revisit the Christ of the Gospel narratives, who has given us a paradigm for accompaniment, human relationships, and Christian healing.

1. This publication includes several formal Comment papers and three longer academic Series papers. The first Series paper documents the estimated scale of health services provided by the faith community (Olivier et al. "Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction." 2015). The second examines controversies between faith and health care (Tomkins et al. "Controversies in faith and health care." 2015). The third discusses strengthening of partnerships between the public health sector and faith-based groups (Duff and Buckingham. "Strengthening of partnerships between the public sector and faith-based groups." 2015). See <https://www.thelancet.com/series/faith-based-health-care>.
2. UNAIDS, *The Gap Report* (Geneva: UNAIDS, 2014). Online: [http://www.unaids.org/en/resources/documents/2014/20140716\\_UNAIDS\\_gap\\_report](http://www.unaids.org/en/resources/documents/2014/20140716_UNAIDS_gap_report)
3. [https://www.unaids.org/en/resources/presscentre/featurestories/2015/october/20150930\\_PEPFAR\\_FBO](https://www.unaids.org/en/resources/presscentre/featurestories/2015/october/20150930_PEPFAR_FBO)
4. Sally Smith, *Religion in the United Nations (UN) Political Declarations on HIV/AIDS: An interdisciplinary, critical discourse analysis* (Glasgow: Glasgow University, Doctorate in Practical Theology, 2018), p129. Online: <http://theses.gla.ac.uk/30615/13/2018smithdpt.pdf>. *The Lancet Series* is important to both public health and faith-based communities working on AIDS, given the significance and influence of this journal. In this context, it marks the beginning of a more pluralistic discourse than the secularist approach traditionally taken by this journal. Second, it demonstrates that there is substantial literature on faith and health care, but little scientific research of a quality that can be included in academic publications. This highlights a quality issue, and a difference of worldview between the public health and faith communities around what is important and what constitutes valid evidence.
5. Smith, 2018, p. 130.
6. PEPFAR convened two consultations with faith-based partners in east Africa in 2012 and 2015. The report from the 2012 consultation can be found at <https://www.pepfar.gov/documents/organization/195614.pdf> and the report from the 2015 consultation can be found at <https://www.pepfar.gov/documents/organization/247613.pdf>.
7. See Joint Learning Initiative on Faith and Local Communities, *HIV and Maternal Health: Faith Groups' Activities, Contributions, and Impact* (Washington, DC: Joint Learning Initiative on Faith and Local Communities, 2014). Online: <https://jliflc.com/resources/hiv-maternal-health-faith-groups-activities-contributions-impact/>
8. UNAIDS, *On the Fast-Track to end AIDS. UNAIDS 2016-2021 Strategy* (Geneva: UNAIDS, 2016). Online: [https://www.unaids.org/sites/default/files/media\\_asset/20151027\\_UNAIDS\\_PCB37\\_15\\_18\\_EN\\_rev1.pdf](https://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf).
9. US President's Emergency Plan for AIDS Relief, *PEPFAR 3.0—Controlling the Epidemic: Delivering on the Promise of an AIDS-Free Generation* (Washington, DC: US Department of State, 2014). Online: <https://www.pepfar.gov/documents/organization/234744.pdf>
10. For example, implementing partners were limited to global FBO networks who had previous partnership experience with UNAIDS and/or PEPFAR on HIV. These do not represent the range of faith traditions or geographic regions. The initiative was limited to global events and regional/country initiatives in a few of PEPFAR/UNAIDS priority countries.
11. Jill Olivier and Sally Smith, "Innovative Faith-Community Responses to HIV and AIDS: Summative lessons from Over Two Decades of Work," *The Review of Faith & International Affairs* 14, no. 3 (2016): 5-21. DOI: 10.1080/15570274.2016.1215839.
12. Collaboration on HIV and AIDS, Religion, and Theology, *The Cartography of HIV and AIDS, Religion, and Theology: A Partially Annotated Bibliography* (Pietermaritzburg: University of Kwa-Zulu Natal, 2016). Online: [http://www.chart.ukzn.ac.za/images/downloads/CHART\\_XII\\_bibliography.pdf](http://www.chart.ukzn.ac.za/images/downloads/CHART_XII_bibliography.pdf).
13. Beverly Haddad, ed. *Religion and HIV and AIDS: Charting the Terrain* (Pietermaritzburg: University of Kwa Zulu-Natal Press, 2011).
14. The response to HIV among Roman Catholic communities occurred in local parishes, dioceses, and among the various efforts of different religious orders. In important ways, these varied responses were coordinated through Caritas Internationalis, a global network of Roman Catholic health and development organizations. This network allowed for coordination between European and North American affiliates and affiliates in sub-Saharan Africa. Father Robert Vitillo, former director of the Caritas Internationalis delegation to the United Nations and Special Advisor on Health and HIV/AIDS, recounted this history of early involvement in an interview on January 16, 2019.

15. See African Religious Health Assets Programme, *Appreciating Assets: The Contribution of Religion to Universal Access in Africa—Mapping, Understanding, Translating, and Engaging Religious Health Assets in Zambia and Lesotho in Support of Universal Access to HIV/AIDS Treatment, Care and Prevention* (Cape Town: ARHAP, 2006). Estimates of the percent of HIV services provided by faith-based health facilities vary widely. Many reports that state these percentages are merely citing earlier reports and are not making such claims following an assessment of health services data. UNAIDS and PEPFAR funded an analysis of HIV service data in Kenya as part of this initiative, which is summarized in chapter 1.
16. UNAIDS estimates that 20,600,000 people were living with HIV in the Southern and Eastern Africa region at the end of 2017, for an HIV prevalence rate of 7.0% for the region. 2018 numbers for other regions were: 5,000,000 (1.5% prevalence) for the Western and Central Africa region; 5,900,000 (.2% prevalence) for the Asian-Pacific region; 340,000 (1.2% prevalence) for the Caribbean region; 1,400,000 (.8% prevalence) for the Eastern Europe and Central Asian region; 1,700,000 (.9% prevalence) for the Latin American region; 240,000 (<.1% prevalence) for the Middle East and North Africa region; and 2,200,000 (.2% prevalence) for the Western and Central Europe and North American region. Source: UNAIDS 2019 estimates available at [aidsinfo.unaids.org](http://aidsinfo.unaids.org)
17. Ecumenical Advocacy Alliance, *Together We Must Do More: Report on Fulfilment of the Personal Commitment to Action from the Strengthening Religious Leadership Working Group* (Geneva: Ecumenical Advocacy Alliance, 2010). Online: <http://www.hivcommitment.net/wp-content/uploads/2010/07/Religious-Leaders-Report.pdf>.
18. Manoj Kurian, *Passion and Compassion* (Geneva: WCC publications, 2016), pp. 6-7.
19. UNAIDS, *Partnership with Faith-Based Organizations: Strategic Framework* (Geneva: UNAIDS, 2009). Online: [http://data.unaids.org/pub/basedocument/2009/jc1786partnershipwithfaithbasedorganizations\\_en.pdf](http://data.unaids.org/pub/basedocument/2009/jc1786partnershipwithfaithbasedorganizations_en.pdf). (pp. 3-4)

From the framework: Faith-based communities are diverse in their forms, structures and outreach. In UNAIDS' experience, it is possible to distinguish these communities based on the way that they operate, at three main levels: 1. informal social groups or local faith communities (e.g., local women's groups or youth groups); 2. formal worshipping communities with an organized hierarchy and leadership (e.g., major religious faith groupings (Hindus or Christians) and sub-divisions of organized religion (e.g. Sunni Islam, Theravada Buddhism or Catholic Christianity); and 3. independent faith-influenced non-governmental organizations (e.g., Islamic Relief and Tear fund). These also include faith-linked networks such as the Ecumenical Advocacy Alliance, Caritas Internationalis, World Conference of Religions for Peace, and the International Network of Religious Leaders Living with HIV. All three levels are important, but the third level organizations provide most HIV-related services. It is also vital to understand both the intra- and inter-religious distinctions—for example, different denominations within the Christian Church, or the different strands within Islam, Buddhism and so on.

Drawing on this background, UNAIDS defines faith-based organizations, religious leaders, and local religious communities as follows:

- Faith-based organizations are defined as faith-influenced non-governmental organizations. They are often structured around development and/or relief service delivery programs and are sometimes run simultaneously at the national, regional and international levels.
  - Religious leaders: these are national or global religious leaders who have important roles within faith communities, especially those with an organized hierarchy, and who are formally designated to represent these communities.
  - Local religious communities: local religious communities include informal and formal worshipping communities. Differences from faith-based organizations can be blurred, however, with many local faith communities running HIV-related activities or projects as an integral part of daily life.
20. UNFPA definitions can be found in their guidelines [https://unfpa.org/sites/default/files/resource-pdf/fbo\\_engagement.pdf](https://unfpa.org/sites/default/files/resource-pdf/fbo_engagement.pdf) (p4) UNDP definitions (building on work by UNAIDS and UNFPA) can be found here [https://www.undp.org/content/dam/undp/documents/partners/2014\\_UNDP\\_Guidelines-on-Engaging-with-FBOs-and-Religious-Leaders\\_EN.pdf](https://www.undp.org/content/dam/undp/documents/partners/2014_UNDP_Guidelines-on-Engaging-with-FBOs-and-Religious-Leaders_EN.pdf) (p5)
  21. United Nations Inter-Agency Task Force on Religion and Development, *Highlights of FBO Engagement by United Nations Entities: 2013-2015* (Geneva: United Nations Inter-Agency Task Force on Religion and Development, 2015). Online: [http://www.partner-religion-development.org/fileadmin/Dateien/Resources/Knowledge\\_Center/UNIATF-ToR-and-2014-Overview.pdf](http://www.partner-religion-development.org/fileadmin/Dateien/Resources/Knowledge_Center/UNIATF-ToR-and-2014-Overview.pdf)

22. See Joint Learning Initiative on Faith and Local Communities, *Religion and Sustainable Development: Partnerships to End Extreme Poverty. Conference Proceedings* (Washington, DC: Joint Learning Initiative on Faith and Local Communities, 2015), p. 27. Online: [https://jliflc.com/wp/wp-content/uploads/2015/08/RSD-Conference-Proceedings\\_Final.pdf](https://jliflc.com/wp/wp-content/uploads/2015/08/RSD-Conference-Proceedings_Final.pdf)
23. The Summit was organized by the Ecumenical Advocacy Alliance and Cordaid, with support from the Dutch Ministry of Foreign Affairs, UNAIDS, International Network of Religious Leaders Living with or Personally Affected by HIV or AIDS (INERELA+), the World AIDS Campaign and the European Council of Religious Leaders (Religions for Peace). <http://www.unaids.org/en/resources/presscentre/featurestories/2010/march/20100323webstory>
24. a) <http://www.hivcommitment.net/index.html>. b) <http://www.frameworkfordialogue.net/>. c) <https://www.oikoumene.org/en/what-we-do/eaaf/faith-on-the-fast-track>
25. [http://www.unaids.org/sites/default/files/media\\_asset/20151027\\_UNAIDS\\_PCB37\\_15\\_18\\_EN\\_rev1.pdf](http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15_18_EN_rev1.pdf)
26. <https://www.pepfar.gov/documents/organization/274400.pdf>
27. For a fuller description of the reasons for the gap and the priorities for closing the gap for people living with HIV, see *The Gap Report*, pp.120-131.
28. For a fuller description of the reasons for the gap and priorities for closing the gap for adolescents and young women, see *The Gap Report*, pp. 132-145.
29. For a fuller description of the reasons for the gap and the priorities for closing the gap for members of key populations communities, see *The Gap Report*, pp. 170-213.
30. For a fuller description of the reasons for the gap and the priorities for closing the gap for children and pregnant mothers living with HIV, see *The Gap Report*, pp. 228-245.
31. UNAIDS, *Partnership with Faith-Based Organizations: Strategic Framework* (Geneva: UNAIDS, 2009). Online: [http://data.unaids.org/pub/basedocument/2009/jc1786partnershipwithfaithbasedorganizations\\_en.pdf](http://data.unaids.org/pub/basedocument/2009/jc1786partnershipwithfaithbasedorganizations_en.pdf).
32. African Religious Health Assets Programme, 2006.
33. Jill Olivier, Clarence Tsimpo, Regina Gemignani, Mari Shoyo, Harold Coulombe, Frank Dimmock, Minh Cong Nguyen, Harrison Hines, et. al. "Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction," *The Lancet* 386, no. 10005 (October 21, 2015): 1765-1775. [https://doi.org/10.1016/S0140-6736\(15\)60251-3](https://doi.org/10.1016/S0140-6736(15)60251-3)
34. The work of the Academic Consortium replicated a study carried out in 2016 by researchers at Emory University's Interfaith Health Program (one of the institutions in the Academic Consortium), updating that study with more recent data and adding the geospatial location of FBHPs in each county in Kenya (online at [www.ihpemory.org](http://www.ihpemory.org)). The initial study can be found at John Blevins, Mimi Kiser, Emily Lemon & Ahoua Kone, "The percentage of HIV treatment and prevention services in Kenya provided by faith-based health providers," *Development in Practice*, 27:5 (2017): 646-657, DOI: 10.1080/09614524.2017.1327027
35. The categories and numbers in tables 1 and 2 come from the website of the Kenya master health facilities list--<http://kmhfl.health.go.ke>

36. Olivier and Wodon edited a World Bank monograph to examine the role of FBHPs in providing services to the poor. Data is limited and varied. One study calculated the patients seen by FBHPs by income across 14 countries and found that the percentage of patients from the lowest economic quintile was roughly the same for FBHPs as for governmental providers. However, FBHPs do serve people from the economic group at higher rates than private sector, non-religious providers. The results from one qualitative study in Burkina Faso demonstrate that FBHPs actually have lower service costs than governmental providers. Finally, a comparative analysis on fees charged by government providers, FBHPs, and private, non-religious providers showed that in Burundi, Sierra Leone, Swaziland, Zambia, and Nigeria, FBHPs charged less than either government or private, non-religious providers; in two countries (Ghana and Malawi), FBHPs charged more than either government or private, non-religious providers. One analysis by Olivier and Wodon included data from Kenya, which showed that government facilities provided more care to people with the lowest 40% of income than did FBHPs, but that FBHPs provided a greater proportion of the care to this group than did private, non-religious providers. See Jill Olivier and Quentin Wodon, eds. *Mapping, Cost, and Reach to the Poor of Faith-Inspired Health Providers in Sub-Saharan Africa* (Washington, DC: The World Bank, 2012). Online: <https://openknowledge.worldbank.org/bitstream/handle/10986/13573/762230v30W-P0Fa0Box374365B000PUBLIC0.pdf?sequence=1&isAllowed=y>.
37. [https://nacc.or.ke/wp-content/uploads/2015/09/KASF\\_Final.pdf](https://nacc.or.ke/wp-content/uploads/2015/09/KASF_Final.pdf)
38. The numbers in tables 1.3 and 1.4 are the sum of reported visits by health facility in each county (for the overall numbers) and by each FBHP in each county (for the numbers provided by FBHPs). The percentage is calculated by dividing the number of visits by FBHPs by the overall number. The data on reported visits is derived from the Kenya Health Information System (hiskenya.org).
39. UNAIDS 2018 estimates. See [aidsinfo.unaids.org](http://aidsinfo.unaids.org)
40. Incidence data is gathered from the *Kenya AIDS Strategic Framework*. See National AIDS Control Council, *Kenya AIDS Strategic Framework* (Nairobi: National AIDS Control Council, 2015). Online: [https://nacc.or.ke/wp-content/uploads/2015/09/KASF\\_Final.pdf](https://nacc.or.ke/wp-content/uploads/2015/09/KASF_Final.pdf).
41. This research was carried out as part of a dissertation for a master's degree in public health at the University of Cape Town by Dr. Carl Mhina. See Carl Mhina, *Patient cost of access to HIV care in Tanzania: a comparative analysis of state and non-state healthcare providers* (Cape Town, SA: University of Cape Town, 2019).
42. For in-depth discussion on the question of the role of faith-based health providers in providing care to the poor, see Jill Olivier and Quentin Wodon, 2012. See especially chapter 1, "Do Faith-Inspired Health Providers Reach the Poor More Than Other Health Providers?", pp.7-24.
43. For further information about the 2017 meeting and planned activities, including a global facility database, see <https://www.oikoumene.org/en/press-centre/news/partnership-and-mapping-are-a-priority-for-wcc-health-and-healing-programme-executive-mwai-makoka>
44. For further information on the challenges that the 2014-2015 Ebola outbreak presented, see Katherine Marshall, and Sally Smith, "Religion and Ebola: learning from experience," *The Lancet* 386, no. 10005 (October 31, 2015): e24-e25. Online: [https://doi.org/10.1016/S0140-6736\(15\)61082-0](https://doi.org/10.1016/S0140-6736(15)61082-0). . See also John Blevins, Mohamed Jalloh, and Dave Robinson, "Faith and Global Health Practice in Ebola and HIV Emergencies," *American Journal of Public Health* 109, no. 3 (March 1, 2019): 379-384.
45. <http://www.meds.or.ke>
46. For an analysis of supply chain mechanisms in Kenya and the ways in which the Mission for Essential Drugs and Supplies contributes to those mechanisms, see John Kariuki, Mercy Karimi Njeru, Watu Wamae, and Maureen Mackintosh, *Local Supply Chains for Medicines and Medical Supplies in Kenya: Understanding the Challenges* (Nairobi: African Centre for Technology Studies, 2015). Online: <https://www.africaportal.org/documents/16735/Issue-Paper-0012015.pdf>
47. <https://imaworldhealth.org>

48. <https://www.intrahealth.org/projects/capacityplus>
49. <https://www.epnetwork.org>. For further information on the contributions of EPN, see <http://apps.who.int/medicine-docs/documents/s19158en/s19158en.pdf>
50. <http://www.bomuhospital.org/index.html>
51. <https://www.mewa.or.ke/projects/mewa-hospital>
52. These approaches are priorities of the Start Free, Stay Free, AIDS Free initiative described in this report. Targets for PVT in this initiative are: 1) Eliminate new HIV infections among children by reducing the number of children newly infected to less than 40,000 by 2018 and 20,000 by 2020 and 2) Reach and sustain 95% of pregnant women living with HIV with lifelong HIV treatment by 2018. Targets for pediatric HIV treatment coverage in this initiative are: 1) Provide 1.6 million children (0-14 years) and 1.2 million adolescents (15-19) living with HIV with ART by 2018, and 2) Provide 1.4 million children (0-14) and 1 million adolescents (15-19) with HIV treatment by 2020. For further information on the Start Free, Stay Free, AIDS Free initiative, see <https://free.unaids.org/>
53. General Assembly Resolution, *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030* (New York: United Nations, 2016).
54. UNAIDS, *Start Free, Stay Free, AIDS Free* (Geneva: UNAIDS, 2018). Online: <https://free.unaids.org/>
55. United Nations Children's Fund and World Conference of Religions for Peace, *Study of the response by faith-based organizations to orphans and vulnerable children* (Geneva: United Nations Children's Fund and World Conference of Religions for Peace, 2004). Online: [https://www.unicef.org/media/files/FBO\\_OVC\\_study\\_summary.pdf](https://www.unicef.org/media/files/FBO_OVC_study_summary.pdf)
56. United Nations Children's Fund, 2004.
57. United Nations Children's Fund, *Partnering with Religious Communities for Children* (United Nations Children's Fund, 2012), p. 29. [https://www.unicef.org/about/partnerships/files/Partnering\\_with\\_Religious\\_Communities\\_for\\_Children\\_\(UNICEF\).pdf](https://www.unicef.org/about/partnerships/files/Partnering_with_Religious_Communities_for_Children_(UNICEF).pdf)
58. United Nations Children's Fund, 2004.
59. United Nations Population Fund, *Culture Matters: Lessons from a Legacy of Engaging Faith-Based Organizations* (New York: United Nations Population Fund, 2008). Online: <https://www.unfpa.org/publications/culture-matters>
60. John Blevins, "Are Faith-Based Organizations Assets or Hindrances for Adolescents Living with HIV? They Are Both," *Brown Journal of World Affairs* 22, no. 2 (2016): 25-38.
61. See *Post Framework for Dialogue Implementation: Kenya, Eastern Deanery AIDS Relief Program*, 2019. Available from WCC-EAA.
62. <http://www.maitamhouseofhope.com>. As of December 2018, over 20% of the young people receiving care and services through the organization were adolescents. See <http://www.maiammaitam.org/wp-content/uploads/2018/12/maitam-christmas-message-20118.pdf>
63. <https://www.worldywca.org/power-to-change-fund/>
64. <https://www.worldywca.org/wp-content/uploads/2014/02/Safe-Spaces-long-web.pdf>
65. For a full report on the consultation in Zambia, see [http://www.e-alliance.ch/typo3conf/ext/naw\\_securedl/secure77e6.pdf?u=0&file=fileadmin/user\\_upload/docs/Bulletins/2013/Consultation\\_on\\_the\\_Global\\_Plan\\_Report\\_FINAL\\_with\\_logos.pdf](http://www.e-alliance.ch/typo3conf/ext/naw_securedl/secure77e6.pdf?u=0&file=fileadmin/user_upload/docs/Bulletins/2013/Consultation_on_the_Global_Plan_Report_FINAL_with_logos.pdf). The list of participants can be found in Annex II of the report.
66. <http://www.chaz.org.zm>
67. [http://www.e-alliance.ch/typo3conf/ext/naw\\_securedl/secure77e6.pdf?u=0&file=fileadmin/user\\_upload/docs/Bulletins/2013/Consultation\\_on\\_the\\_Global\\_Plan\\_Report\\_FINAL\\_with\\_logos.pdf](http://www.e-alliance.ch/typo3conf/ext/naw_securedl/secure77e6.pdf?u=0&file=fileadmin/user_upload/docs/Bulletins/2013/Consultation_on_the_Global_Plan_Report_FINAL_with_logos.pdf)
68. See United Nations Children's Fund, 2004 and United Nations Children's Fund, 2012.

69. Participants generated the following topics:

### **Pressing challenges and obstacles**

1. *TB/HIV co-morbidity among children has been largely overlooked globally and is grossly under-reported.*
2. *While the proportion of children living with HIV who receive ART treatment more than doubled between 2010 and 2014 (from 14% to 32%), coverage remains notably lower than that for adults (41%).*
3. *Even when services are readily available, stigma can prevent parents from bringing their children forward for services.*
4. *Early initiation of ART treatment in children living with HIV is important. One half of children living with HIV who do not receive such treatment die before their second birthday and treatment delay can worsen neuro-cognitive impairments and stunting.*
5. *Essential medications and supplies are often not available, creating frustration, defaults, and desperation among parents and primary caregivers. Supply chain and distribution systems are complicated and too many medicines continue to require refrigeration, even in countries without a reliable electrical grid.*
6. *Funding privileges treatment services, jeopardizing programs that provide psychosocial programs and support services. Services are often siloed, delaying early identification of HIV infection and initiation of treatment.*
7. *Antiretroviral medications are not formulated in ways that are amenable to children or that support distribution in low- and middle-income countries.*
8. *Some faith-based organizations have held attitudes that contributed to the marginalization of people living with and affected by HIV; at times, our silence could be linked to the worsening situation of HIV infection.*

### **Establishing priorities to further the gains made in treating pediatric HIV**

1. *Variability and disruption in funding can have catastrophic results for formerly successful projects; successful programs cannot be maintained without adequate and sustainable funding from both national and international sources. National and global HIV strategic plans should include cross-sectoral input and collaboration and bring all ministries of government to the table to develop a coordinated response.*
2. *Invest in programs to prevent HIV infection in parents;*
3. *Faith-based organizations need to better understand the needs of adolescents living with HIV or at risk of HIV infection. We especially need to understand the needs of girls and to develop more effective programs to assure that adolescents enter and are maintained in school.*
4. *Support the development of portable, universal medical records in order to maintain adherence to ART, support retention in care, and track clinical progress as children and families move from one place to another.*
5. *Support comprehensive support services that extend past HIV clinical treatment alone. These services include nutritional support; services to children with disabilities; mental health services; spiritual, social, and emotional support; education; economic empowerment and assistance and social services; attention to the impact of conflict and other humanitarian crises; and sensitivity to cultural and religious contexts.*
6. *Invest in social services for children and families, including social protection, in order to address the underlying causes that hinder the response to HIV, including poverty, abuse, stigma, and harmful social norms and develop social indicators to demonstrate effectiveness of these interventions.*
7. *Involve men and boys in HIV programs. Without addressing their needs, we will never fully address HIV vulnerability among women and girls, including elimination of inter-personal and domestic violence.*
8. *Expand availability of EID of HIV through access to and availability of timely lab testing, including virologic tests. Such expansion will be furthered through innovative systems and new technologies to allow infected infants to be started on ART rapidly.*
9. *Scale up HIV testing of children in contexts such as index-case based testing and OVC programs, malnutrition and TB clinics, and sick child wards. Training on disclosure to children of their HIV status must be provided for health care workers and parents/caregivers.*



10. *Providing effective and well-tolerated drugs for children remains critical to ensuring scale up of pediatric treatment and improved clinical outcomes. Formulations must be palatable, suitable for infants and young children, adaptable for varied weights, and co-formulated as much as possible. New pediatric formulations that are better tolerated, less toxic, and fully harmonized with adult treatment strategies are needed. Second and third-line treatment regimens must be available in pediatric formulations to allow ongoing treatment of children once initial regimens are no longer effective.*
11. *Innovative strategies for prevention, retention and adherence are needed especially for adolescents, who are at increased risk of loss to follow up to care and of onward transmission of HIV through risk behaviors.*
12. *Strengthen the capacity of, and retaining, paid and volunteer community health workers and facilitate task shifting in order to expand outreach, efficiency, and effectiveness.*

### **Identifying the core commitments of faith-based pediatric HIV providers and religious leaders**

1. *Address the psycho-social and spiritual needs of children and families.*
2. *Deliver testing and treatment services at the local community level.*
3. *Utilize sermons and other educational services, including pastoral and clergy training and formation programs, to deliver direct, comprehensive, effective, and understandable messages for individuals, families, and communities in relation to physical, emotional, behavioral and spiritual health and wholeness.*
4. *Shape positive attitudes that counteract fear and tendencies toward stigma and discrimination.*
5. *Integrate value-based sexual and responsible relationship education into our curricula and into preparation for life-changing transitions (adolescence, marriage, death and mourning, etc.).*
6. *Initiate and sustain effective advocacy approaches to address social justice-related barriers and obstacles to universal access to early and sustained testing and treatment for HIV, TB, and other coinfections.*
7. *Increase partnership and collaboration with government and other civil society actors.*
8. *Assume a critical role in implementing, and monitoring progress in achieving, the Sustainable Development Goals (SDGs) and other international commitments and to safeguard respect for human rights.*
9. *Assure access to treatment and provide social, emotional and spiritual support for arriving migrants and refugees.*
10. *Maintain focus and concern on marginalized, low-prevalence, and/or hard-to-reach populations within our respective countries.*
11. *Contribute to ethical and theological reflection, and ecumenical and inter-religious dialogue on overcoming obstacles and barriers to effective EID and treatment of children living with HIV.*

These lists are a summary of key topics identified and discussed in the 2016 consultation. For a description of those topics and the language used in the consultation report, see Caritas Internationalis, *Early Diagnosis and Treatment for Children and Adolescents Living with HIV: Urgent Call by Religious and Faith-Inspired Organizations for Greater Commitment and Action* (Geneva: Caritas Internationalis, 2016). Online: <https://www.caritas.org/wordpress/wp-content/uploads/2016/04/ActionPlan.pdf>

70. <https://www.youtube.com/watch?v=GL3bdFT4yRo>
71. <https://www.oikoumene.org/en/resources/documents/wcc-programmes/diakonia/aaa/faith-on-the-fast-track/act-now-for-children-and-adolescents-living-with-hiv-1>
72. Act now for children and adolescents living with HIV
73. <https://aidsfree.usaid.gov/resources/prevention-update/editions/june-2017/khutbah-and-sermon-guides-children-and-hiv-religious>
74. <https://www.paediatrichivactionplan.org/>
75. <http://www.frameworkfordialogue.net>
76. <https://www.oikoumene.org/en/press-centre/news/kenya-voice-of-faith-communities-crucial-in-overcoming-hiv>

77. <https://www.oikoumene.org/en/press-centre/news/zambia-201con-hiv-we-do-not-compete-we-work-together.201d>
78. <http://bit.ly/ContextualBibleStudyToolkit>
79. <https://www.worldywca.org/wp-content/uploads/2014/02/Safe-Spaces-long-web.pdf>
80. <http://inerela.org/resources/save-toolkit/>
81. <https://www.oikoumene.org/en/press-centre/news/in-nigeria-thursdays-in-black-is-flourishing>
82. <https://www.oikoumene.org/en/press-centre/news/anglican-community-launches-thursdays-in-black-at-makerere-university-in-uganda>
83. <https://www.oikoumene.org/en/press-centre/news/lead-by-example-get-hiv-tested>
84. <https://www.pepfar.gov/partnerships/ppp/dreams/>
85. National AIDS Control Council, *Faith Sector Response to HIV and AIDS in Kenya, Action Plan 2015/2016-2019/2020* (Nairobi: National AIDS Control Council, 2015). Online: <https://nacc.or.ke/wp-content/uploads/2016/11/FAITH-ACTION-PLAN-2.pdf>
86. <http://hopeofchildren.net/index.html>
87. <http://www.cbavc.org/menu.aspx?/=51&/our-programs.html>
88. <http://www.icphhealth.org>
89. <https://gnrc.net/en/>
90. Profiled in United Nations Children’s Fund, *Partnering with Religious Communities for Children* (United Nations Children’s Fund, 2012).
91. <http://focus1000.org>
92. Blevins, Jalloh, and Robinson.
93. See [https://www.hopecapetown.com/images/PDF/Documents/20150516\\_hope\\_brochure\\_en.pdf](https://www.hopecapetown.com/images/PDF/Documents/20150516_hope_brochure_en.pdf). The chair of the Board of Trustees of Hope Cape Town is Reverend Stefan Hippler, a Roman Catholic priest. Father Hippler has written on the integration between western clinical models and spiritual practices of religious healers; see <https://stefanhippler.com/tag/sangoma/>. Similar projects have also been established in the Eastern Cape province; see <https://bhekisisa.org/article/2016-03-03-sangomas-learn-to-meld-muti-with-conventional-medicine> for further information.
94. <https://usi.org.ng/projects-implemented/>
95. <https://africachap.org/what-we-do/>
96. <https://www.who.int/hiv/pub/self-testing/hst-questions-answer/en/>
97. The evaluation can be found at: <http://ihpemory.org/publications/ihp-reports/>
98. For further information on the curriculum, see the following: <https://www.oikoumene.org/en/press-centre/news/201cfacing-the-storm-of-hiv-we-can-move-together-be-agents-of-change201d>.  
<https://www.oikoumene.org/en/press-centre/news/four-voices-one-concern-2013-addressing-201cfaith-healing-only201d-in-context-of-hiv>  
<https://www.oikoumene.org/en/press-centre/news/god-has-brought-ways-of-defeating-hiv>  
<https://www.oikoumene.org/en/press-centre/news/building-momentum-as-wcc-ehaia-addresses-faith-healing-only-practices-in-francophone-africa>
99. For further information on the curriculum, see the following: <https://www.oikoumene.org/en/press-centre/news/in-nigeria-voices-on-gender-justice-hiv-prevention-and-scriptures>  
<https://www.oikoumene.org/en/press-centre/news/adolescents-and-young-people-talk-positive-masculinities-and-femininities-with-religious-leaders-in-nigeria>

100. For information on the launch of the curricula, see: <https://www.oikoumene.org/en/press-centre/news/wcc-hones-training-on-attitudes-toward-hiv-treatment>  
<https://www.oikoumene.org/en/press-centre/news/young-people-in-nigeria-focus-on-positive-masculinity-femininity>  
<https://www.oikoumene.org/en/press-centre/news/manuals-on-hiv-prevention-and-gender-issues-in-faith-communities-launched-by-wcc>  
 Further launching of the Manuals and Handbooks took place in Lomé, Togo to ensure wider dissemination. See <https://www.icilome.com/actualites/866398/lotte-contre-le-vihsida-les-eglises-dans-l-arene>
101. <http://www.ecrtrust.org>
102. <https://www.facebook.com/pages/category/Religious-Organization/Zambia-Interfaith-Networking-Group-zingo-Platform-404041519784838/>
103. <https://childrenandhiv.org/wp-content/uploads/Yussuf-Ayami-The-Faith-based-Response-Zambia-Interfaith-Networking-Group-on-HIV-AIDS-Compatibility1.pdf>
104. <https://www.counterpart.org/stories/towards-zero-maternal-death/>
105. See UNAIDS, *Women and HIV: A Spotlight on Adolescent Girls and Young Women* (Geneva: UNAIDS, 2019). Online: [https://www.unaids.org/sites/default/files/media\\_asset/2019\\_women-and-hiv\\_en.pdf](https://www.unaids.org/sites/default/files/media_asset/2019_women-and-hiv_en.pdf)
106. *Start Free, Stay Free, AIDS Free*. <https://free.unaids.org/>
107. <https://www.pepfar.gov/press/265876.htm>
108. [http://www.unaids.org/sites/default/files/media\\_asset/blind\\_spot\\_en.pdf](http://www.unaids.org/sites/default/files/media_asset/blind_spot_en.pdf)
109. <https://www.oikoumene.org/en/get-involved/thursdays-in-black> .
110. <https://genderjustice.org.za>
111. <https://www.oikoumene.org/en/press-centre/news/zimbabwe-symposium-emphasizes-working-with-men-in-hiv-response>
112. For further information on these programs, as well as other AJWS initiatives, see <https://ajws.org/what-we-do/sexual-health-and-rights/>
113. <https://www.abaadmena.org/documents/ebook.1487166563.pdf>
114. <http://www.mpvusa.org/mpv-principles>
115. <http://menengage.org/wp-content/uploads/2016/12/Faith-Based-Approaches-Consultation-Summary-Report.pdf>
116. For a history of the first two decades of the Circle, see Njagondwe Fiedler, *A History of the Circle of Concerned African Women Theologians 1989-2007* (Oxford: African Books Collective, 2017). Online: <https://muse.jhu.edu/book/56506>.
117. Richard Parker and Peter Aggleton, "HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action," *Social Science and Medicine* 57, 1 (2003): 13-24, p. 14.
118. Parker and Aggleton, p. 15.
119. Parker and Aggleton, p. 16.
120. Gillian Paterson, *AIDS-Related Stigma. Thinking Outside the Box: The Theological Challenge*. Geneva: Ecumenical Advocacy Alliance and the World Council of Churches, 2005. See pp. 3-5 for Paterson's description of the ten principles. Note that at the time of publication the WCC and the EAA were two separate organizations that worked collaboratively. The publication of Paterson's paper is only one example of the close collaboration between the two. Since then, EAA has become a program of the WCC.
121. It is worth noting that Paterson wrote this in 2005, as more coordinated efforts to provide comprehensive HIV treatment were growing quickly with PEPFAR funding, which started in 2004.
122. United Nations Programme on HIV/AIDS, *A Report of a Theological Workshop on HIV- and AIDS-related Stigma* (Geneva: UNAIDS, 2005). Online: [http://data.unaids.org/publications/irc-pub06/jc1056\\_theological-report\\_en.pdf](http://data.unaids.org/publications/irc-pub06/jc1056_theological-report_en.pdf)

123. Farid Esack and Sarah Chiddy, *Islam and AIDS: Between Scorn, Pity and Justice* (Oxford: Oneworld Publications, 2009).
124. For a history of the relationship between Christianity, moral conceptualizations of illness, and stigma see Peter Lewis Allen, *The Wages of Sin: Sex and Disease, Past and Present* (Chicago: University of Chicago Press, 2002).
125. UNAIDS, *Global HIV and AIDS Statistics—2019 Fact Sheet* (Geneva: UNAIDS, 2019). Online: <https://www.unaids.org/en/resources/fact-sheet>
126. [https://www.oikoumene.org/en/what-we-do/religious-leaders-and-hiv-testing/LeadingByExample\\_DownloadablePosters.pdf](https://www.oikoumene.org/en/what-we-do/religious-leaders-and-hiv-testing/LeadingByExample_DownloadablePosters.pdf)
127. <https://www.oikoumene.org/en/what-we-do/religious-leaders-and-hiv-testing>
128. <https://www.oikoumene.org/en/resources/documents/wcc-programmes/diakonia/eaaf/faith-on-the-fast-track/act-now-for-children-and-adolescents-living-with-hiv-1>
129. <http://www.apcom.org/sites/default/files/Discussion%20paper-Islam%2812%29.pdf>
130. <http://inerela.org>
131. [https://ajws-americanjewishwo.netdna-ssl.com/wp-content/uploads/2015/05/lgbt\\_rights\\_one\\_pager.pdf](https://ajws-americanjewishwo.netdna-ssl.com/wp-content/uploads/2015/05/lgbt_rights_one_pager.pdf)
132. <https://ajws.org/what-we-do/sexual-health-and-rights/sex-worker-rights/>
133. Emory University Interfaith Health Program, *Valuing Every Human Life: How Faith-Based Organizations Can Support Key Populations with HIV Prevention, Treatment, and Support Services* (Atlanta, GA: Interfaith Health Program, 2013), pp. 33-34. Online: <http://ihpemory.org/wp-content/uploads/2014/06/Key-Populations-Report-Final.pdf>. MEWA's services include medical detox (1 week), residential treatment (4 months), outpatient treatment (3 months), group counselling, 1 to 1 counselling, daily meditation, sessions on special topics, computer classes, a gym and fitness classes, library, family treatment, aftercare support, referral services, and outreach programmes.
134. <http://iam.org.za>
135. <http://www.stigmaindex.org/about-stigma-index>
136. <http://bit.ly/Dignityfreedomandgrace1>
137. <https://www.kerkinactie.nl>
138. <http://www.eshancci.org>
139. <http://www.mpvusa.org>
140. <https://www.aim.ngo>
141. See John Blevins, *Christianity's Role in United States Global Health and Development Policy: To Transfer the Empire of the World* (New York: Routledge, 2019), pp. 109-111; 119-121. See also Socrates Litsios, "The Christian Medical Commission and the Development of the World Health Organization's Primary Health Care Approach," *American Journal of Public Health* 94, no. 11 (2004): 1884-1893.
142. UNAIDS, *The AIDS Response and Primary Health Care: Linkages and Opportunities* (Geneva: Joint United Nations Programme on HIV/AIDS, 2018), p. 10. [https://www.who.int/docs/default-source/primary-health-care-conference/aids.pdf?sfvrsn=189b259b\\_2](https://www.who.int/docs/default-source/primary-health-care-conference/aids.pdf?sfvrsn=189b259b_2)
143. <https://www.oikoumene.org/en/resources/documents/executive-committee/uppsala-november-2018/statement-on-ecumenical-witness-and-action-for-primary-health-care-for-all>. For the ways in which the primary health care movement relates to the witness of the WCC, see the special issue of *Contact* magazine on "Primary Health Care Revisited." For specific discussion on this relationship in the context of HIV, see "Revisiting Health Care and Justice" in that issue. Online: <https://www.oikoumene.org/en/what-we-do/health-and-healing/Contact2018Final.pdf>.
144. <http://www.gin-ssogie.org/family-and-traditional-values-regional-joint-declarations/silom-manifesto/>
145. UNAIDS, *Partnership with Faith-Based Organizations: Strategic Framework*, p. 16.

146. Kurian, 2016.
147. <https://www.oikoumene.org/en/what-we-do/children-adolescents-and-hiv/Childrenletterwriting2018Bookletweb.pdf>.
148. For further information on the Rome Action Plan, see Caritas in Veritate Foundation, *Universal Access to Medicines: Ethical Reflections on Ending Pediatric HIV* (Chambésy: FCIV, 2018). Online: <http://www.fciv.org/downloads/wp11-book-web.pdf>
149. James Cairn, ed. *HIV and AIDS Advocacy and Media Relations: Handbook for Religious Leaders* (New York: Religions for Peace, 2008). Online: <https://rfp.org/wp-content/uploads/2017/09/HIV-and-AIDS-Advocacy-Media-Relations-Handbook-for-Religious-Leaders.pdf>
150. Britt Herstad, *A Call to Act: Engaging Religious Leaders and Communities in Addressing Gender-Based Violence and HIV* (Washington, DC: The Futures Group and Religions for Peace, 2009). Online: <https://rfp.org/wp-content/uploads/2017/09/A-Call-to-Act-Engaging-Religious-Leaders-and-Communities-in-Addressing-Gender-Based-Violence-and-HIV.pdf>
151. <https://www.islamic-relief.org/landmark-final-consultation-on-gender-justice-declaration/>
152. <https://www.islamic-relief.org/wp-content/uploads/2019/03/CSW2019.pdf>. See also <https://www.islamic-relief.org/islamic-relief-at-csw-2019/>
153. [http://www.partner-religion-development.org/fileadmin/Dateien/Resources/Knowledge\\_Center/2017\\_Annual\\_Report\\_UNIATF.pdf](http://www.partner-religion-development.org/fileadmin/Dateien/Resources/Knowledge_Center/2017_Annual_Report_UNIATF.pdf). (p29)
154. For a list of ACHAP members, see <https://africachap.org/about-the-achap/members/>. This website includes links to the respective websites of member organizations.
155. <https://blackaids.org/>
156. <https://www.caritas.org/>
157. <https://www.oikoumene.org/en/what-we-do/eea>
158. <https://www.oikoumene.org/en/what-we-do/ehaia>
159. <http://inerela.org/>
160. <https://www.worldywca.org/>
161. <http://www.emory.edu/home/index.html>. The Interfaith Health Program is the specific program at Emory working on the initiative. For further information, see <http://ihpemory.org>.
162. <https://www.muhas.ac.tz>
163. <https://www.spu.ac.ke>
164. <https://www.uct.ac.za>. The International Religious Health Assets Programme is the specific program at University of Cape Town working on the initiative as a member of the Academic Consortium. For further information, see <http://www.irhap.uct.ac.za>.
165. <https://www.unijos.edu.ng>
166. Paterson, p. 8.
167. Paterson, pp. 8-9.





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