

“ORDINARY ACTS OF LOVE AND HOPE POINT TO THE EXTRAORDINARY
PROMISE THAT EVERY HUMAN LIFE IS OF INESTIMABLE VALUE.”
-- ARCHBISHOP DESMOND TUTU

Valuing Every Human Life

How Faith-based Organizations Can Support
Key Populations with HIV Prevention, Treatment,
and Support Services



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ROLLINS
SCHOOL OF
PUBLIC
HEALTH

Interfaith Health Program
Hubert Department of Global Health

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Rollins School of Public Health
Emory University**

1518 Clifton Rd., NE
CNR 8050
Atlanta, GA 30322

<http://www.ihpemory.org>

Established to actively promote the health and well-being of individuals and communities who face health disparities, the Interfaith Health Program (IHP) brings together a diverse community of scholars and public health practitioners to assure access to health programs and services.

Through alliances with national and global partners, IHP facilitates collaboration, provides training, builds networks, conducts research, and implements programs that improve the health and wellness of communities around the world. IHP's work is rooted in respect for diverse religious beliefs and practices, justice, and human rights for all people.

Authors

John Blevins

Associate Research Professor
Interfaith Health Program, Rollins School of Public Health, Emory University

Emmy Corey

Graduate, Candler School of Theology, Emory University

Special thanks to the following individuals for their contributions:

Trey Comstock

Student, Rollins School of Public Health, Emory University

Alex Plum

Student, Rollins School of Public Health, Emory University

Karyn DeLuca

Communications Specialist, Interfaith Health Program
Rollins School of Public Health, Emory University

Mimi Kiser

Assistant Professor, Interfaith Health Program
Rollins School of Public Health, Emory University

Sandra Thurman

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

The Reverend Canon Gideon Byamugisha

Anglican Church of Uganda

Father Mena Attwa

Coptic Hospital, Nairobi, Kenya

CDC Staff

Renee Saunders

Veronica Davison

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Glossary

AA	Alcoholics Anonymous	LGBT	Lesbian, gay, bisexual, and transgender
AB	Abstinence and Be Faithful (foregoing discussion of Condoms)	M/E	Monitoring and evaluation
ABC	Abstinence, Be faithful, and Condoms	MARP	Most at-risk populations
ACLU	American Civil Liberties Union	MAT	Medication assisted treatment
AIDS	Acquired Immunodeficiency Syndrome	MEWA	Muslim Education and Welfare Association
ART	Antiretroviral Therapy or Antiretroviral Treatment	MSM	Men who have sex with men
ARV	Antiretroviral	NA	Narcotics Anonymous
BCC	Behavior change communication	NGO	Non-governmental organization
COP	Country Operating Plan	NIDU	Non-injecting drug users
CSO	Civil society organization	NORAD	Norwegian Agency for Development
CSW	Commercial sex workers	NSP/NSEP	Needle/syringe exchange programs
EHAIA	Ecumenical HIV and AIDS Initiative in Africa	OST	Opiate substitution therapy
FBO	Faith-based organization	OVC	Orphans and vulnerable children
FHI 360	Family Health International and Academy for Educational Development	PACANet	Pan-African Christian AIDS Network
GNP+	Global Network of People Living with HIV/AIDS	PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
HCT	HIV counseling and testing	PLHIV	Person or People Living with HIV
HIV	Human immunodeficiency virus infection	PWID	People who inject drugs
ICCO	Interchurch organization for development cooperation	SAVE	Safer practices, Access to treatment, Voluntary counseling and testing, Empowerment
IDU	Injecting drug users	SIDA	Swedish International Development Cooperation Agency
IEC	Information, education, and communication	STI	Sexually transmitted infection
INERELA+	International Network of Religious Leaders Living With or Affected by HIV/AIDS	SW	Sex workers
IOM	Institute of Medicine	SWEAT	Sex Workers Education and Advocacy Task Force
LCI	Local capacity initiative	UNAIDS	The Joint UN Programme on HIV/AIDS
		WCC	World Council of Churches

Executive Summary

Around the world, HIV prevalence rates for commercial sex workers (CSW), people who inject drugs (PWID), and men who have sex with men (MSM) outpace prevalence rates for the population as a whole. In addition, people in these three groups often face social stigma, punitive legal systems, and judgment from care providers that create barriers to effective prevention, treatment, and support programs to address their particular needs and priorities. Globally, the HIV prevalence data for these key populations are glaringly incomplete and further research into the epidemiological profiles for all three groups is urgently needed. While targeted prevention initiatives for CSW, PWID, and MSM have been developed, they do not reach most members of these communities. The legal and policy environment in many countries exacerbates these issues because members of key populations are often subject to criminal prosecution for the behaviors that put them at risk for HIV. Despite these challenges, comprehensive services for key populations are a priority for the President's Emergency Plan for AIDS Relief (PEPFAR).

Religion has a complex effect for people in key populations in relation to HIV risk or HIV services. On the one hand, it contributes to stigma and judgment that contribute to risky behaviors and create barriers to care; on the other, it has been a strong motivating factor for compassionate programs and courageous advocacy. Religions can offer theological perspectives that support effective HIV prevention, treatment, and support services. These perspectives may be developed not only by religious leaders but by people of faith working at the grassroots level. There are a number of effective faith-based programs that provide essential services to members of key populations. These programs offer a set of best practices for faith-based work with key populations.

In order to address the complex influences of religion and support effective faith-based responses, this report contains eight key issues to guide collaboration between faith-based organizations and HIV programs:

1. Encourage FBOs to include members of key populations in their administrative and programmatic structures.
2. Provide contexts in which members of key populations who are also people of faith can describe their own religious and spiritual perspectives.
3. Build the capacity of grassroots FBOs working with key populations in limited contexts to expand their programs.
4. If FBOs are limited by religious authorities from providing services to key populations, then create networks that allow them to partner with CSOs to provide services to key populations.
5. Support African religious leaders, activists, and scholars to articulate compassionate responses to key populations rather than pushing for adoption of Western approaches alone.
6. Build relationships with upcoming African church leadership to create dialogue and opportunities for discernment.
7. Provide training to FBO staffs, CSO staffs, and other relevant stakeholders on the characteristics of effective work with key populations.
8. Identify leaders in religious traditions who can serve as allies and advocates for key populations

Introduction

In 1996, Dr. William Foege, Former Director of the US Centers for Disease Control and Prevention wrote that “three conditions are required for people to feel responsible for the future—and faith groups foster each of them. Kinship. Equity. Continuity. In faith groups, we understand a tradition that goes backward and a responsibility that goes forward.” (Foege, 1996). Dr. Foege’s early advocacy for building partnerships between public health programs and religious organizations has developed into groups of growing research and practice initiatives that are helping us understand and demonstrate religion’s contributions to public health.

But religion has not always had positive effects on public health. The history of religious responses to HIV reveals that religion may be an asset for the health of individuals and communities and it may also be a liability. As public health programs endeavor to build stronger collaborations with their faith-based partners they will need better ways to assess religion’s function.

Since the United States Congress authorized the President’s Emergency Plan for AIDS Relief (PEPFAR) in 2003, the program has had a transformational impact on the global response to HIV. In the last five years, the large-scale and sustained efforts made possible in large part by PEPFAR have begun to lower HIV prevalence rates around the world and make medical treatment available to millions of people, allowing them to live healthy lives. The good news of the advances is not a reality for everyone, however. Some continue to bear disproportionate disease burden and remain vulnerable to HIV infection or disease progression because of inadequate HIV prevention, treatment, and support services. For groups such as men who have sex with men (MSM), people who inject drugs (PWID), and commercial sex workers (CSWs), the advances made through strong, sustained programs remain largely elusive. Instead these key populations face stigma, marginalization, and judgment.

For these groups, religion may indeed be a liability and not an asset in regard to HIV risk or progression. This does not have to be the case. In fact, there are effective, evidence-based programs offered by faith-based organizations that have been lifelines to HIV services for key populations.

This report lays out the complex issues of HIV prevalence for key populations, demonstrating the disproportionate HIV burden faced by these communities. It also traces the ways in which religion can serve to heighten stigma or ground courageous, compassionate responses to the challenges HIV presents. The report is composed of five sections:

- I. The epidemiology of key populations
- II. Unique needs and issues of key populations
- III. PEPFAR strategic plan for key populations
- IV. Religious beliefs, FBOs, and a sustained response to HIV
- V. FBO best practices with key populations
- VI. Perspectives from religious leaders working with key populations

The report offers an in-depth assessment of the ways in which religion impacts key populations in relation to HIV, examining both the influence of religious beliefs and the services that faith-based and civil society organizations provide. Dr. Foege’s words serve as a reminder of the potential of religion to contribute to better health. If religion is to offer such contributions to key populations, we will have to develop ways to assess and understand its function. Our hope is that this report will be a tool to support such assessment.

Section I: Epidemiology of Key Populations

Around the world, HIV prevalence rates for commercial sex workers, people who inject drugs, and men who have sex with men outpace prevalence rates for the population as a whole.

“ . . . behind these percentages are names and numerous narratives of defiance, resilience, compassionate solidarity, and transformed lives in the face of the pandemic, as well as deep frustrations, despair, confusion, depression, hopelessness, trauma, and unthinkable loss.”

Nyambura Njoroge
Minister in the Presbyterian Church of East Africa and Director, Ecumenical Initiative on HIV/AIDS, World Council of Churches

In addition, people in these three groups often face social stigma, punitive legal systems, and judgment from care providers that create barriers to effective prevention, treatment, and support programs to address their particular needs and priorities. Globally, the HIV prevalence data for these communities are glaringly incomplete and further research into the epidemiological profiles for all three groups is urgently needed (Beyrer, Baral, Grievenson, Goodreau, Chariyalerstsak, et. al., 2012). Despite these gaps, the data on HIV prevalence in sub-Saharan Africa for men who have sex with men, commercial sex workers, and people who inject drugs demonstrate the scope of the epidemic and the impact of HIV disease on the women and men in these communities.

Figure 1 shows national HIV prevalence rates for eleven PEPFAR priority countries in sub-Saharan Africa as well as prevalence rates for MSM, CSWs, and PWID in those same countries.

Beyond these prevalence statistics, research in regional and local contexts reveals a number of important, inter-related issues in the global epidemiology of HIV disease for men who have sex with men, commercial sex workers, and people who inject drugs.

Gender differences among key populations

Though data on HIV prevalence among PWID are lacking, numerous studies demonstrate that women who use drugs have much higher prevalence than male drug users do.

In a study of 1,459 PWID surveyed in six states in Nigeria, women had a prevalence rate 3 to 15 higher than men in five of the six states (Eluwa, Strathdee, Adebayo, Ahonsi, Adebajo, 2013). Similarly, prevalence rates for women injection drug users were at least twice as high as those for men in Kenya, Zanzibar, and Tanzania (Nieburg and Carty, 2011).

Difference in HIV prevalence among male and female drug users in five states in Nigeria. Source: Eluwa, et.al., (2013)

State	Male (%)	Female (%)
Cross River	2.9	7.4
Kano	2.4	37.7
Kaduna	3.4	36.5
Oyo	1.9	31.5
Lagos	1.9	13.6

Difference in HIV prevalence among male and female drug users in Kenya, mainland Tanzania, and Zanzibar. Source: Nieburg and Carty (2011).

Country	Male (%)	Female (%)
Kenya	32	80
Mainland Tanzania	27	58
Zanzibar	14	74

Table 1: HIV Prevalence among drug users in select African countries

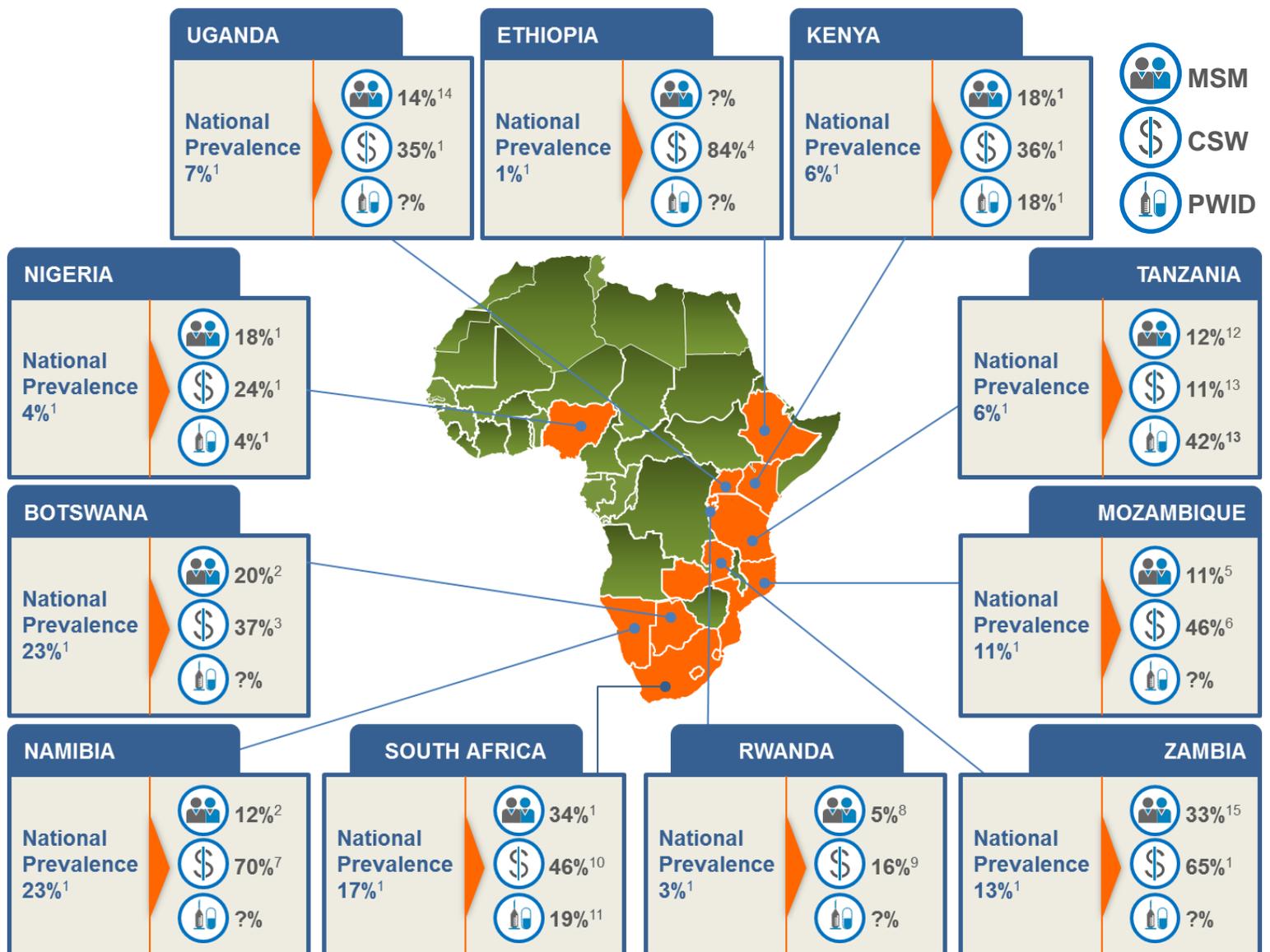


Figure 1: HIV prevalence rates for MSM, CSWs, and IDUs in eleven PEPFAR priority countries in sub-Saharan Africa*

*NOTE: Data on HIV prevalence for MSM, CSWs, and PWID are not complete. Many governments do not gather HIV prevalence data for these groups. All HIV prevalence data cited are drawn from peer-reviewed sources. Whenever possible, data is drawn from the same source: 2011 HIV prevalence data compiled by UNAIDS. However, UNAIDS has no data for key populations for many countries. In such instances, other peer-reviewed data sources have been used. When >1 source reported on HIV prevalence for key populations, two criteria were used to determine which was cited: the age of the data (preference given to more recent sources) and the sample size (preference given to national-level samples over localized, highly contextual samples).

1 Joint United Nations Programme on HIV/AIDS (UNAIDS) Prevalence data, 2011. (<http://aidsinfo.unaids.org>). Note: CSW data for Zambia comes from UNAIDS 2007 data.

2 Baral, S., Trapence, G., Motimedi, et al. (2009). HIV Prevalence, Risks for HIV Infection, and Human Rights among Men Who Have Sex with Men (MSM) in Malawi, Namibia, and Botswana. PLoS ONE 4(3): e4997. doi:10.1371/journal.pone.0004997

3 Mmelesi M., Mothate T, Fidzani B, et.al. (2010) Botswana HIV Prevention Response and Modes of Transmission Analysis. Gaborone, Botswana: National AIDS Coordinating Agency.

4 Aklilu, M., Messele, T., Tsegaye, A., et.al. (2001). Factors associated with HIV-1 infection among sex workers of Addis Ababa, Ethiopia. AIDS 15(1): 87-96.

5 Nala, R., Lane, T., Inguane, C., et. al. (2013). HIV prevalence and population size estimation among men who have sex with men in three cities in Mozambique, 2011. Kuala Lumpur, Malaysia: 7th IAS Conference on HIV Pathogenesis, Treatment, and Prevention.

6 Zango, A., Dube´, K., Kelbert, S., et al. (2013). Determinants of Prevalent HIV Infection and Late HIV Diagnosis among Young Women with Two or More Sexual Partners in Beira, Mozambique. PLoS ONE 8(5): e63427. doi:10.1371/journal.pone.0063427

7 UNAIDS Namibia. (2011). Sex Work and HIV in Namibia: Review of the literature and current programmes. Windhoek: UNFPA Namibia and UNAIDS Namibia.

8 Binagwaho, A. (2009). Exploring HIV Risk Among MSM in Kigali, Rwanda. Chapel Hill, NC: MEASURE Evaluation.

9 Rwanda Ministry of Health (2008). Rwandan HIV/AIDS Data Synthesis Project. Kigali: TRACPlus.

10 Stacey, M. (2013). Estimating the Size of the Sex Worker Population in South Africa. Cape Town: SWEAT.

11 International Harm Reduction Sub-Saharan Africa Regional Overview. <http://www.ihra.net/sub-saharan-africa>.

12 Baral, S. et. al. (2008). A Systematic Review of HIV epidemiology and risk factors among MSM in Sub-Saharan Africa 2000-2008. Mexico City: International AIDS Conference.

13 U.S. President's Emergency Plan for AIDS Relief (2011). Tanzania Operational Plan Report, FY 2011. Washington: U.S. Department of State.

14 Hladik, W., Barker, J., Ssenkusu, J., et. al. (2012). HIV Infection among Men Who Have Sex with Men in Kampala, Uganda—A Respondent Driven Sampling Survey. PLoS ONE 7(5): e38143. doi:10.1371/journal.pone.0038143.

15 Beyrer, C. (2009). Epidemiology of HIV Among MSM in Africa: Implications for Rectal Microbicides. Cape Town: 5th IAS Conference on HIV Pathogenesis, Treatment, and Prevention.

Overlapping epidemics

Epidemiologists categorize populations according to relevant factors related to the disease or condition being studied. In the context of HIV epidemiology, this often means classifying people according to certain behaviors associated with HIV risk. However, people themselves are more than categories and their behaviors do not fit neatly into single categories. Both female and male sex workers may be involved in transactional sex in order to pay for drugs (Stacey, Konstant, Rangasami, Stewart, 2013). Some men who have sex with men use drugs to enhance sexual encounters (Colfax, Santos, Chu, Vittinghoff, Pluddemann, *et. al.*, 2010; Parry and Pithey, 2006; Beyrer, Baral, van Griensven, Goodreau, Chariyalertsak, *et. al.*, 2012). Finally, men who have sex with men may often have female partners as well (Beyrer, *et. al.*, 2012; Taegtmeyer, Davies, Mwangome, van der Elst, Graham, 2013). Many people most at risk for HIV infection do not fit neatly into single risk behavior categories. The configurations of risk behaviors and social groups are variable and individual, creating numerous bridging social networks in which HIV can be transmitted to a new social group through the risk behavior of a person who moves between disparate groups.

Drug use and co-morbidities

Drug use correlates to increased risk for HIV infection and for disease progression for those who are HIV positive. Medical and psychiatric co-morbidities among drug users include hepatitis, tuberculosis, and mental illness. Risks are increased both for injection and non-injection drug users (Altice, Kamarulzaman, Soriano, Schechter, and Friedland, 2010). Mental illness correlates highly to drug use and drug use is common form of self medication for people with untreated persistent mental illness, particularly in contexts in which psychiatric and mental health services are not widely available. Drug use also correlates to decreased adherence to antiretroviral (ARV) medications (Ashley, Levine, and Needle, 2006); this leaves people with HIV susceptible to viral resistance to ARVs. Although research on viral resistance among drug users worldwide is minimal, a study of drug users in Kenya found resistance to ARV resistance among 13.5% of study participants. This has treatment implications for those with resistant virus and prevention implications since resistant virus can be transmitted from one person to another (Osman, Lihana, Kibaya, Ishizaki, Bi, 2013).

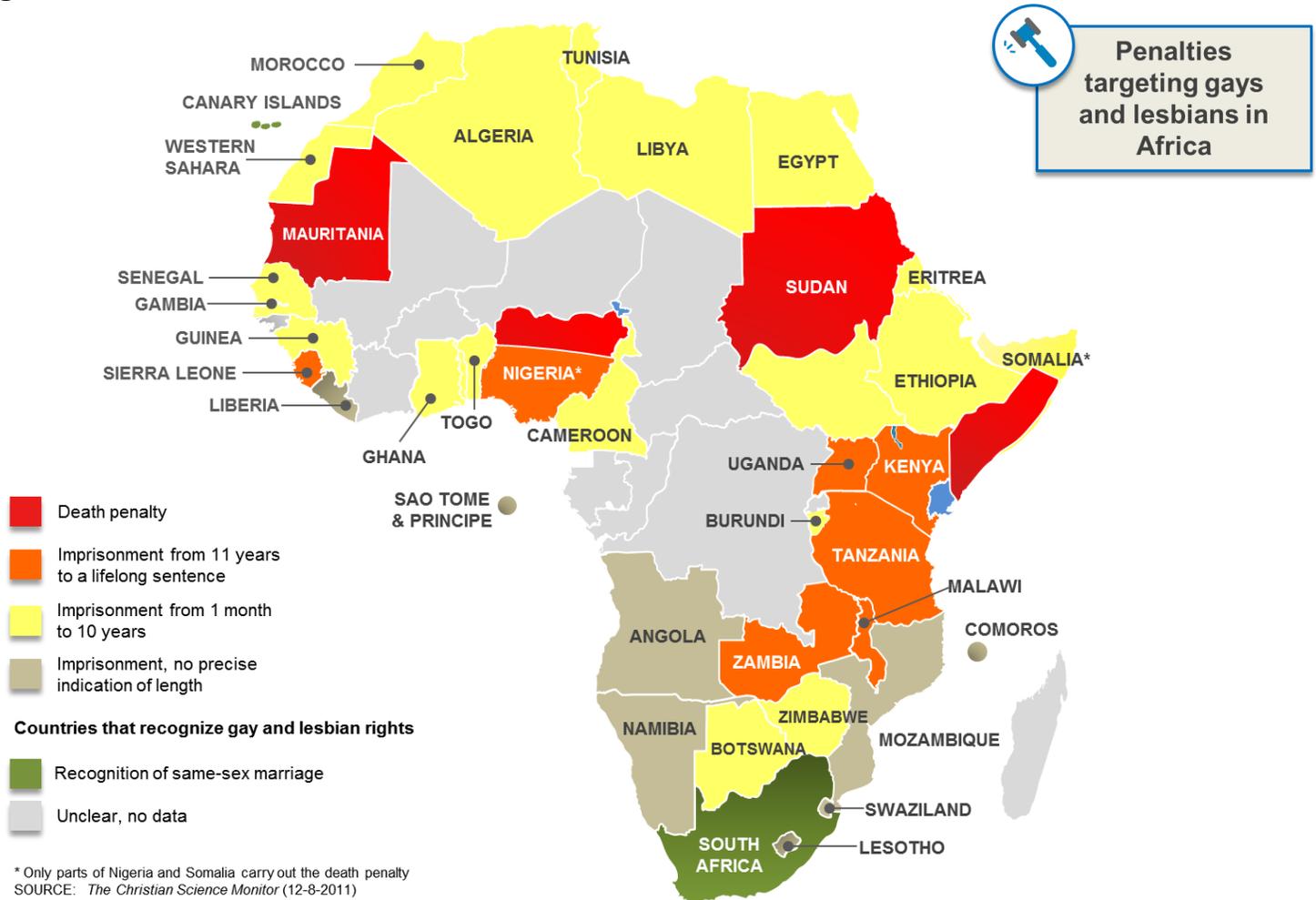
Research into the epidemiology of HIV disease among drug users has focused primarily on injection users because of the potential for disease transmission through shared needles; however, the risk of infection and more rapid disease progression are of concern for non-injection drug users (NIDUs) as well. For example, a study of 398 drug users in Lagos, Nigeria actually found a higher HIV prevalence rate among NIDUs (10%) than among drug users as a whole (9.8%). A study of 113 drug users in the Nigerian cities of Kano and Port Harcourt found an HIV prevalence rate of 10.8% among NIDUs and no HIV infection among PWID (Adelakan and Lawal, 2006). Other studies demonstrate far higher prevalence rates among PWID than among NIDUs but still identify non-injection drug use as a significant contributor to HIV risk (Needle, Kroeger, Belani, and Hegle, 2006).

Section II: Unique Needs and Issues for Key Populations

Poor reach of targeted prevention and support programs

Globally, MSM comprise 5-10% of all HIV infections but around the world only 9% of MSM are reached with targeted prevention initiatives. Similar targeted initiatives reach less than 20% of sex workers and only 8% of PWID. Globally, condoms are used in only 9% of risky sex acts and the supply of condoms falls millions short of existing demand. (Global HIV Prevention Working Group, 2007) For CSWs, PWID, and MSM, stigma and social isolation lead to misunderstanding or judgment from those who work in HIV prevention programs. For example, a study of prevention counselors working with MSM in Mombasa found high levels of discomfort and a general perception that all MSM were commercial sex workers (Taegtmeyer, et. al., 2013).

Legal Context: Laws in the United States and around the world



The global legal and policy environment creates macro-level, systemic challenges and barriers for CSWs, PWID, and MSM. In ten of the eleven PEPFAR priority countries in sub-Saharan Africa, sexual activity with someone of the same gender is a criminal offense. For example, in Uganda, the Parliament passed a law in December 2013 that would mete out life imprisonment for same gender sexual activity if one more of the people were HIV-positive. South Africa alone provides legal recognition and protection for people in same-sex relationships.

Drug use is criminalized and in seven of the countries, the predominant legal response is incarceration over treatment for those who are convicted of drug use. Kenya, Nigeria, Rwanda, and Tanzania offer some alternatives to incarceration though there has been little study on the impact of these programs. Likewise, sex workers face a challenging legal environment in the eleven countries studied in this report. Existing laws that impact MSM, CSWs, and PWID are unevenly applied and create social isolation and marginalization even when not universally enforced.

Table 2: Status of current laws for key population and availability of risk reduction programs in the eleven PEPFAR priority countries in sub-Saharan Africa

	Laws that pose obstacles for PWID		Most PWID have access to risk reduction		Laws that pose obstacles for MSM		Most MSM have access to risk reduction		Laws that pose obstacles for CSWs		Most CSWs have access to risk reduction	
	Gov't	Non-Gov't	Gov't	Non-Gov't	Gov't	Non-Gov't	Gov't	Non-Gov't	Gov't	Non-Gov't	Gov't	Non-Gov't
Botswana	X	X	X	X	X	X	X	X	X	X	✓	X
Ethiopia	X	X	X	X	X	X	X	X	✓	✓	✓	✓
Kenya	✓	X	X	X	✓	X	X	X	✓	X	✓	✓
Mozambique	X	✓	✓	NA	X	X	NA	X	X	X	✓	X
Namibia	NA	X	NA	NA	NA	X	✓	X	NA	X	✓	✓
Nigeria	✓	✓	X	X	X	✓	X	X	X	✓	✓	✓
Rwanda	✓	✓	NA	NA	✓	✓	✓	X	X	X	✓	✓
South Africa	X	X	X	NA	✓	X	X	X	X	X	X	X
Tanzania	✓	✓	X	X	X	X	X	X	✓	X	✓	✓
Uganda	X	X	NA	✓	X	X	NA	✓	X	X	NA	✓
Zambia	X	X	NA	NA	X	X	NA	NA	X	X	✓	✓

X Criminalization; little or access to risk reduction

✓ No criminalization; access to risk reduction

NA: Data not available

Source: UNAIDS Country Reports (<http://www.unaids.org/en/regionscountries/countries/>)

The provision of targeted HIV prevention and health programs that address both immediate needs and long standing behavioral, environmental, and structural factors offers a much-needed alternative to incarceration. However, such programs are not widely available. As was noted above, prevention initiatives for MSM, PWID, and CSWs reach only a small percentage of these communities. Programs that work with CSWs to address underlying economic factors that cause some women and men to turn to commercial sex are not widespread and there are sharp disagreements among the leaders in these programs as to whether commercial sex work should be equated with sex trafficking. These debates have programmatic implications because one of the key differences focuses on the question of continued criminalization or decriminalization of commercial sex work (Bernstein, 2007). Services for PWID are sorely lacking and there are few treatment options for both the psychological and physiological effects of addiction in most of the countries studied.

None of the countries studied has implemented national needle or syringe exchange programs (NSPs) but local NSPs are active in some of the countries. Opiate substitution therapy centers (OSTs) are only offered in Kenya (offering methadone) and South Africa (offering buprenorphine) (Mather, 2008). Providing both NSP and OST services has a strong impact on the health of drug users by helping insulate them from infections such as HIV and hepatitis and by providing low threshold services through which they can enter into drug treatment programs. Such provision also impacts HIV prevalence over time by reducing risk of HIV transmission among users and by encouraging alternatives to injection drug use. Despite these benefits, only 33,000 people who inject drugs in low and middle income countries had access to such services according to a 2007 report (Global HIV Prevention Working Group, 2007).

The legal and policy environment in PEPFAR priority countries is also influenced by policy debates in the United States. In regard to the specific issues related to key populations, three debates have had a substantial impact on HIV prevention, treatment, and support services: abstinence-only prevention programs, a ban on needle and syringe exchange programs, and the requirement of organizations receiving PEPFAR funding to sign an anti-prostitution pledge.

Abstinence only prevention

When the original legislation authorizing PEPFAR was passed by the US Congress in 2003, 20% of the entire allocation was earmarked for prevention services. The legislation stipulated that 1/3 of the funds dedicated to prevention services be used to support abstinence-until-marriage programs.

“Anybody can abstain and be faithful if they have shelter and food. But if I sleep in the street with no work and no one to protect me, I need to have condoms.”

**Alma Legesse, Ethiopian sex worker and mother
(quoted in Evertz, 2010)**

A 2006 report by the Government Accounting Office noted that many PEPFAR country teams felt that this funding requirement would “undermine the integration of prevention programs by forcing them to isolate funding for AB activities.” (United States Government Accountability Office, 2006, p. 6)

The 2003 legislation that established PEPFAR was set to expire in 2008. In 2007, as the program was up for re-authorization in the US Congress, the Institute of Medicine (IOM) released a comprehensive evaluation of the PEPFAR program. That report determined that the mandates for allocating 1/3 of prevention funds for abstinence had adversely affected the implementation of programs and complicated the implementation of comprehensive, integrated and evidence-based approaches (IOM, 2007).

This mandate was dropped in the 2008 reauthorization and was replaced with a call for each PEPFAR country office to develop balanced prevention activities in consultation with partner country government that responded to epidemiological data on HIV prevalence in the country. If prevention funding for “abstinence, delay of sexual debut, monogamy, fidelity, and partner reduction” fell to less than 50% of the overall prevention budget in any particular country, the country office staff must provide “a compelling explanation” to justify the allocation (IOM, 2013). Under programs carried out under the reauthorization, prevention initiatives have broadened in scope and approach and targeted prevention initiatives for key populations have expanded.

Needle Exchange Ban

A ban on federal government funding for NSPs was first enacted by Congress in 1988 as part of the Public Health and Welfare Act. By the 1990s a consensus was emerging among social scientists and public health researchers that NSPs were effective in reducing transmission of HIV and other infectious diseases without increasing drug use, leading the Institute of Medicine to recommend that the ban be lifted (Norman, Vlahov, and Moses, 1995). Despite the scientific evidence, the ban on NSPs remained in place through the Clinton and Bush Administrations and was adopted as the official PEPFAR policy when the program was funded. Barack Obama made a pledge to rescind the ban during the 2008 Presidential campaign but when he delivered his first budget to Congress, President Obama made no move to rescind the ban.

In 2009, the Congress lifted the ban and in July 2010, the Department of Health and Human Services developed guidelines for implementing NSPs with federal dollars. PEPFAR followed suit, issuing revised guidance on prevention program for people who inject drugs: “PEPFAR-supported NSPs can include the distribution of injection equipment, exchange of sterile syringes for previously-used syringes, and opportunities for safe disposal of injection equipment. Because syringe exchange offers an opportunity for sustained contact between NSP staff and the person exchanging the injection equipment, NSPs are a preferred public health practice.” (PEPFAR, 2010)

This revised policy was not to remain in place. Efforts to re-instate the ban were part of the 2012 budget deliberations and the ban was included in the bill passed by Congress. President Obama signed the budget into law, effectively re-instating the prohibition on using federal funds for NSPs. This remains the PEPFAR policy to date. Programs funded by PEPFAR may conduct NSPs but they may not federal funds for such programs; PEPFAR’s strategic plan identifies NSPs as a key component of comprehensive HIV prevention programs.

Anti-Prostitution Pledge

The 2003 legislation that established PEPFAR contained stipulations that no funds be used to “promote or advocate the legalization or practice of prostitution or sex trafficking.”

“The oath paralyzes people, makes those working in the field unsure of what they can or can’t do.”

Rekha Masilamani, Pathfinder International
(quoted in Center for Health and Gender Equity Policy Brief)

The legislation further stipulated that any organization that receives PEPFAR funds must have a policy explicitly opposing prostitution. These requirements were problematic for some organizations that worked to provide services for sex workers; some of these organizations were advocating for the decriminalization of prostitution based on research that showed that continued criminalization was a significant barrier to accessing social support, prevention, and treatment services.

The first requirement was not as restricting for these organizations because they could carry out their advocacy efforts without using PEPFAR funds. However, the second requirement, dubbed the anti-prostitution pledge, proved to be the most problematic. Under this stipulation, organizations could not adopt such positions at all, even if their advocacy efforts were being carried out without use of PEPFAR funds.

In 2005, the Alliance for Open Society International filed a challenge to the pledge requirement and Pathfinder International joined as a second plaintiff. The case wound its way through district and federal courts with two other organizations, Global Health Council and InterAction, joining as co-plaintiffs. In 2011, the 2nd Circuit of the US Court of Appeals sided with the plaintiffs, ruling that the pledge violated guarantees of free speech afforded by the U.S. Constitution. The federal government appealed the case to the US Supreme Court and arguments were heard in front of the court in April 2013. In June 2013, in a 6-2 vote the US Supreme Court upheld the ruling from the 2nd circuit and overturned the pledge requirement. The Court reasoned that the government had overstepped its authority in legislating what organizations must adopt as policy on First Amendment grounds.

Organizations and individuals filing briefs in support of the plaintiffs in their efforts to overturn the pledge requirement:

- Heartbeat International (a conservative Christian pro-life organization) on free speech principles
- ACLU (noting there is not unanimity of opinion, the ACLU claims that this diversity of opinion unfairly punishes those on one side of the debate)
- UNAIDS
- Deans and Professors of Public Health (included 16 academics and representatives of 18 NGOs (including American Jewish World Service)
- Becket Fund for Religious Liberty and the Christian Legal Society (the mandate upholds moral values they support but does so in a legal framework of mandating beliefs that they must oppose)
- Independent Sector (representing over 600 civil society organizations around the world)
- Rutherford Institute
- Cato Institute
- Thomas Jefferson Center
- Nine current or former members of Congress, both Democrat (Berman, Leahy, Daschle, Lee, Lowey, Waxman,) and Republican (Enzi, Frist, Kolbe)

Organizations and individuals filing briefs in support of the petitioners in their efforts to uphold the pledge requirement:

- American Center for Law and Justice
- Coalition Against Trafficking in Women (on behalf of 46 other signatories, including a number of international groups)

Source: <http://www.scotusblog.com/case-files/cases/agency-for-international-development-v-alliance-for-open-society-international-inc/>

Section III: PEPFAR Strategic Plan for Key Populations

In November 2012, the United States Department of State released the *PEPFAR Blueprint: Creating an AIDS-free Generation*. This 54 page document lays out the strategic plan for PEPFAR across the entire scope of HIV prevention, treatment, and support services that it funds. Key populations are referenced regularly. In the document, PEPFAR commits itself to a vision of an AIDS-free generation and adopts five key principles to achieve it, including: “End stigma and discrimination against people living with HIV and key populations, improving their access to, and uptake of, comprehensive HIV services.” (PEPFAR blueprint, 2012, p. 5). The document lays out a number of action steps; many of those steps specifically reference key populations:

Action Step: Increase coverage of HIV treatment both to reduce AIDS-related mortality and to enhance HIV prevention

To implement this action step PEPFAR is and will:

In accordance with each national epidemiological context, working with countries to prioritize key populations (e.g. MSM, SW, PWID) for ART, ensuring ART programs support a non-stigmatizing clinical environment that affords all individuals meaningful access to treatment services, including both facility and community-based care and support.

Action Step: Work toward the elimination of new HIV infections among children by 2015 and keeping their mothers alive

To implement this action step PEPFAR is and will:

Invest in high-impact, evidence-based interventions to prevent HIV infection among women of childbearing age, including interventions targeting male partners of these women. Specifically, PEPFAR will support HIV services for women in key populations, as well as populations with high prevalence.

Action Step: Increase access to and uptake of HIV testing and counseling, condoms and other evidence-based and appropriately targeted prevention interventions.

PEPFAR will support efforts to create enabling environments for key populations and address the stigma, discrimination and violence that increase their risk for HIV infection and often prevent them from entering, or being retained in, health services.

To implement this action step PEPFAR is and will:

Promote risk reduction and healthy behaviors through behavior change communication and social marketing programs directly linked to core combination HIV prevention interventions, including those designed to reach specific setting and key populations.

PEPFAR Strategic Plan for Key Populations

Action Step: Increase access to and uptake of HIV services by key populations.

To implement this action step, PEPFAR is and will:

1. Ensure that PEPFAR country portfolios are closely informed by the epidemic profile of the country, including the role of key populations.
2. Invest in epidemiologic studies to determine burden of disease among key populations, avoiding delaying the pilot and scale-up of known effective interventions.
3. Collect, analyze and share epidemiological data on program investment to inform plans, making course corrections when appropriate and monitoring progress.
4. Increase our commitment to “go where the virus is” by addressing key populations in countries with generalized, concentrated and mixed epidemics.
5. Stimulate greater country and regional programming for key populations through challenge grants to PEPFAR country teams, including in countries with concentrated epidemics that may not have a COP process.
6. Expand the evidence-base for effective interventions for key populations through implementation science awards linked to country programs to facilitate rapid scale-up of high-impact innovations.
7. Support civil society and faith-based work best able to address the epidemic in key populations through mechanisms such as country small grants.
8. Use diplomatic channels to help create an enabling environment allowing key populations to access health services.
9. Prioritize engagement in health diplomacy to promote the health and human rights of women, girls, and LGBT populations, and advance gender equality.
10. Ensure that the evolution of HIV-related programs toward country ownership supports the human rights of, and continuation of services for, key populations, including through partnerships with civil society.
11. Through the Local Capacity Initiative (LCI) Fund support country civil society organizations that advocate for key populations, from both a policy and program perspective, to do the following:
 - a) Reduce legal and policy structural barriers to an effective HIV response.
 - b) Reduce stigma and discrimination, creating greater access to HIV services.
 - c) Ensure that key populations are involved in the planning and implementation of programs that affect their lives.

Action Step: Partner with people living with HIV to design, manage and implement HIV programs responsive to and respectful of their needs.

To implement this action step, PEPFAR is and will:

Support through the Local Capacity Initiative (LCI) and other mechanisms, civil society organizations that advocate for key populations including PLHIV to pursue policy and programmatic interventions that:

- a) Reduce legal, policy and structural barriers to an effective HIV response.
- b) Reduce stigma and discrimination, creating greater access to HIV services.
- c) Ensure that key populations are involved in the planning and implementation of programs that affect their lives.

PEPFAR Strategic Plan for Key Populations

In addition to the *PEPFAR Blueprint*, a number of other publications are available providing details on PEPFAR's activities related to key populations.

Comprehensive Prevention for People Who Inject Drugs.

This 2010 PEPFAR guidance lays out three elements to PEPFAR's prevention efforts with PWID: (1) community-based outreach programs; (2) sterile needle and syringe programs (NSPs); and (3) drug dependence treatment, including medication assisted treatment (MAT) with methadone or buprenorphine and/or other effective medications as appropriate, based on the country context. The guidance also lists ten core interventions that PEPFAR supports:

1. Community-based outreach;
2. NSPs;
3. Opioid substitution therapy (OST) and other drug dependence treatment;
4. HIV counseling and testing (HCT);
5. ART for PWID living with HIV;
6. Prevention and treatment of sexually transmitted infections (STIs);
7. Condom programs for PWID and their sexual partners;
8. Targeted information, education and communication (IEC) for PWID and their sexual partners;
9. Vaccination, diagnosis and treatment of viral hepatitis; and
10. Prevention, diagnosis and treatment of tuberculosis.

Guidance for the Prevention of Sexually Transmitted HIV Infections.

This 2011 PEPFAR guidance distinguishes between concentrated, mixed, and general HIV epidemics and defines a concentrated epidemic as one in which "transmission mainly occurs within most-at-risk populations, including sex workers, MSM, and people who inject drugs." The guidance calls for context-specific responses to the type of epidemic occurring in any given country through the implementation of evidence-based programs that addresses the particular needs of those most affected.

Technical Guidance on Combination HIV Prevention.

As part of PEPFAR's overall strategy, this document addresses prevention programs for Men Who Have Sex With Men. This 2011 guidance lists six core interventions supported by PEPFAR:

1. Community-based outreach;
2. Distribution of condoms and condom-compatible lubricants;
3. HIV counseling and testing;
4. Active linkage to health care and antiretroviral treatment (ART);
5. Targeted information, education and communication (IEC); and
6. Sexually transmitted infection (STI) prevention, screening and treatment.

In order to optimize HIV prevention with MSM, the guidance also encourage sex "best practice" approaches:

1. Involve MSM;
2. Ensure confidentiality;
3. Provide staff training;
4. Collect and use strategic information;
5. Link, integrate and co-locate services;
6. Incorporate research advances and new technologies.

The six core interventions and six best practices are all described in detail in the guidance document.

PEPFAR Strategic Plan for Key Populations

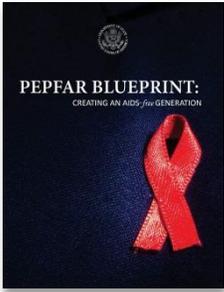
Interventions for Most-At-Risk Populations in PEPFAR Countries.

In 2009, PEPFAR convened a conference for organizations working with key populations that received PEPFAR funding in order to:

1. identify effective strategic responses to key populations;
2. describe best practices and challenges with measurement approaches;
3. develop a monitoring and evaluation (M/E) framework for key populations;
4. build the capacity of multi-sectoral partners to provide specific programs for key populations;
5. identify best practices and challenges for addressing policies, stigma, and discrimination; and
6. describe examples of effective programmatic efforts for reaching all three groups.

A Framework for Ethical Engagement with Key Populations in PEPFAR Programs. Members of PEPFAR's Scientific Advisory Board have authored guidance on ethical engagement with key population that is built on three principles: inclusion, non-discrimination, and community engagement. The document elaborates on those principles and provides two short case examples of ethical dilemmas that may arise in working with key populations—the provision of PEPFAR services, including ARVs, to persons in detention, and the provision of PEPFAR services to key populations in settings where their identities, behaviors, or practices may be criminalized. Using the principles in the framework, the document discusses possible options for addressing these dilemmas.

For further information on PEPFAR's strategic plan for key populations, see . . .



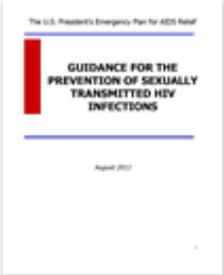
PEPFAR Blueprint: Creating an AIDS-Free Generation (2012)

Available at: <http://www.pepfar.gov/documents/organization/201386.pdf>



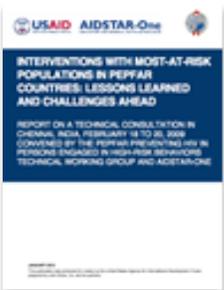
Comprehensive HIV Prevention for People Who Inject Drugs (2010)

Available at: <http://www.pepfar.gov/documents/organization/144970.pdf>



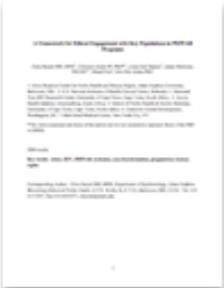
Guidance for the Prevention of Sexually Transmitted HIV Infections (2011)

Available at: <http://www.pepfar.gov/reports/guidance/171094.htm>



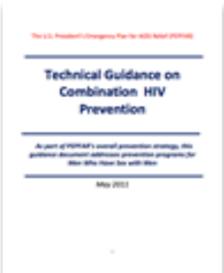
Interventions for Most-At-Risk Populations in PEPFAR Countries (2009)

Available at: http://www.aidstar-one.com/sites/default/files/AIDSTAR-One_MARPS_Report_final_0.pdf



A Framework for Ethical Engagement with Key Populations in PEPFAR Programs

Available at: <http://www.pepfar.gov/sab/210110.htm>



Technical Guidance on Combination HIV Prevention: As part of PEPFAR's overall strategy, this document addresses prevention programs for Men Who Have Sex With Men (2011)

Available at: <http://www.pepfar.gov/documents/organization/164010.pdf>

Section IV: Challenges and Opportunities: Religious Beliefs, FBOs, and a Sustained Response to HIV

Religion is not monolithic. Different beliefs can be seen both across religious traditions and within the same tradition. Religious beliefs have socio-cultural implications. This can be readily seen in regard to HIV/AIDS as some beliefs align more clearly with proven HIV prevention, treatment, and support programs while others contribute to or reinforce stigmatization for people infected and affected by HIV.

In a 2010 speech to leaders from various religious traditions, Michel Sidibe, the Executive Director of UNAIDS, highlighted the implications of different beliefs in the response to the epidemic:

People most at risk of HIV infection include men who have sex with men, sex workers and people who use drugs. Incidence is higher among people marginalized and stigmatized in society. This makes it more difficult to reach them with services and compounds their vulnerability. What are we doing to address this?

Are we fighting to address their rights? Are there mechanisms to deliver services that they may be accessed by the people who are most vulnerable?

Michel Sidibe, Executive Director of UNAIDS, March 2010



“ Those here represent the best of theological traditions—compassion, love, care, and support for the human family made by God. You are the people who teach the world how to “see the divine in the other.” To respect the dignity, value and worth of every human being— something the world desperately needs today.

But you know as well as I that religious messages can change the farther they get from the source. Theology based in compassion and dignity can be translated into judgment and intolerance for those who are living with HIV, their families and those engaging in behaviour that is taboo according to some doctrines or cultures. I am talking about our brothers and sisters who live lives we may not understand—men who have sex with men, people who use drugs, sex workers.

We hear the framing of “innocent and guilty” returning to public debate. This kind of language drives those most at risk underground, afraid to find out their own status, victims of fear, social rejection, isolation and institutional injustice. HIV spreads, endangering the entire community. This is not just bad public health. This is an affront to universal human rights.

Religions the world over preach compassion and dignity and human rights for those living with HIV and those most at risk. I have seen and heard many such thoughtful and benevolent statements from religious leaders and communities over the years. Many of you are in this room. These have impressed me deeply and I hope we can find some words together through this dialogue that will inspire one another and motivate people of faith to deeper action. (Sidibe, 2010)



Dr. Sidibe's words are a powerful reminder that religion has been and continues to be a tremendous and unique resource in response to HIV and AIDS but that it also has been and continues to be a tremendous source of stigma and judgment for those living with or affected by HIV. Efforts to build effective partnerships with FBOs to provide services to key populations must account for this dynamic function of religion and align with FBOs that have used religious belief as a foundation to offer effective programs in HIV prevention, treatment, and support. Further, such efforts must also assess how potential FBO partners understand HIV in key populations. Early faith-based responses to the epidemic were piecemeal, with individuals or local religious bodies responding to a particular need that affected neighbors in their community. These responses, often centered around care for children orphaned by the epidemic, did not coalesce into coordinated faith-based responses for a number of years. Even when these efforts grew in scale to become national responses, they could espouse compassionate messages in regard to children infected or affected by HIV while still condemning others such as drug users, commercial sex workers, and men who have sex with men (Prince, Denis, and van Dijk, 2009). In order to examine the variability in positions on HIV by religious bodies this section examines central theological positions that frame such responses.

Theological Positions That Impact Key Populations

Religions develop various theological claims about the nature of God and about God's relationship to human beings. These claims vary across traditions and within individual traditions. Such claims are key factors in determining whether religious bodies and FBOs will respond to people living with HIV with compassion or stigma. While many theological positions can impact the actions of faith-based organizations, this report focuses on two key issues that are central to faith-based programs working with key populations: 1) moral frameworks and 2) structures of authority.

Moral Frameworks

Religious traditions present a framework for making sense of the world around us. Such a framework includes moral claims regarding right and wrong. However, religion is not the only cultural system that offers its followers such a framework. Scholars in cultural studies (Treichler, 1999) and in religious studies specifically (Germond and Cochrane) have argued that any system that presents normative claims and encourages practices that adhere to those claims creates a framework for making sense of the world. From this viewpoint, public health research and clinical medicine offer such frameworks and these frameworks provide the normative criteria for determining our varied and coordinated HIV prevention, treatment, and support programs.

At times, religious frameworks and public health frameworks overlap in regard to their claims. However, at times they may diverge.

HIV treatment and prevention practices have often been instances in which this divergence becomes contentious. For example, HIV prevention programs rarely make normative claims whether certain types of sexual behaviors are right or wrong and instead focus on preventing transmission of a virus through use of condoms or other barrier protection. They promote harm reduction programs for working with drug users but do not tend to focus on questions of right and wrong in either individual or cultural contexts that contribute to addiction. Various religious traditions have framed these issues differently, arguing that these issues are moral in nature and not merely behavioral.

Some researchers have argued that HIV prevention efforts grounded in the ABC model of **A**bstinence, **B**e faithful, and **C**ondoms end up presenting two opposing moral worldviews (Blevins, 2007; Mulwo and Tomaselli, 2009). Abstinence and fidelity are not merely health behaviors an individual chooses; they are behaviors built on certain normative beliefs regarding what kinds of sexual behaviors are right and wrong. Condoms offer an alternative moral worldview regarding the moral rightness of preventing the transmission of a virus that can cause illness or death.

Competing worldviews are not limited to sexual risk behaviors; they also come into play in working with drug users. Jarrett Zigon, an anthropologist who has conducted extensive fieldwork with PWID in Russia, argues that harm reduction approaches employed by NGOs and faith-based recovery programs that demand abstinence from drug use represent a breakdown of a unified moral perspective in Russian society (Zigon, 2009, 2010). Each is grounded in a set of assumptions about right and wrong in regard to drug use and in offering programs to drug users. These assumptions represent competing moral worldviews. Framing the issue in this way presents religious traditions in opposition to public health programs and such opposition is certainly apparent in many instances. However, this obscures alternative perspectives in which individuals and organizations can employ a religious tradition to support the same moral worldview as that employed by HIV prevention programs.

In fact, this kind of alignment between religious commitments and public health priorities has created a powerful resource for advocating for public health initiatives in contexts that do not focus on moral questions related to sexual behaviors or drug use. For example, Paul Farmer has employed liberation theology to examine public health and development efforts (Kidder 2009; Farmer and Gutierrez, 2013). Christian theologians employing liberation perspectives have developed the idea that God has a preferential option for the poor. In brief, this position holds that while God loves all humanity the clear message from Christian scriptures demonstrates that God is allied with the poor because God stands with those who suffer. This position was first developed by the Latin American Roman Catholic theologian Gustavo Gutierrez (Gutierrez, 1973) and has become a central tenet of other theologians employing liberation perspectives. Of course, another option is to have HIV prevention efforts mirror the same moral worldview as that employed by the religious positions described above. This approach can be seen in abstinence-only prevention efforts. The limitations of such efforts were detailed in section II.

Farmer and others have used this claim to articulate the moral dimensions of public health practices.

Despite this theological position aligning with various public health initiatives, it has not been widely employed in relation to sexual health or harm reduction efforts. However, this is beginning to change. Liberation theologians have developed the idea that God's alliance with those who suffer extends to anyone who finds themselves on the social margins whatever the context. And so, God's preferential option extends to sexual minorities (Althaus-Reid 2001, 2003, 2004, 2007, 2009; Blevins, 2008; Blevins, 2011; Dlamini, Blevins, Lloyd, Esack, Mambuba 2012) or to drug users (Biehl and Eskerod, 2009; Blevins, 2009). Further, Islamic religious scholars have articulated similar positions (Esack and Chiddy, 2009; Kugle, 2010; De Soudy, 2013). Such perspectives shift the understanding of sin. Sin is expressed not so much in individuals' personal decisions but in the social structures and institutions that support inequality, stigma, and violence. This kind of moral worldview offers possibilities to align HIV prevention efforts with key populations and the work of some faith-based organizations.

“Harm must be eliminated (al-darar yuzal).” In relation to AIDS, efforts toward eliminating harm . . . must be stepped up and continued.

It becomes the Shari'ah-ordained responsibility of every Muslim, indeed anyone who values human life and the survival of the family, to join hands and play a role in whatever capacity they can to make this campaign all-embracing and effective.

Mohammad Hashim Kamali, in *Islam and AIDS: Between Scorn, Pity, and Justice*

¹ Of course, another option is to have HIV prevention efforts mirror the same moral worldview as that employed by the religious positions described above.

When religious leaders promote discriminatory attitudes towards, or the rejection of, certain populations, many members of society see this as legitimate and even a mandatory part of expressing their faith.

Amnesty International, 2013

When individuals or organizations claim that God's preferential option extends to sexual minorities and people who use drugs, they often challenge statements made by authorities from various religious traditions.

The question of authority becomes a key issue, then, for faith-based responses to key populations. The ability to question authoritative religious teachings or to offer alternatives to such teachings varies across religions and within various strands of any one tradition.

Faith-based responses to the HIV epidemic have often originated from grassroots organizations or from individuals who challenge traditional religious teachings and articulate an alternative position that supports compassion rather than judgment (Thurman, 2014 (forthcoming)). Over time, those in authority may integrate these alternative positions into their own teachings and mobilize broader institutional and organizational capacities to bring grassroots responses to scale. For example, early piecemeal responses to children orphaned by HIV by faith-based organizations have coalesced into a variety of national and international faith-based programs working with orphans and vulnerable children (OVC) (Tony Blair Faith Foundation 2011).



**World Council
of Churches**

Some examples of this shift in regard to religious traditions and key populations can be seen. For example, the World Council of Churches (WCC), a global network of Protestant Christian traditions, called for acceptance of various theological positions on human sexuality as early as 2003 (World Council of Churches, 2003). In 2012, a broad-based gathering of Christian and Muslim religious leaders representing key health service organizations across eastern Africa committed to including representatives of key populations in their programmatic and administrative decision-making (PEPFAR 2012b). The Ecumenical HIV and AIDS Initiative in Africa (EHAIA) sponsors Bible studies in which various groups including men who have sex with men and commercial sex workers read and interpret the Bible for themselves and do not rely solely on the interpretation of religious leaders (Njoroge 2012).

Islam has fewer formal organizational structures than Christianity. The structures such as dioceses, synods, presbyteries, conferences, or councils found in various Christian traditions have no clear counterpart in Islam. As such, the specific effects of religious authority look different within Islam. Within Islam, there are a number of examples in which faithful Muslims develop alternative interpretations to positions put forth by some religious or legal interpreters. Positive Muslims, an FBO in South Africa, has published an anthology of Muslim scholars responding to various issues related to the HIV epidemic. The volume, entitled *Islam and AIDS: Between Scorn, Pity, and Justice* includes chapters on homosexuality and drug use (Esack and Chiddy, 2009). An analysis of various programs working PWID in Muslim cultural contexts demonstrates that there is a broad range of responses with some programs (for example, in Iran and Bangladesh) employing harm reduction principles. Such principles are not seen to be contrary to Shariah (Kamarulzaman and Saifuddeen, 2010). One researcher argues that this flexibility of interpretation is influenced by HIV prevalence in local contexts with authorities demonstrating greater flexibility in interpretation where more people are infected and HIV becomes a personal issue and not merely an academic one (Hasnain, 2005).

All of these efforts that grant authority to those most affected by an issue to speak for themselves rather than merely to have leaders issue pronouncements on the issue represent contextual theological reflections that have become a strong movement within religious communities today (Graham, Walton, and Ward, 2005). The best-practice programs described in Section V all represent programs informed by this kind of theological position.

Partnerships

Even in contexts in which religious leaders exert tight control over what faith-based organizations might do or say, many faith-based programs working in the areas of HIV prevention, treatment, and support explicitly look for partnerships with FBOs from other parts of the world or with other CSOs in their own community that can work with key populations without the strictures put into place by religious authorities (Dufour, Maiorana, Allen, Kassie, Thomas, and Myers, 2013). For the staff in these FBOs, effective programs that can help PLHIV stay healthy are more important than doctrinal conformity.

In addition, there are growing examples of inter-religious partnerships that maximize limited resources from FBOs to offer services to key populations. In Kenya, Protestant (Christian Health Association of Kenya), Roman Catholic (Kenya Episcopal Conference), and Muslim (Supreme Council of Kenyan Muslims) organizations have developed formal collaborations for providing HIV primary care services, some of which are specifically targeted to key populations. Persepolis, a drug treatment and harm reduction program in Iran, has a strong and long-standing partnership with the Teutonic Order, a Christian FBO from Germany (http://www.do-international.de/partners_persepolis.php; Razzaghi, Massirimanesh, Afshar, Ohiri, Claeson, and Power 2006). These kinds of partnerships within a single religious tradition, across various religious tradition, and between a religious tradition and a civil society institution can all serve to make the resources of FBOs available to key populations.

Theological positions from various religious traditions clearly stand in tension with HIV prevention programs working with key populations. Such positions, however, are not the only ones articulated or supported by individual people of faith or by FBOs. Some FBOs are developing theological positions that align with sound HIV prevention practices for key populations; they represent an important resource that reconfigures the ways in which religion can offer support to key populations rather than judgment.



Section V: When Faith and Health Align: FBO Best Practices with Key Populations

This section of the report describes programmatic efforts through or in partnership with faith-based organizations to address the HIV prevention, treatment, and support needs of key populations. This section highlights six organizations:

- The International Network of Religious Leaders Living With or Affected by HIV/AIDS (INERELA+)
- St. Paul's Reconciliation and Equality Centre
- Sex Workers Education and Advocacy Task Force (SWEAT)
- Coptic Hospital, Nairobi
- Muslim Education and Welfare Association (MEWA)
- The Inner Circle
- American Jewish World Service

Some of the organizations are international in scale while others are offering services at the grassroots. One is not an FBO at all but is a non-governmental organization whose staff members have recognized the importance of religion in their work. With various emphases and commitments and across varied religious traditions and cultural contexts, these programs demonstrate that religion can be an important resource for HIV prevention, treatment, support, and advocacy programs with key populations.



MISSION STATEMENT: To equip, empower and engage religious leaders living with and personally affected by HIV to live positively and openly as agents of hope and change in and beyond their faith communities.

Since 2002, the International Network of Religious Leaders Living With or Affected by HIV/AIDS (INERELA+) has offered a clear religious voice of compassion and has advocated for sound HIV prevention, treatment, and support initiatives. INERELA+'s "SAVE" approach to HIV prevention offers an alternative to dominant faith-based HIV prevention strategies that emphasize abstinence and fidelity alone:

Long used as the foundation of comprehensive HIV prevention programmes around the world, ABC stands for 'Abstinence; Be faithful; use Condoms.' Unfortunately, the way in which it has been presented to far too many in the past is more like: 'Abstain. If you can't abstain, be faithful. And if you can't be faithful, use a condom'.

The implication that the use of a condom automatically marks a person as unable to be faithful fuels stigma and acts as a disincentive to evidence-based prevention. Furthermore, ABC fails to consider a person's HIV status. While abstinence may be appropriate at some stages of life, at others – within a faithful marriage, for instance – it is not; and yet an HIV-negative person whose spouse is positive is at risk even within a faithful marriage. The ABC doctrine is:

- Narrow – limiting itself to one mode of HIV transmission
- Inaccurate – in assuming that people who are abstinent or faithful will completely avoid HIV, and by implying that those who are faithful do not need to use condoms as an added protective measure
- Stigmatizing to PLHIV – by implying that people who are HIV positive have failed in abstinence and faithfulness
- Inadequate – by leaving out messages for families, communities and nations, and placing the burden of prevention on the individual.

It ignores the role of HIV counselling, testing and treatment in prevention, and fails to highlight other possible means of HIV prevention, like safe blood transfusion, safe injections, safe circumcision, and prevention of mother-to-child transmission.

“HIV is a virus, not a moral condition, and the response to it should be based on public health measures tempered by human rights principles.”

“What We Do” on the INERELA+ website
(<http://inerela.org/about-us/what-we-do/>)

The SAVE approach provides a more holistic way of preventing HIV by incorporating the principles of the ABC (Abstinence, Be faithful and Condom use) as well as providing additional information about HIV transmission and prevention, providing support and care for those already infected and actively challenging the denial, stigma and discrimination so commonly associated with HIV.

(<http://inerela.org/about-us/what-we-do/>)



SAVE Prevention Model

S

Refers to safer practices covering all the different modes of HIV transmission, like safe blood transfusions, and the use of condoms, or sterile needles for injecting. Abstinence remains the most reliable method of avoiding exposure to STIs, but it must not be taught in isolation.

A

Refers to available medications – not just ART, but treatment for HIV-associated infections, and provision of good nutrition (particularly to help ensure adherence to ART) and clean water.

V

Refers to voluntary HIV testing and counselling. If you know you are positive, you can protect yourself and others, and take steps to live a healthy, productive, positive life.

E

Refers to empowerment through education. Denial, stigma and discrimination associated with HIV remain pernicious and ubiquitous. This is why empowerment through education is a vital component of all work on HIV. People need accurate information about HIV to make informed decisions and protect themselves, their partners and children from HIV. Education also challenges the stigma and discrimination that can make the lives of people with HIV so difficult.

The complete SAVE toolkit is available from INERELA+'s website: www.inerela.org.

INERELA+ has explicitly supported interfaith collaboration and has developed formal positions in support of compassionate and effective prevention programs for key populations. These include *What's Faith Got to Do With It? A Global Multifaith Discussion on HIV Issues* (Opinde, Chintando, and Nickles, 2012) and the international conference, *Dialogue on Transformative Theological Reflections: Sexual Diversity* held in Johannesburg, South Africa in September 2013.

INERELA+ has country chapters in:

- Bolivia
- Botswana
- Brazil
- Burundi
- Cameroon
- Costa Rica
- Democratic Republic of the Congo (DRC)
- Dominican Republic
- Ethiopia
- Ghana
- Guatemala
- Haiti
- India
- Kenya
- Madagascar
- Malawi
- Mozambique
- Nicaragua
- Nigeria
- Peru
- Rwanda
- South Africa (INERELA+ Secretariat)
- Tanzania
- Uganda
- Zambia
- Zimbabwe

In addition, over 7,000 individuals across five continents are part of the INERELA+ network. The organization has strong partnerships with a broad cross-section of faith-based and civil society organizations, including:

- American Jewish World Service
- Bread for the World
- Christian Aid
- Church of Sweden
- Churches United Against HIV & AIDS
- Ecumenical Advocacy Alliance
- Ecumenical HIV & AIDS Initiative in Africa
- Ford Foundation
- FHI 360
- GNP+
- ICCO
- Norwegian Church AID
- PACANet
- Save the Children
- Southern Africa AIDS Trust
- Sex Workers Education and Advocacy Task Force (SWEAT)
- Swedish International Development Cooperation Agency/Norwegian Agency for Development (SIDA/NORAD)
- Tearfund
- UNAIDS
- United Nations Development Programme
- United Nations Population Fund
- World AIDS Campaign
- World Association for Christian Communication
- World Council of Churches
- World Vision International

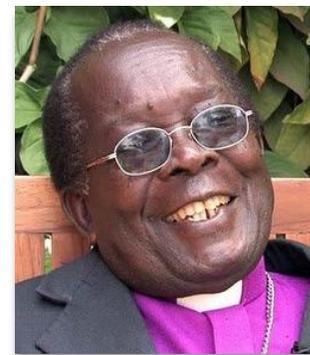


Uganda has emerged as an epicenter in the roiling debates over homosexuality in Africa. On one side, a spectrum of governmental, civil society, and religious organizations opposing homosexuality rallied to pass a law in December 2013 that makes same-sex sexual behavior a crime punishable by life imprisonment. In addition, Ugandans who know of people engaging in same-sex sexual behavior can be imprisoned for three years if they do not report this behavior under the terms of the law. Until it was amended following outcries from many governmental and civil society organizations from the United States and Europe, the earlier version of this law would have named some forms of same-sex expression—including consensual sex in which one person was disabled or HIV-positive—as crimes worthy of death (The Anti-Homosexuality 2009; Kron 2012).

On the other side, some Ugandan officials have dismissed the outcries as yet one more instance of Western societies and governments attempting to determine Uganda's own social structures and cultural values, framing the bill as evidence of the nation remaining true to God's law. In this debate, voices of same gender-loving Ugandans and their allies are not often heard; quite often, they are never even considered.

The St. Paul's Reconciliation and Equality Centre has worked to make those voices heard. The Centre offers HIV prevention and support services, development initiatives, and gender empowerment programs. In partnership with a US-based FBO, the St. Paul's Foundation for International Reconciliation, the centre has supported capacity-building and technical assistance efforts to various CSOs working to provide comprehensive HIV services.

Bishop Christopher Senyonjo, a retired Anglican bishop from Uganda, founded the Centre after working for a number of years as an advocate for LGBT people in Uganda. Those efforts had been met with some degree of disapproval but when the Anti-Homosexuality Bill was introduced into the Ugandan Parliament in 2009, disapproval changed to condemnation. In response to these actions, Bishop Senyonjo stated:



“There has been a lot of persecution leveled against me ever since I expressed interest in working with LGBT people. These have sadly touched various facets of my life like housing, pension and episcopacy in an effort to seclude and intimidate me and my family. I want to assure you that there is no turning back on this road to full inclusion and pastoral sensitivity to all God's people in our Church and therefore, I call upon the good leadership of my Church in Uganda to respond pastorally and quickly to all these unfortunate and open-ended forms of anarchy, which only serve to dent the good image of the Church.”

Bishop Senyonjo and the staff at St. Paul's Centre are working to provide vital HIV services to MSM in Uganda. They are also acting courageously to advocate for a society that rejects violence, condemnation, and stigma. They do this work in conjunction with a host of faith-based and civil society partners in Uganda and around the world. They do this work as people of faith.

sweat



Sex Workers Education & Advocacy Taskforce

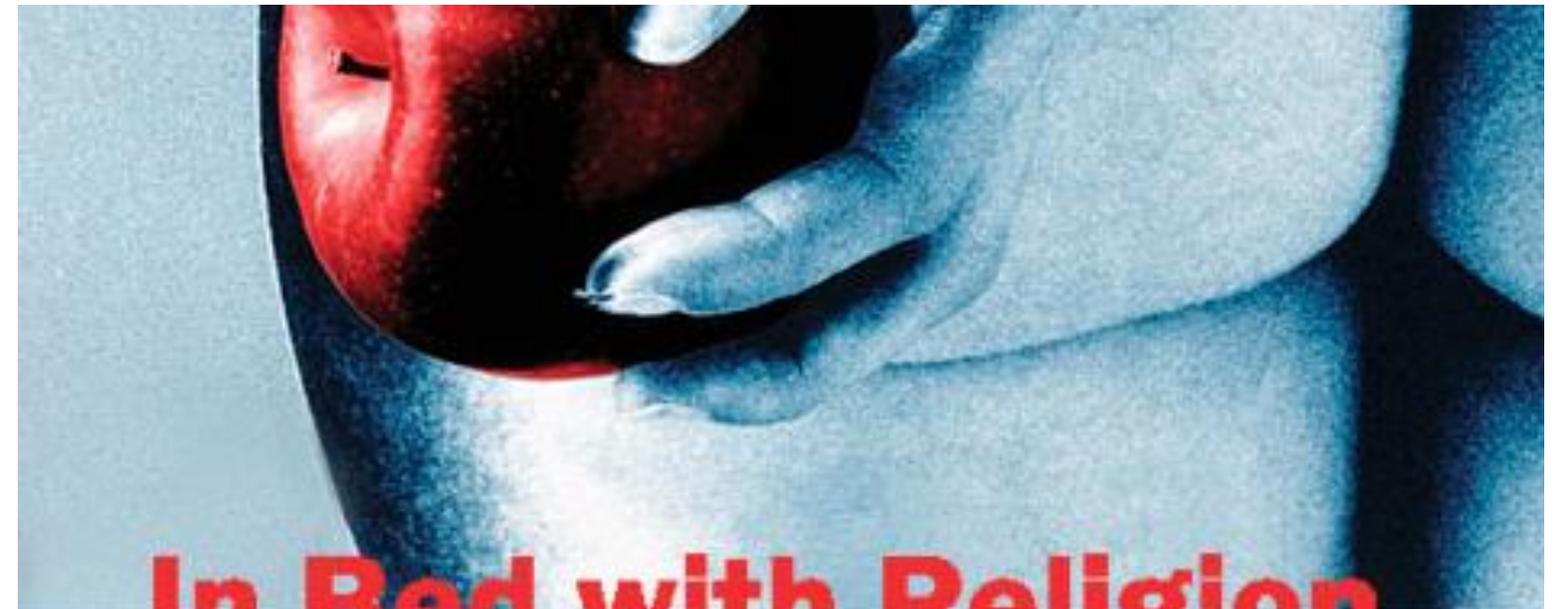
The Sex Workers Education and Advocacy Taskforce (SWEAT) is not a faith-based organization. But as a CSO, SWEAT has collaborated with FBOs such as INERELA+ in joint programmatic initiatives. SWEAT was founded in the early 1990's following the collapse of Apartheid governmental rule in South Africa and registered as an official non-profit entity in 1996 and helped launch similar global initiatives such as Sisonke (<http://www.nswp.org/members/africa/sisonke>). SWEAT emphasizes research and advocacy activities designed to build the evidence base of social, political, and political forces that impact sex workers.

In December 2012, SWEAT organized a workshop entitled *In Bed With Religion: Reconciling Sex Work and Faith*. The workshop brought together religious leaders, religious scholars, and public health researchers to examine the ways that religion influences sex workers' lives. Workshop presenters included:

- **Farid Esack** — Dr. Esack edited *Islam and AIDS: Between Pity, Scorn, and Justice* and is chair of the Department of Religious Studies at the University of Johannesburg. He presented on Islamic theological and ethical positions on sexuality.
- **John Blevins²** — Dr. Blevins is a Christian theologian and professor with the Interfaith Health Program at the Rollins School of Public Health at Emory University, Atlanta, GA USA. He argued that God's preferential option for the poor extends to sex workers and that the first people who should speak about God's relationship to sex workers should not be pastors or theologians but sex workers themselves.
- **Christopher Lloyd** — Reverend Lloyd is the Director of the South African country chapter of INERELA+ (SANERELA+). He spoke of the need for faith-based efforts grounded in social justice to speak to issues central to sex workers' lives.

However, the most important perspectives offered at the workshop came not from these scholars and researchers but from sex workers themselves. Various SWEAT program participants spoke and SWEAT's drama group, UMZEKELO, presented a skit describing the ways in which religion has been used to justify violence against sex workers. The workshop offered an example of the importance of partnerships between faith-based organizations, religious leaders, and civil society organizations to build coalitions for advocacy and service provision.

² Dr. Blevins is the author of this report.



In Bed with Religion

reconciling sex work and faith

Key Points from *In Bed with Religion*

“Religious leaders appear to be removed and disinterested in sex workers and their plight. Religious leaders have perfected the art of ignoring problematic groups. We need to be empowering religious leaders to understand the dynamics of stigma and discrimination and vulnerability as it impacts on sex workers.”

Christopher Lloyd, SANERELA+

“What does Islam say about sex outside marriage? They will immediately say it is haram. It is not permitted. But there is actually the phenomenon of temporary marriages.”

Farid Esack, Professor and Chair, Dept. of Religious Studies, Univ. of Johannesburg

“What you can tell us in the stories of your lives is that you already know what it means to be saved. You already know what it is to be loved. You already know what it means to have surprising places where grace breaks in into your work and into your lives. Far better than I can tell. Far better than a theologian can tell. The people who should be speaking are not people like me but people like you. Because you are the ones who can give the testimony of how God works in your life. To hear that story, ask a sex worker.”

John Blevins, Interfaith Health Program, Emory University

I like God even when I'm in the streets. God is here With me!

Duduzile Dlamini
SWEAT Peer Educator

Sex workers are mothers. Sex workers are fathers. They are sisters. They are brothers. Sex workers are believers. Sex workers are faithful.

Kgomotso Matsunyane — Media personality and producer, SWEAT Board Member

Coptic Hospital, Nairobi, Kenya



The Coptic Hospital in Nairobi is a ministry of the Coptic Orthodox Church; one of the oldest Christian traditions, the church was founded by St. Mark the Evangelist (one of the Apostles) in 61 CE in Alexandria, Egypt. The hospital in Nairobi offers comprehensive HIV primary care services to over 5,000 PLHIV, through centers on its main medical campus, a clinic in the Lungu Lungu area of the Mukuru kwa Njenga informal settlement, and a clinic in Maseno, a small town in rural Kenya. At the center on its main medical campus, Coptic offers a low-threshold street outreach program offering targeted services to commercial sex workers. The program combines medical care, psychosocial support, job skills and vocational training, and financial assistance. Coptic works with sex workers to identify other options for livelihood.

The program encourages the women in the program to explore alternatives to sex work but offers services to women in the program regardless of the decision they make in regard to leaving or continuing in sex work. Some of the women who first began as participants in the outreach program now work at Coptic or in other positions and some of the women who become members of the Coptic congregation in Nairobi, though this is not a requirement of the program. The program is small because the staff are intentional at developing trusting relationships with program participants as the key to long-term changes for the women who participate. The outreach program has provided some type of service encounters to hundreds of sex workers over the years; however, to date, eighteen women have stayed with the program, leaving sex work to find other ways to meet their financial needs and those of their families.



Muslim Education and Welfare Association (MEWA)



The Muslim Education and Welfare Association (MEWA) in Mombasa, Kenya 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 PWID. 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 these PWID are also HIV positive. A study conducted in collaboration with the University of Nairobi showed that almost 50 percent of injection drug users tested were HIV-positive.

The MEWA Drug Treatment Centre offers a number of services:

- Medical Detox (1 week)
- Residential Treatment (4 months)
- Outpatient Treatment (3 months)
- Group Counselling
- 1 to 1 Counselling
- Daily Meditation
- Special Topics
- Computer Classes
- Fitness Gym
- Modern Library
- Family Treatment
- Aftercare Support
- Referral Services
- Outreach Programmes
- NSEP

MEWA's treatment models is 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.

Abdalla Badrus is the Director of MEWA's Drug Rehabilitation and Resource Center. A former drug user himself, Abdalla is representative of MEWA's staff and volunteers, most of whom are recovering addicts. 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 8,000 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 community-based program is providing "health, hope, and healing" to drug users, their families, and the broader community.

The Inner Circle



Transforming Society into one that is inter-connected and inclusive of different Faiths and Beliefs, Gender and Sexual Diversity

The Inner Circle is a large, 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.

When it was founded in 1996, the organization operated largely as an underground support system, with study circles (halgaats) offered in the home of Imam Muhsin Hendricks. These study circles have continued into the present, offering a vital context for helping Muslims who are queer to reconcile Islam with their sexuality. In 2004, The Inner Circle officially registered as a Not for Profit Human Rights Organization.

Today, Imam Hendricks coordinates the various activities of The Inner Circle, which 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 *Islam, Sexual Diversity, and Access to Health Services*.



The role of religious /cultural stigmatization in access to health *from Islam, Sexual Diversity, and Access to Health Services*

Rejection of MSM in Muslim societies is real and sometimes translates into violence. Many MSM constantly deal with the pain of rejection and avoid situations in which they may feel rejected. Sex can provide short term relief from rejection.

MSM may avoid accessing health services for fear of further rejection and victimisation.

Some religious leaders are uninformed about HIV and preach that it is a punishment from God for homosexuality. This can make HIV services inaccessible to MSM who hide because of fear. Burial rights may be denied to those who died as homosexuals or with HIV. This further discourages MSM from revealing their HIV status. Families may hide the 'shame' by stating that the death was due to tuberculosis or cancer.

Religious stigmatisation adds to low levels of self-esteem amongst MSM which further exacerbate the lack of self-care and protection against HIV.

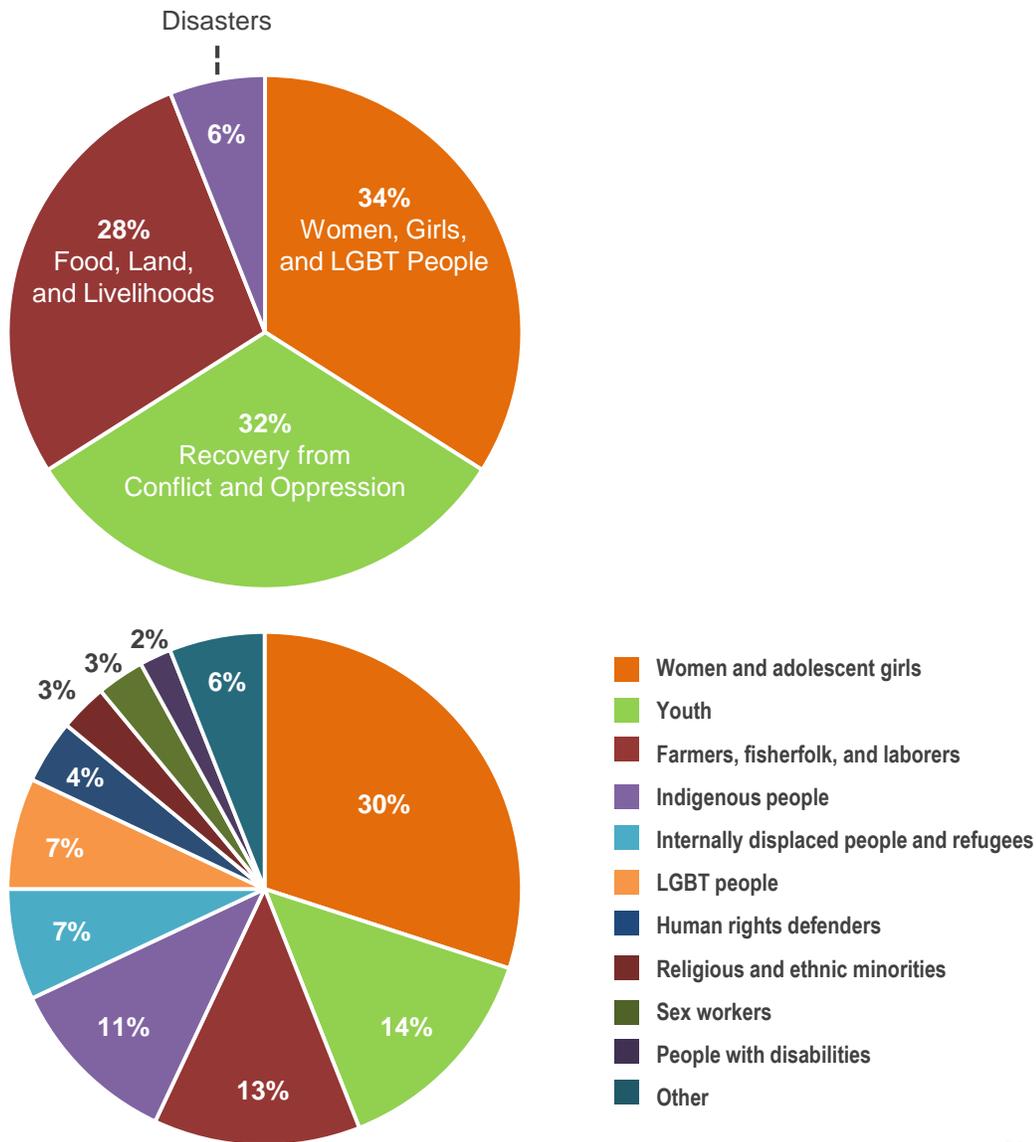
Culturally females are viewed as inferior to males and often effeminate men as viewed a degree lesser than females. MSM feel that they do not fit the construction of masculinity or femininity and may struggle to understand their own identity or their place within Muslim culture.



American Jewish World Service (AJWS) was founded in 1985 and has worked to carry out its original vision of *tzedakah*: the Jewish concept of justice. AJWS furthers justice through the promotion of human rights, education, economic development, healthcare and sustainable agriculture. In the last year, AJWS worked with over 300 local grassroots organizations in sustained programs in 21 countries around the world. Focus areas include civil and human rights, conflict and emergency response, social and economic development through girl effect, health, natural resource rights and economic justice, sexual health and rights, sustainable development, and universal education. AJWS also works to provide time-limited emergency relief and assistance through an average of seventy other grassroots partners each year.

Finally, AJWS has developed a network of twelve global strategic allies comprised of international organizations with a long-standing record of successful, respectful partnerships with grassroots organizations across the globe. These allies allow AJWS to offer technical assistance, resource-sharing, and capacity building to the grassroots organizations they support.

Percentage of AJWS Budget Devoted to Key Issues and Key Populations Supported by AJWS



AJWS' Work with PEPFAR Key Populations

Since 2000, AJWS has provided over \$3.2 million to local, in-country partners around the world to address stigma and discrimination for commercial sex workers and men who have sex with men and to provide social support and medical services for these communities. AJWS has funded twenty-one projects in Burma, Cambodia, Dominican Republic, El Salvador, Haiti, India, Kenya, Nicaragua, Sri Lanka, Thailand, and Uganda. In addition, AJWS has organized sustained efforts in the United States to advocate for changes in U.S. federal laws that ban needle and syringe exchange programs (NSEPs) and banned organizations from receiving PEPFAR funds that did not sign the anti-prostitution pledge that was a stipulation for funding before it was struck down by the U.S. Supreme Court in 2013.

DOMINICAN REPUBLIC

Movimiento de Mujeres Unidas (MODEMU)
(3 years supported)

Project: Promoting Sex Worker Rights

Purpose: To promote the rights of sex workers through community health promoter outreach and political advocacy at the local and national levels.

EL SALVADOR

Asociación de Mujeres Flor de Piedra
(8 years supported)

Project: Promoting Sex Workers' Sexual and Reproductive Health

Purpose: To protect the rights of sex workers by running public awareness initiatives, engaging in advocacy with decision-makers, raising awareness about sexual rights among sex worker groups and strengthening the organization's ability to work with its communities.

HAITI

Association Nationale de Protection des Femmes et Enfants Haitiens (ANAPFEH) (2 years supported)

Project: Protecting the Human Rights of Sex Workers in Delmas

Purpose: To reduce sex workers' vulnerability to violence and HIV and AIDS by creating safe spaces for learning and organizing, reaching out to sex workers in the workplace, and providing psychosocial and medical support in cases of violence.

Femme en Action contre la Stigmatisation et la Discrimination Sexuelle (FACSDIS) (2 years supported)

Project: Advocating for LBT and Sex Worker Rights

Purpose: To decrease sexual and gender-based violence (SGBV) against LBT people and sex workers through awareness campaigns, vocational training and accompaniment of SGBV survivors.

Fondation SEROVie (Four years supported) (4 years supported)

Project: Advancing the Human Rights Agenda of the Haitian LGBT Community

Purpose: To advance human rights of LGBT people by providing human rights education, mobilizing communities and developing a referral system for medical and psychological support.

Kouraj Pou Pwo Dwa Moun an Ayiti (KOURAJ) (2 years supported)

Project: Ending Discrimination and Stigmatization of Sexual Minorities

Purpose: To end the discrimination and stigmatization facing sexual minorities in Haiti by establishing strong advocacy groups and networks, and raising awareness through regular public dialogues and film screenings.

Movimiento Social-Cultural de los Trabajadores Haitianos (MOSCTHA) (13 years supported)

Project: HIV/AIDS Prevention and Services

Purpose: To equip young Haitians to protect their health and prevent the spread of HIV, AIDS and sexually transmitted infections by raising awareness on sexual and reproductive health and rights, creating safe spaces for dialogue, holding workshops for sex workers and sexual minorities, and providing medical consultations and home visits.

NICARAGUA

Asociacion Nicaraguense de Transgeneras (ANIT) (2 years supported)

Project: Advancing the Rights of Transgender People

Purpose: To defend and promote the sexual health and rights of transgender people by conducting human rights education and leadership-building; denouncing human rights violations; conducting workshops on gender identity, stigma and discrimination and HIV prevention; and conducting awareness-raising workshops with the staff of public institutions.

Grupo de Mujeres Jóvenes Ex-trabajadoras Sexuales 'Las Golondrinas' (7 years supported)

Project: Sex Worker and Health Rights

Purpose: To protect and respect sex workers' rights through human rights education, sexual and reproductive health trainings, and advocacy with local authorities.

KENYA

UHAI - The East African Sexual Health and Rights Initiative (UHAI - EASHRI) (4 years supported)

Project: Capacity Building for LGBTI and Sex Worker Movements

Purpose: To build the capacities of organizations in the LGBTI and sex worker rights movements in Uganda and Kenya, including AJWS grantees, through training and convenings.

UGANDA

Crested Crane Lighters (CCL) (4 years funded)

Project: Community Mobilization for Sex Workers' Rights

Purpose: To advance the health and human rights of sex workers through community outreach, peer education on sexual and reproductive health, HIV counseling and entrepreneurship training.

Support Initiative for People with Congenital Disorders (SIPD) (5 years funded)

Project: Public Education and Advocacy

Purpose: To advance the rights of children and people with intersex conditions and decrease discrimination through public education and referrals to health care providers.

Years Supported: 5

Women's Organization Network for Human Rights Advocacy (WONETHA) (4 years funded)

Project: Building Capacity for Sex Workers' Rights

Purpose: To promote the human rights and empowerment of sex workers through trainings in functional adult literacy and security management and human rights workshops for sex workers and police.

SRI LANKA

Equal Ground (8 years supported)

Project: Community Empowerment and Mental Well-Being

Purpose: To promote self-acceptance and awareness about sexuality, health and rights through a 'safe space' for workshops and counseling, outreach across the country, training of trainers, publications and engagement with national media.

BURMA

Rays of the Rainbow (6 years supported)

Project: Lesbian, Gay, Bisexual, Transgender, and Intersex Community Empowerment

Purpose: To build lesbian, gay, bisexual, transgender and intersex leadership and address homophobia through human rights workshops that bring together LGBTI and non-LGBTI youth and migrants, and to support the involvement of LGBTI people in community-development activities.

CAMBODIA

Women's Network for Unity (WNU) (8 years supported)

Project: Sex Workers' Human Rights and Leadership

Purpose: To empower sex workers to advocate for access to social services and freedom from violence and discrimination.

INDIA

Point of View (POV) (1 year supported)

Project: Advancing the Right to Health for Transgender Communities

Purpose: To increase knowledge of the female-to-male transgender population of Mumbai around their right to basic healthcare and legal services by supporting community organizing and education; to facilitate connections between the medical community in Mumbai and transgender individuals through public health drives.

SAATHII (8 years supported)

Project: Livelihood Support for Transgender Communities

Purpose: To support the community organization AMANA to increase the capacity of transgender and MSM communities to access mainstream healthcare, education and employment services through training and workshops; to conduct community outreach and advocacy activities to reduce the stigma and discrimination facing this population.

Sampada Grameen Mahila Sanstha (SANGRAM) (8 years supported)

Project: Peer-led HIV/AIDS Education Among Sex Workers

Purpose: To defend the rights of sex workers and empower them to design and implement sustainable programs for their own health; and to combat discrimination and stigma within the wider community through community organizing, rights-based education, and peer-led HIV and AIDS programs.

THAILAND

Anjaree Group (2 years funded)

Project: Lesbian, Bisexual and Transgender Education, Outreach and Advocacy

Purpose: To strengthen and educate communities on gender, sexuality and rights by documenting cases of violence and discrimination against lesbian, gay, bisexual, transgender and intersex communities.

Sao-Sao-ed (SSE) (4 years supported)

Project: Lesbian, Gay, Bisexual and Transgender Empowerment

Purpose: To empower Thailand's lesbian, gay, bisexual, transgender and intersex communities and promote equality and non-discrimination, regardless of sexual orientation and gender identity, by raising public awareness of violence and discrimination faced by LGBTI people through running media and public campaigns and facilitating research and studies on LGBTI rights.

Section VI: Faithful Voices: Perspectives from Religious Leaders Working with Key Populations

This section contains interviews with two religious leaders who have played instrumental roles in shaping two of the organizations just described -- Coptic Hospital and INERELA+.



An Interview with Father Mena Attwa, Priest of the Coptic Orthodox Church and Director of Coptic Hospital, Nairobi

Father Mena Attwa is the Director of the Coptic Hospital in Nairobi, Kenya. He has been the key administrative leader in the comprehensive HIV treatment program offered at Coptic and its two satellite clinics. In August 2013, Father Mena met with staff from the Interfaith Health Program at Emory University to discuss Coptic's outreach program with commercial sex workers.

Question: Can you just give me a little bit of background on the Coptic program you guys have developed with commercial sex workers? Anything you'd like to give as background?

Fr. Mena: The Coptic program started when we were working with street boys- we have a street boys project which is called Raha kids. That program only works with boys and young men until age 15 or 16 or so. It has been around for about five years and is doing very well. A sister runs the program and it has about 75 people enrolled. The boys are given clothes, food, shelter and a place to sleep. All participants are provided informal education and we sponsor formal educational opportunities for those who qualify. The program is focused on a holistic approach to taking care of these children and the spiritual emphasis is very important to us.

With the success of Raha Kids, we decided to try and reach out to young women. One of the priests decided to go out and try to reach commercial sex workers. It started informally: he would go out in the evening and speak to commercial sex workers and gave them information about the church. Once the sex workers came, Coptic gave them jobs to do during the day – cleaning and other work to get them as tired as possible! Over time we realized that some of them were not interested in our congregation. We stay in relationship with them to the degree they want; however, there were a handful who seemed very interested in the church and some of them have full time jobs with Coptic now. They participate in weekly spiritual meetings and were offered HIV testing at the Hope Center [note: The Hope Center is Coptic's comprehensive HIV program]. Most of our activities in this program are coordinated through the Hope Center because we feel that stigma would be lower there. 18 women from the program are now members of the church. We offer spiritual and psycho-social counselors for the women to provide them ongoing support and we sponsor a weekly fellowship.

The reality of the lives of the women in the program is that they never intended to be sex workers. It's not about them wanting to do that. It's about the need to provide for families. So we have to address the economic needs. We work with the women to help them find jobs because that is such an important priority. We have seen successes with the program—and we've had our share of challenges as well.

Q: It sounds as if the way you've approached this ministry is to attend to the psycho-social needs of the participants as a gateway into caring for them as a whole person—that you recognized that economic needs were a key driver for entry into commercial sex

work and you worked to attend to those needs.

FM: We have to. Bringing them the message of Christ is great and a lot of them know it, but the reality for our participants is, "How are we going to provide for our kids?" And so we've committed ourselves to showing them the love of Christ and also being able to provide for their needs, bringing them the word of Christ and also being able to physically provide in other ways. It can't be one sided only. When God opens the door for you to be able to provide in both aspects, you have to attend to both the physical and the spiritual. Caring for this community is giving me a living message that is real and it's nice to be part of that. I feel that throughout the whole mission, actually.

From caring for psycho-social needs it becomes about empowering people to be able to take care of themselves. Instead of being an enabler, you become someone who empowers. And then the women start giving back to the program. They start to reach out to other ladies and help them.

Q: You've already spoken a little bit about what motivates you from a spiritual and service perspective. Do you have any thoughts about that motivation in light of the recognition that religious communities may be the place where stigma is the starting point rather than compassion?

FM: I really believe that compassion is what drove Christ to do what he did for our sake. If you look at every aspect of who Christ was... he was sitting with the sinners and tax collectors. That was his mission. If we put a stigma against people, then our salvation would not be real.

To know the Gospel it's clear that you have to have that compassion. That comes first. You can't be in a position to put someone else in a bubble or a corner because that was not what Christ did at all. To stigmatize is against everything Christ taught. As a church we have to do better—to make sure that we are not putting people in a bubble, not making them feel different than anyone else. And so we have to realize that and understand that God has accepted all and that's our job is to really accept all, to love all.

I think when we stigmatize people, it actually causes them to stumble and lose the meaning of who Christ is and that is a big problem. Churches need to stay away from stigmatizing. If society wants to marginalize or put people in a bubble, the church has to be their refuge and be the place that gives them comfort and hope that there is something beyond this life and what's happening in this life.

An Interview with Father Mena Attwa, Priest of the Coptic Orthodox Church and Director of Coptic Hospital, Nairobi *(continued)*

Q: On another topic, I wondered if you could talk a little about your work in the Hope Center with people who struggle with drug use.

Alcohol use has been the big one — especially in our industrial area clinic and our rural clinic where it is a really big stumbling block for patients to take their medication and it's really making them sicker.

Q: And it's more home brew, I assume?

FM: Oh yeah, it's all home brew. Especially in the industrial area there, it's all home brewed. And Makadara slum area it's a very difficult area. So I think that's where our big problem was and that's why it became a priority -- especially at that site.

Q: When you think about the people in your clinic who are using drugs or alcohol, do you see any correlation between their drug and alcohol use and either psychosocial issues or mental illness?

FM: I think we see a big correlation with psychosocial issues. Again, it comes back to instead of depending on God, you end up depending on substances to fill the void that is there. I think that's where you see most of the problems that they're having. Because of the psychosocial issues that they are having, they do turn to alcohol or drugs. It's very clear actually. Most of our alcohol users are coming from very difficult backgrounds— some of them without jobs. It's very clear that is an issue. You can see the household incomes for those patients and you can see that is a clear problem.

Q: You've already talked in-depth about your theological perspectives of offering compassion to sex workers and people struggling with alcohol use. Was this a source of controversy in your congregation or among other Coptic communities?

FM: The bishop that started this hospital, His Grace Bishop Antonious Markos and the bishop now, Bishop Paul, both are doctors. It was like a must for them to reach out to people in different ways. And what they knew best was medicine and they felt like that was very much needed. They knew medicine well and felt like it was needed in this part of the world and they kind of combined that together and that's what allowed them to do this work. There was never a time where us having an HIV clinic or us dealing with the people that we deal with—it's never really been an issue. We never saw a problem from the mother church or from the congregation. And a lot of our congregation members are HIV positive patients—a good number of them that have come through. They came, they found out about us and have been enrolled in the program. So there are a number that are HIV positive and are fine with that and others are okay with it and I think that's breaking that barrier as well. I think that was a drive behind generally, starting with two bishops that had that background and desire and the support has always been there from the mother church for us to continue doing the work.

Q: Do you have any advice for someone who is a part of a FBO or religious community who feels called to do this work, but finds that they are facing controversy in their tradition or local community? Any thoughts as to how you might engage in that controversy in both a faithful and productive way?

FM: Christ himself faced a lot of controversy because they were upset because he sat with sinners and they were upset when he didn't. It was always a controversy for him. I think being part of this kind of work and being a Christian means you're going to offend some people along the way. Not that that is encouraged or anything.

You have to be willing to take that leap of faith and realize that if you're really doing it for the sake of Christ and not for your own gain or your own recognition then His hand will be the one to lead and guide you. Definitely within the framework of what you're able to do. Don't stop it before trying to step out of the boat. Try to step out of the boat first, see how it works and then let God do the rest. The problem is that even before we try, we say "no it can't work and it won't happen because my church or my community doesn't allow it." And so we don't take those risks. Take the risk and allow God to do the rest. And if He wants it to work, and I'm saying this with all my heart, if he wants it to work, it will work. And if it's not meant to work, then he will put a stop to it in one way or the other. But we have to be willing to take risks. We have to understand that being a Christian means being different than the rest of the world and being willing to really stick our necks out for the sake of Christ because spreading the Gospel and bringing his word to people is our main mission in life.

Q: Is there any final thing you would want to communicate on this topic?

FM: I really feel it's a very big blessing for us as a church to be a part of this work and to show the rest of the world that FBOs are not hypocritical, they're not only out there to shove the Gospel down people's throats and that's all they care about. I think it's important for us as a church to show that's not the goal. Again, I think the goal is Christ and bringing people to Christ and to love of Christ. The difference between us and other non-profits is that we should be doing the work with God's grace. It's our responsibility as a church to do these things. We cannot take a backseat, we can't say it's not our responsibility to go after this group of people.

We can't sit back and watch the researchers and doctors worry about that stuff and we're on the pulpit every week and preaching and that's all we do because that's not what Christ did. Christ travelled from city to city to heal over and over again and his disciples did the same and that's how we need to live our lives. We need to be part of this.



An Interview with Reverend Canon Gideon Byamugisha

Gideon Byamugisha is a priest in the Anglican Church of Uganda. His public witness of support and compassion for all people living with HIV/AIDS has helped to shape the global church's best responses to the epidemic.

Gideon found out he was HIV positive in April 1991, soon after his wife became ill. His colleagues were largely supportive but pleaded with Gideon to keep his infection a secret. He refused, becoming the first known religious leader in Africa to publicly declare his HIV-positive status.

It took a decade for Gideon's singular decision to grow into a broader response, but in 2002, forty-two other religious leaders added their voices to his to found INERELA+: the International Network of Religious Leaders Living with or Personally Affected by HIV/AIDS. Those voices number in the thousands today and represent a powerful social movement to replace stigma and discrimination with compassion and comprehensive education.

Q: What is your advice on reaching key populations without being seen as trying to interfere with religious and cultural beliefs? It seems like a delicate dance.

GB: We need to re-conceptualize the meaning of "Most At-Risk" by redefining the key populations and framing the concepts in a way that fits into the paradigm of moral systems & religious engagement. For example, public health researchers put up a slide showing the key populations: 1. CSW, 2. MSM, etc. But in the religious leaders' minds, they are saying "We told you. We told you that these are the behaviors that put people at risk." Now the presenter falls into a ditch, where the presentation causes further alienation. "They need to come to the Lord; they need to change their behavior!" So we're no longer talking about assisting the key populations, but about blaming the key population.

We need to change the language – to redefine those who are most at risk without alienating them. Those most at risk are:

1. Those people who lack accurate information on how HIV spreads.
2. Those people who are fatalistic or pessimistic on HIV – their attitude makes them vulnerable.
3. Those who lack appropriate skills for protection: condom skills, can't advocate for themselves, want to say no, but say yes.
4. Those who lack services – accessible, non-stigmatizing services For example, they want counseling, but it's patronizing so they don't come back. They need ARVs, but they can't get them because of attitudes in the government.
5. Those who lack supporting environments – places that make safe behavior common and routine.

Q: In public health, epidemiologists look at behaviors and give names like MSM, focusing on the behavior and not the person. But this term can stigmatize. How do we describe the things that people in key populations need without contributing to such stigma?

GB: Name the risk, not the behavior. For example, it is not the behavior of MSM or CSW that puts them at risk. It is the failure to take precautions. Many MSM and CSW do not know what to do to prevent transmission regardless of their behaviors. But we keep focusing on the behaviors themselves. We further stigmatize people by doing this.

In Uganda, there was a time when mutually monogamous relationships had highest rate of HIV, while CSWs had much lower risk. In Uganda, some CSWs learned that if they get HIV, they were out of business. So there was an incentive for them to use protection so they charge \$50 for condom or \$200 for no condom. It comes down to creating environments where there are supports for people to minimize their risk.

Q: What are the opportunities and challenges involved in getting FBOs to adopt the perspective you're describing?

GB: I really do believe that most faith leaders are eager to engage whenever the conceptualization of the problem changes. INERELA+ has pioneered a language that makes sense to religious leaders. We don't spend time giving prescriptions for preventing HIV (the ABC approach). Instead, we spend time trying to discover what messages reach faith leaders. What makes a leader's heart change so that they're more willing to help those who are at risk? If you focus on what people at risk need to do in order to prevent themselves, then the religious leaders wash their hands and say, "See, we told them to change behavior, but they won't." But if we re-frame it, we can reduce stigma and shame, stop blocking access to treatment and testing.

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An Interview with Reverend Canon Gideon Byamugisha (CONTINUED)

Q: Religious traditions bring stories and language to the table, too. We can begin to engage in a theological conversation. As a Christian religious leader, you can remind Christians that the person they meet is a child of God. And so, we don't have to agree 100% with someone else, but one of the commitments that we have for another human being is that we don't allow harm to come to them if I have a way to stop it. Aren't those theological positions a specific resource that religious traditions can contribute?

GB: Every religious tradition has compassion, care, justice, but we are looking at issues where those theological commitments get blocked. How can a Christian parliamentarian believe we are created in the image of God, but then go into parliament in Uganda, and support a bill to kill the gays? The theology is okay, but then what is it that makes people overlook doing the good they know?

We have data from behavioral scientists, biomedical researchers, but we don't have a lot of data that is looking at what is the belief that makes people of faith do less than they are supposed to do in this whole effort of reducing stigma and shame and denial and discrimination around action and inaction of AIDS.

We need to focus on Faith Based Communities operating in most at-risk communities. Can we combine key populations with these key communities? The Western notion emphasizes the individual member of a key population, but in an African interpretation of the world the emphasis is on the community. When we say the individual is at risk, the African says, "What has the individual done that the community doesn't want them to do?" But if we frame it as community, then the religious leader has to say, "Oh! I'm part of the problem!" Now he thinks twice.

Q: Can you talk more about this "individuals-at-risk vs. communities-at-risk, US vs THEM. How do we move beyond this dichotomy and put us all in the same boat. Many CSWs and MSMs are going to be at the church or mosque, so they are not "others" to our religious communities - they are part of the religious communities. How do we hear their voices?

GB: Who has power and who is outside of power? There is a tendency for the majority to always suppress minority groups and scapegoat them. Minorities have to work to reorganize themselves. The voices of CSWs, MSM, PWID need to be heard. What is still lacking from those voices is the community element - they need to be organized not only as individuals but as supportive communities.

In Uganda, I have seen a group called SMUG (Sexual Minorities of Uganda) but I have never heard a parent say "We are lining up for support of our children." I haven't heard from religious leaders, "The people who you are calling IDUs or MSM, they are in my community, in my church, in my mosque." People at risk need to be organized and need to fight for it.

Father Mena and Reverend Byamugisha offer insights into the kinds of theological perspectives and religious practices that can offer compassionate care to PLHIV. They are not the only ones who have articulated such positions, but are powerful examples of leaders whose perspectives can support others most affected by HIV and AIDS.

Conclusion

Faith-based organizations bring much-needed organizational capacity and social capital to the global fight against HIV and AIDS. These are essential resources that play an integral role in this fight. However, the resources of religious traditions can also be mobilized to support stigmatization and marginalization for those living with or affected by HIV and AIDS. This is especially true for members of key populations.

This report was written to make the case for effective, faith-based HIV prevention, treatment, and support initiatives for key populations. Such initiatives will only be fully realized when religious traditions utilize their unique resources to support compassionate services and speak out against stigmatization. This report concludes by listing eight key issues that support such efforts to fulfill “the extraordinary promise that every human life is of inestimable value:”

- 1 Encourage FBOs to include members of key populations in their administrative and programmatic structures.
- 2 Provide contexts in which members of key populations who are also people of faith can describe their own religious and spiritual perspectives.
- 3 Build the capacity of grassroots FBOs working with key populations in limited contexts to expand their programs.
- 4 If FBOs are limited by religious authorities from providing services to key populations, then create networks that allow them to partner with CSOs to provide services to key populations.
- 5 Support African religious leaders, activists, and scholars to articulate compassionate responses to key populations rather than pushing for adoption of Western approaches alone.
- 6 Build relationships with upcoming African church leadership to create dialogue and opportunities for discernment.
- 7 Provide training to FBO staffs, CSO staffs, and other relevant stakeholders on the characteristics of effective work with key populations.
- 8 Identify leaders in religious traditions who can serve as allies and advocates for key populations

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