Building on Firm Foundations

The 2015 Consultation on Strengthening Partnerships Between Faith-based Organizations and PEPFAR to Build Capacity for Sustained Responses to HIV/AIDS

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

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MESSAGE FROM THE U.S. GLOBAL AIDS COORDINATOR AND U.S. SPECIAL REPRESENTATIVE FOR GLOBAL HEALTH DIPLOMACY

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) could not have achieved its tremendous accomplishments in the global HIV/AIDS response without the crucial contributions of communities of faith around the globe. Since its founding in 2003, PEPFAR has partnered with faith-based organizations (FBOs), building on their long-standing service delivery capacity and community relationships. Together with our other partners, we have reached 7.7 million people with life-saving antiretroviral treatment, provided comprehensive services and medicine to 14.2 million pregnant women to prevent mother-to-child transmission of HIV, and supported more than 5 million children who have been orphaned or made vulnerable by this relentless epidemic.

In some of the areas hardest hit by the epidemic, FBOs provide a significant percentage of HIV/AIDS care and treatment. In Nairobi, Kenya, for example, FBOs provide services to over 40 percent of people living with HIV who are on antiretroviral therapy. In most countries where PEPFAR works, these organizations have been on the ground for decades—and in many cases over a hundred years—long before the advent of AIDS, serving the poorest of the poor from informal urban settlements to remote rural settings. Their commitment, leadership, and outreach have been a cornerstone of PEPFAR's success from the very beginning of the program, and they continue to be essential partners for an effective response to the epidemic.

In December 2014, PEPFAR entered its most challenging phase of work to date with the release of *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*, focusing on increased impact for a sustainable response. In order to reach the ambitious 90-90-90 goals set out by the Joint United Nations Programme on HIV/AIDS (UNAIDS) –90 percent of people living with HIV know their status, 90 percent of people who know their status are receiving treatment, and 90 percent of people on HIV treatment have a suppressed viral load– by 2020, PEPFAR and its partners have to rapidly shift the way we all do business. We have to focus on reaching geographic areas and populations where the burden of HIV/AIDS is greatest and recommit to leaving no one behind.

Our faith-based partners have quickly responded to this programmatic realignment, which will yield greater impact. At the 2015 Consultation that is the subject of this report, discussion centered on the pressing challenges we all face, including the need to get more people tested and into treatment, the need for better data collection and analysis, and the use of that data to inform and improve programs that reach and treat key and vulnerable populations, particularly young women and adolescent girls.

We enter into the post-Millennium Development Goals era with clarity on core populations and groups that continue to be underserved. More and more men are

presenting late in disease, when reversing the immunologic destruction is difficult. We need to ensure that men are diagnosed and started on life-saving treatment immediately, as recommended by the World Health Organization. FBOs are essential in reaching this cohort, along with all other affected by and infected with HIV.

Continued and robust participation of our faith-based partners is critical if we are to reach the ambitious goals set out in *PEPFAR 3.0* and by UNAIDS. It is only by working together that we can reach our goal of controlling the epidemic in our lifetime.

Ambassador-at-Large Deborah L. Birx, M.D.
U.S. Global AIDS Coordinator and
U.S. Special Representative for Global Health Diplomacy

PREFACE

Religious faith has had a profound and complicated influence on the global response to HIV since the earliest days of the epidemic. At times, religious belief has served as the motivating force behind strong, compassionate responses. And yet it has also served to justify violence or hatred against some of the most vulnerable. Long before the AIDS epidemic, faith-based health systems provided health services in communities around the globe. Now they provide a substantial proportion of HIV prevention and treatment services, especially in sub-Saharan Africa.

Faith-based organizations (FBOs) are the largest non-governmental providers of HIV services in the East African region.[1] Studies have demonstrated that many people in the sub-Saharan African region prefer to access health services from faith-based facilities because they trust the staff in these facilities to treat them with dignity and care.[2]

What is less clear is whether religiously-motivated stigma creates barriers to accessing faith-based facilities among those who are stigmatized, especially among communities with a high prevalence and incidence of HIV infection, including men who have sex with men (MSM), sex workers, and people who inject drugs (PWID).[3]

As leaders in the global response to HIV/AIDS, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and its global partners, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) have worked to build strong collaborations with FBOs and have worked alongside religious leaders in calling for compassionate care for people living with or affected by HIV. PEPFAR and UNAIDS are redoubling their efforts to provide and build support for comprehensive, sustained, effective prevention, treatment, and support services in order to further the progress made in the HIV/AIDS response. These efforts will be strengthened if the distinctive and substantial contributions of FBOs are understood, appreciated, and utilized. At the same time, these efforts must also address ongoing stigma and discrimination against people living with HIV. The voices of religious leaders and countless people of faith who speak out against discrimination are one of the most powerful tools to dismantle stigma and discrimination, including discrimination motivated by religious belief.

In April 2015, PEPFAR convened a meeting of religious leaders and senior staff representing over 50 faith-based organizations from four East African countries—Kenya, Rwanda, Tanzania, and Uganda—to identify the core issues that must be addressed if the strong contributions of faith-based partners are going to be maximized. This report describes those issues, summarizes the content from the 2015 Consultation, and outlines a set of key recommendations that will serve as a roadmap moving forward. Now more than ever, the strong, effective global response to HIV/AIDS must be scaled up or the tremendous gains that have been made will be lost. FBOs, religious leaders, religious communities, and people of faith from across the globe are essential to that response.

Acronyms

ACHAP	African Christian Health Association Platform
ANC	Antenatal care
ART	Antiretroviral treatment or antiretroviral therapy
CBO	Community-based organizations
CDC	U.S. Centers for Disease Control and Prevention
CHAK	Christian Health Association of Kenya
CHAT	Continuum of Care for Persons Living with HIV/AIDS in Tanzania
CSSC	Christian Social Service Commission
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
ELCA	Evangelical Lutheran Church in America
ELCT	Evangelical Lutheran Church in Tanzania
EPN	Ecumenical Pharmaceutical Network
FBO	Faith-based organization
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HTC	HIV Testing and Counseling
KEC	Kenya Episcopal Conference
LGBTI	Lesbian, gay, bisexual, transgender, and intersex
MEDS	Mission for Essential Drugs and Supplies
MEWA	Muslim Education and Welfare Association
MOU	Memorandum of understanding
MSM	Men who have sex with men
NGO	Non-governmental organizations
OVC	Orphans and vulnerable children
PWID	People who inject drugs
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
RCLS	Réseau des Confessions Religieuses de Lutte Contra les SIDA
SUPKEM	Supreme Council of Kenyan Muslims
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development
WCC	World Council of Churches
WHO	World Health Organization

Executive Summary

We stand at a critical juncture in our effort to achieve an end to the AIDS epidemic. Since 2003, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) has made great strides in building capacity, strengthening health and community systems, and ensuring that life-saving medications are getting to those in need.

The challenge in front of us now lies in not ceding our hard-won gains. PEPFAR and its global partners, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS), the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the World Health Organization (WHO), and a host of national governments, have identified a number of priorities in those efforts:

- Resources must be maximized in places with high HIV incidence, prevalence, and disease burden, ensuring synergy between HIV prevention and treatment services.
- Essential programs with the greatest impact must take precedence.
- Efforts must be coordinated among governments, civil society, and global partners to ensure efficiency and support sustainability.

UNAIDS summarizes the rationale behind these efforts succinctly: "to achieve detailed, localized understanding of country epidemics and focus services and resources on the locations and populations most affected."[4] The next five years are crucial and provide a short window of opportunity to act decisively, to achieve ambitious program goals, and to ensure control of the epidemic. In 2020, we will look back to see whether our efforts have translated into continued advancement or in the surrender of twenty years of work because we failed to take advantage of the opportunity in front of us today.

In order to ensure that progress in the HIV/AIDS response continues every resource must be identified, aligned, and mobilized. FBOs and religious communities offer an impressive array of such resources including:

- substantial service delivery and supply chain networks,
- a global cadre of volunteers willing to offer their time and talents,
- long-standing histories of care and support in every community on the planet,
- deep wells of trust,
- vital facilities in distant locations where few other health facilities can be found,
- and a moral vision that provides a foundation for compassion and care for all people in need.

Building on Firm Foundations: The 2015 Consultation on Strengthening Partnerships Between Faith-based Organizations and PEPFAR to Build Capacity for Sustained Responses to HIV/AIDS was convened in Limuru, Kenya in April 2015 with religious leaders from Kenya, Rwanda, Tanzania, and Uganda, as well as representatives from governments and multilateral organizations. Its purpose was to identify and mobilize the resources of FBOs. This report documents the topics and issues raised in that consultation as well as recommendations from participants for moving forward.

FBOS AND THE RESPONSE TO HIV/AIDS

Two wounded men are brought to Membo Hospital in Uganda. *photo: Daily Monitor*

For over a century, FBOs and religious leaders have been part of the fabric of local communities across East Africa. They are well known and trusted, standing in solidarity with those in need. This legacy of service and trust has been the key to providing effective services for people living with HIV. Since the launch of PEPFAR in 2003, FBOs have been essential partners. As the largest provider of HIV services outside of national governments, faith-based health systems fill an urgent and continued need in sustaining global efforts to respond to HIV/AIDS. FBO contributions are especially impressive for pediatric HIV and prevention of mother-to-child transmission (PMTCT) programs; FBOs across East Africa – and of course, in other partner countries—offer extensive, high-quality services as described in this report.

In addition, FBOs fill crucial gaps in HIV prevention services, particularly with the emerging population of adolescents living with HIV/AIDS. The same FBOs that developed strong pediatric programs are now helping these children grow into adolescence and adulthood with a stronger understanding of their worth, dignity, and wholeness. Despite progress made, key challenges remain for adolescent programs and FBOs are working hard to develop effective and enduring responses to those challenges.

Finally, faith-based networks create, support, and sustain initiatives that make strong, coordinated health services possible. These include extensive supply chain mechanisms that provide essential drugs and medical supplies to remote areas in safe and timely ways and training institutions that are educating the next generation of health care professionals across East Africa.

For some key and vulnerable populations, a number of issues complicate access to HIV services. These populations include adolescent girls and young women, orphans and vulnerable children (OVC), people who inject drugs (PWID), sex workers, transgender persons, and men who have sex with men (MSM). Stigma and discrimination (sometimes expressed through an appeal to religious traditions) hamper efforts to offer targeted, coordinated services for these communities. At the 2015 Consultation, participants heard about effective faith-based programs that address the specific needs of these communities.

MAKING THE CASE

Without question, religious organizations have been crucial in sustained responses to HIV/AIDS, bringing to the table substantial community infrastructure and health assets; at the same time, it has also presented tremendous challenges to those responses. The 2015 Consultation offered wisdom and insight from religious leaders who introduced innovative faith-based initiatives that offer compassionate care to anyone in need. They serve as strong advocates for accountability and quality in service delivery, champion universal health coverage, and call for equitable treatment for all people.

STRONG PARTNERSHIPS

FBOs bring critical resources but they cannot and should not have to shoulder this effort alone. It is essential to build partnerships between FBOs, civil society, and governments, among others, to carry out this work. PEPFAR and its global partners—especially UNAIDS and the Global Fund—are all committed to supporting and sustaining these partnerships.

RECOMMENDATIONS FOR ACTION

2015 Consultation participants developed ten recommendations to maximize the capacities of FBOs in a coordinated, sustained response to HIV/AIDS.

1. Leverage the trust that has developed between FBOs and local communities to build strong, more comprehensive, all inclusive, integrated HIV prevention efforts built not on stigmatization but on unconditional love.

2. Develop the capacity for FBOs to advocate for improved health care for all citizens and hold governments accountable.

3. Maximize the existing organizational infrastructure of faith-based health systems to reach communities impacted by HIV, including vulnerable and hard-to-reach populations, people in steady relationships, key populations, youth, those culturally marginalized, those from remote geographical areas, and people of all genders.

4. Strengthen the capacity of FBOs to develop proper systems and tools for gathering, sharing, and utilizing data for critical decision-making and holistic advocacy at all levels including: key populations, gender-based violence, HIV/AIDS, and sensitive/affirming religious messages.

5. Strengthen community input and investment into FBO administration and programming.

6. Develop and make widely available mechanisms to support the organizational development of FBOs.

7. Increase FBOs' capacities to advocate, and to develop and implement effective programs including effective systems for monitoring, evaluation, and learning.

8. Expand FBO networks by bringing in new or previously unaffiliated FBOs and engaging other religious traditions.

9. Hold ineffective FBOs accountable.

10. Offer leadership development initiatives to better equip the next generation of leaders.

PEPFAR has made tremendous advances in the global HIV/AIDS response possible, but the next five years are critical for sustaining and strengthening hard-won progress. PEPFAR is currently supporting life-saving treatment for over 7.7 million men, women, and children in its partner countries, but millions more lives are at stake. Drawing on their legacy of faithful service and strong collaboration, FBOs can build on the firm foundations they have established as key partners in these efforts. The 2015 Consultation and this report summarizing that meeting offer testimony to the contributions that FBOs can and will make as we work together to end the AIDS epidemic by 2030.

A STORY OF FAITH

Nineteen-year-old "Faith" is not wearing this scarf to make a fashion statement. Although she is a typical teen girl who loves pretty clothes, painted nails, poetry, and spending time with her friends, she is wearing a scarf in this photo because she is afraid of the backlash she will receive if her schoolmates, teachers, and neighbors learn that she is living with HIV.

Faith is an orphan whose parents both died from AIDS when she was a toddler. She has seen the isolation others in her community have faced when their HIV status became public and has decided not to tell those outside of her family that she was born with HIV because her mother did not have access to treatment when she was pregnant.

Faith did not always know her own status. At 11 years old, she began receiving services at Lea Toto in Kibera, an informal settlement community in Nairobi, Kenya. Lea Toto, which means "to raise a child" in Kiswahili, is part of Children of God Relief Institute—Nyumbani. It is one of the world's largest providers of HIV primary care services for children, currently serving nearly 3,000 children living with HIV/AIDS. With PEPFAR support through the United States (U.S.) Agency for International Development (USAID) and the U.S. Centers for Disease Control and Prevention (CDC), Lea Toto can provide Faith, and others like her, with life-saving antiretroviral medication, psychosocial support, and the kinship of other children her age who were also born with HIV.

When children turn eight years old, the program informs them of their HIV status in a loving and supportive environment and begins educating them about the importance of adherence to medication, self-help skills, and prevention education. To address the challenges adolescents living with HIV/AIDS face as they become young adults, Lea Toto is now working to develop a transitional program for adolescents. The program will prepare the current 650 adolescents, aged 14-18, to transition from Lea Toto's pediatric HIV care services to adult care clinics run by other FBOs or government-run facilities.

Stigma and discrimination threaten the health of people living with HIV because they often impact adherence to treatment, performance at school and work, and overall quality of life. When people living with HIV are not on medication and do not disclose their status to their partners and others, it increases the risk of passing on the virus. The same is true for pregnant women who, without medication, are highly likely to transmit HIV to

their unborn children. Stigma and discrimination do not just occur in communities—people living with HIV experience stigma in health care facilities as well. FBOs play an essential role in helping to reduce stigma in communities, and FBOs that also provide health care services are critical to ensuring that health care providers offer non-discriminatory, compassionate care to all they serve.

Faith's story is only one example—albeit a powerful one—of the pernicious effects of stigma and the life-giving support of FBOs in the face of that stigma. These stories have been repeated countless times over the course of the HIV/AIDS epidemic. This report tells these stories through the work of Children of God Relief Institute—Nyumbani and of other faith-based providers from across East Africa who were part of the 2015 Consultation. It identifies and describes their unique contributions and it names and defines the unfinished challenges that FBOs face in the ongoing global response to HIV/AIDS. These stories of the individuals and organizations who were present at the 2015 Consultation offer a tangible witness to the essential roles of faith-based partnerships.

Consultation Overview

From April 13-15, 2015, PEPFAR, in collaboration with St. Paul's University and Emory University's Interfaith Health Program, convened religious leaders and leaders of FBOS from Kenya, Rwanda, Tanzania, and Uganda in Limuru, Kenya. *Building on Firm Foundations: The 2015 Consultation on Strengthening Partnerships Between Faith-Based Organizations and PEPFAR to Build Capacity for Sustained Responses to HIV/AIDS* built on an earlier 2012 PEPFAR consultation with FBOs.

At the first meeting, participants discussed challenges and opportunities for sustainability; identified best practices of FBOs; defined the types and functions of different FBOs; described the opportunities and challenges of FBOs in the area of HIV prevention; and learned effective models of financing, management, and monitoring and evaluation of programs. Key recommendations from the 2012 Consultation focused on two core areas:

1. Leveraging the unique role and function of FBOs, and

2. building the capacity of FBOs, their employees, and volunteers to strengthen organizational structures, programs, accountability, and leadership.

The 2012 Consultation reflected the transition within PEPFAR at the time toward funding of in-country programs and leaders to support a sustained response to HIV and AIDS. In 2011, President Barack Obama challenged PEPFAR to achieve an AIDS-free generation; in 2012, former Secretary of State Hillary Clinton introduced the *PEPFAR Blueprint: Creating an AIDS-free Generation.* A hallmark of the *Blueprint* was its focus on shared responsibility to support country leadership of HIV/AIDS programs. That shared responsibility includes leadership not only from national governments but also from local civil society organizations, non-governmental organizations (NGOs), and FBOs.

The benefits from this transition to country leadership have been clear, but daunting challenges remain. New cases of HIV infection remain stubbornly high in some places, especially in those areas with high HIV burden. Progress made has been threatened by financial, programmatic, and administrative limitations. Admirably, PEPFAR and its global partners are not backing down from these challenges but are recommitting themselves to such efforts. Clearly, "business as usual" will not end the AIDS epidemic; reaching this ambitious goal requires equally ambitious program targets.

In 2014, UNAIDS released *Fast-Track: Ending the AIDS Epidemic by 2030*.[5] The strategy outlines ambitious 90-90-90 targets—countries are now adopting 90-90-90 goals as their own, where 90% of people living with HIV know their HIV status, 90% of people who know their HIV status are accessing treatment, and 90% of people on treatment have suppressed viral loads. By 2030, UNAIDS has committed to raising each of those targets to 95 percent. The Fast-Track approach "assumes that by 2020 community-based services should account for approximately 30% of antiretroviral therapy and testing services, compared to the current levels of approximately 5%."[6] FBO service provision will be a critical part of this scale up.

Similarly, PEPFAR has laid out an ambitious agenda in *PEPFAR 3.0: Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation.*[7] *PEPFAR 3.0* includes five action agendas related to impact, efficiency, sustainability, partnership, and human rights, as it relies on clear data to shift PEPFAR's program priorities in an effort to achieve maximum impact. Reaching the milestones put forth in these strategies requires that all resources are maximized and entrenched barriers to services are lowered.

Without question, FBOs contribute tremendous resources to these efforts. They provide a substantial proportion of HIV services, especially in sub-Saharan Africa, and they have long-standing histories of trust in local communities. And yet, in some instances religiously motivated stigma undergirds barriers

to HIV prevention, treatment, and support services that are crucial for communities with high HIV incidence and prevalence.

For example, the passage of the Anti-Homosexuality Act in Uganda in 2014 has impacted services not only for MSM but for other people living with HIV as well. These challenges are complex and contentious, and they must be addressed in order to further the progress that has been made. The 2015 Consultation was convened in order to discuss all of these issues as the objectives drafted for the Consultation demonstrate:

1. Identify and define the essential elements required to build the capacity of FBOs to support a sustained response to HIV/AIDS.

2. Identify and describe innovative faith-based models for working with hard-to-reach and vulnerable communities.

3. Describe the ways in which a strengthened HIV response for PMTCT and pediatric HIV can support maternal and child health programs.

4. Describe and define the ways in which gender impacts the risk for HIV infection and access to HIV services for women and men.

5. Describe challenges and opportunities for FBOs to work with key and vulnerable populations—MSM, sex workers, and PWID.

6. Define the priorities and strategies that inform PEPFAR's global efforts.

7. Define the role of FBOs and faith leaders in advocacy for universal access to HIV services.

8. Develop a set of key recommendations to guide efforts to build partnerships between FBOs and PEPFAR into the future.

Through plenary sessions, small group breakouts, lectures, and facilitated discussions, the 2015 Consultation provided participants opportunities to share lessons learned over the past three years, hear about new programs and priorities from senior PEPFAR staff, describe innovative programs to reach key and vulnerable populations, explore some of the ongoing challenges facing FBOs, and draft a set of key recommendations that can guide continuing collaboration among FBOs, PEPFAR, and other global partners. The core messages from the 2015 Consultation sessions can be found on the following pages along with snapshots of strong faith-based programs and insights from key FBO leaders.

FBOs and the Response to HIV/AIDS

THE HISTORY OF FBO INVOLVEMENT

Photo of staff and patients at Macheme Lutheran Hospital, Tanzania. *photo: Macheme Lutheran Hospital*

The mission to care for those in need is deeply woven into the very meaning of religious faith. Motivated by these religious commitments, faith-based health facilities provided some of the first medical services in the East African region and established the first hospitals in the region in the nineteenth century. Since then, they have been providing life-saving health services to people in need not only in Kenya, Rwanda, Tanzania, and Uganda but also in countries across sub-Saharan Africa and around the world.

Almost a century after the founding of these first facilities, faith-based health systems responded to the urgent challenges posed by HIV/AIDS at a time when local and national governments were struggling to develop and implement a response. From the earliest days of the HIV epidemic—even before the virus had been isolated and named—FBOs were caring for those who were sick and dying. In global contexts, FBOs were among the first programs to respond to the particular needs of children living with, affected by, and orphaned from HIV/AIDS.[8]

Today, faith-based HIV programs, linked in national, regional, and global networks, continue this faithful response, offering care to millions of people living with HIV across East Africa and in other parts of the world. Participants at the 2015 Consultation represented this legacy well. These participants came from 24 different FBOs, religious denominations, and faith-based health systems that support over 2,000 facilities across East Africa. They are located in large cities and small villages throughout the region, offering their services to anyone in need regardless of their religious background or economic status.

Since its creation in 2003, PEPFAR has built strong partnerships with FBOs around the globe, and by 2005, there was already a clear understanding of the underestimated and underutilized institutional capacity of FBOs to respond to the needs of communities they serve:

> Faith-based groups are priority local partners. In many countries [where PEPFAR works], more than 80 percent of citizens participate in religious institutions. In certain nations, upwards of 50 percent of health services are provided through faith-based institutions, making them crucial delivery points for HIV/AIDS information and services. Local community- and faith-based organizations remain an underutilized resource for expanding the reach of quality services. They are among the first responders to community needs, with a reach that enables them to deliver effective services for hard-to-reach or underserved populations. Community- and faith-based groups, trained in program management and HIV/AIDS best practices, often design the most culturally appropriate and responsive interventions and have the legitimacy and authority to implement successful programs that deal with normally sensitive subjects.[9]

From 2009-2014 (the most recent period for which data are available), PEPFAR provided nearly $945,000,000 through its implementing agencies to directly support FBOs as prime partners to implement HIV prevention, care, and treatment services. In Kenya, Rwanda, Tanzania, and Uganda—the four countries represented at the 2015 Consultation—PEPFAR provided over $505,000,000 through its implementing agencies to FBOs as prime partners during that same period. Total amounts provided by

PEPFAR to FBOs are actually much higher because these amounts do not include funds provided to FBOs serving as sub-partners to non-FBO prime partners.[10]

CARE AND TREATMENT

FBOs provide a substantial percentage of HIV care and treatment services in East Africa, and their long-standing relationships in local communities allow for partnerships with local faith communities to address pressing psychosocial issues for people living with HIV. While HIV/AIDS is a generalized epidemic in East Africa, some areas bear a greater burden. This reality is one of the guideposts both of *PEPFAR 3.0* and *Fast-Track*, which focus on concentrating efforts to the geographic areas and populations with the highest burden. The Office of the U.S. Global AIDS Coordinator and Health Diplomacy (OGAC), which coordinates PEPFAR, is working with partners countries to control the epidemic "by pivoting to a data-driven approach that strategically targets geographic areas and populations" to achieve the most impact.[11] To put it simply: doing the right things, in the right places, right now.

Reaching the hard-to-reach: FBOs providing essential services in the remote areas of Turkana County

Turkana County, a sprawling, rural area in the northwestern corner of Kenya bordering the countries of Ethiopia, South Sudan and Uganda, is one of the high HIV incidence counties identified in Kenya's *HIV Prevention Revolution Roadmap*. The county is the largest in area in Kenya; its 68,680 square kilometers comprise about 12% of the entire area of the country. Faith-based health facilities providing ARTs are the essential lifeline to people living with HIV/AIDS in Turkana County. In Turkana, faith-based facilities offer more HIV services than any other single sector, including facilities managed by Kenya's Ministry of Health. 60 percent of people living with HIV on ARTs receive services from FBOs in Turkana County.

The Lokichogio Health Center provides health care services to people and refugees—many of them nomadic—who call the remote northwest corner of Turkana County near the borders of Uganda and South Sudan home. Far-flung health facilities, food insecurity, persistent tensions with factions in neighboring countries, and high numbers of refugees all contribute to health insecurities for the residents of Lokichogio . The Lokichogio Health Center works to provide basic health care, PMTCT, laboratory services, and HIV/AIDS counseling, testing, and treatment.

As a member organization of CHAK, the Africa Inland Church Health Ministry offers comprehensive health services to communities in 5 hospitals and 52 health units across Kenya. Staff from the Lokichogio Health Center provided important perspectives on the distinctive issues faced by rural faith-based providers at the 2015 Consultation.

Countries are developing strategic plans to respond to HIV/AIDS with a similar focus. In Kenya, the National AIDS Control Council has developed a new HIV prevention strategy that aligns closely with *PEPFAR 3.0*, concentrating efforts in those areas with highest HIV incidence and disease burden. This strategy, the *HIV Prevention Revolution Roadmap,*[12] calls for resources and services to be targeted toward the nine counties with the highest HIV incidence (incidence is defined as the number of people newly infected in a calendar year divided by the total population of the county) and 10 counties with the highest HIV disease burden (disease burden is defined as the total number of people living with HIV residing in the county). Drawing from 2013 epidemiological data, the *HIV Prevention Revolution Roadmap* identifies a total of 13 counties as high incidence, high burden, or both high incidence and high burden. To understand just how large an impact that FBOs have had and can have on HIV/AIDS, one need only look at the data from these counties.

Deriving The Data

The data on the percentage of HIV adult and pediatric services provided by faith-based facilities were derived from an analysis of existing data from two national-level data platforms in Kenya. The first data platform (ehealth.or.ke), maintained by the Ministry of Health in Kenya, contains information on all registered health facilities in the nation. A list of all health facilities in each county was generated along with a subset of all facilities identified as faith based. Any facilities thought to be faith-based, but not listed as such were tagged. If they could be verified as faith-based (e.g., through the organization's website), they were added to the list of faith-based facilities. After the facilities master list was compiled, the second data platform was employed. This platform (hiskenya.org) contains data on health service delivery across Kenya. The MOH 731 database on the hiskenya.org platform contains summary data on HIV health services indicators developed through the National AIDS and STI Control Programme (NASCOP) in Kenya. Using the hiskenya.org platform, aggregate county-level data on HIV services were generated. These data were compared to data generated through pivot tables on the faith-based facilities in each county. The percentages listed in this report are cumulative for services delivered from 2012 to 2014.

1. Faith-based health systems provide a substantial proportion of services, especially in high-incidence and high-burden counties.

   In high-burden counties, 28 percent of people living with HIV on ARTs receive services from faith-based facilities. Percentages for Mombasa and Nairobi Counties (two high-burden counties) are especially impressive, with 52.3 percent of people living with HIV on ARTs receiving services from FBOs in Mombasa, and 47.3 percent in Nairobi.[13]

2. Faith-based health facilities are an integral part of health care delivery in Kenya, particularly for those who cannot access for-profit providers. They comprise 70 percent of non-governmental facilities in the not-for-profit sector.

   Faith-based health facilities comprise 11.3 percent of all health facilities, both public and private. Among the non-governmental not-for-profit sector, 70 percent of facilities are faith-based. In other words, faith-based facilities comprise 70 percent of the non-governmental facilities that provide services to the public-at-large, regardless of ability to pay.

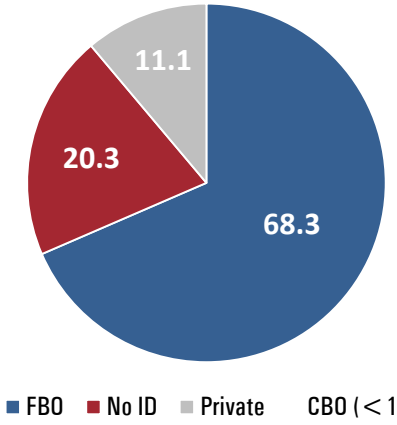
   There are three national faith-based health systems in Kenya: the Christian Health Association of Kenya (CHAK) is supported by Protestant Christian communities, the Kenya Episcopal Conference (KEC) is supported by Roman Catholic parishes and diocesan ministries, and the health facilities of the Supreme Council of Kenyan Muslims (SUPKEM) are supported by Muslim communities.

   Each of the faith-based networks—CHAK, KEC, and SUPKEM—provides a variety of services to people living with HIV, with both CHAK and KEC providing the greatest percentage of services from the faith-based sector: 18.9 percent and 56.9 percent respectively. In addition, other FBOs not formally affiliated with these networks account for 24 percent of all treatment visits to people living with HIV provided by FBOs. These other FBOs are diverse, independent organizations from various religious traditions (including Christianity, Islam, and Hinduism) that are not part of the CHAK, KEC, or SUPKEM networks.[14]

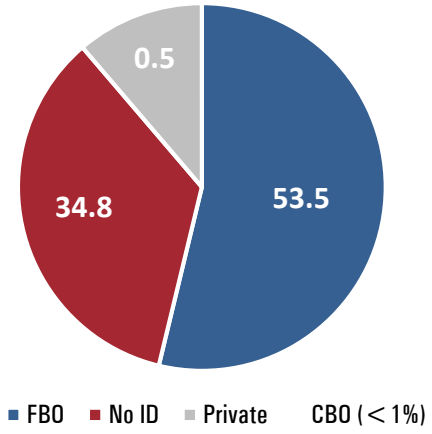
3. Faith-based health facilities demonstrate a broad-based commitment to providing HIV services. They are by far the largest non-governmental provider of HIV services.

   Despite common perceptions that FBOs are reluctant to provide services to people living with HIV, a substantial proportion of faith-based health facilities offer at least one service in the areas of HIV prevention, treatment, or support. In nine high-incidence counties, 69 percent of all faith-based health facilities provide at least one HIV service; in the high-burden counties, 58.3 percent provide at least one HIV service. Among all non-governmental providers, FBOs provide by far the largest proportion of HIV services to people living with HIV on treatment.[15]

Percentage of people living with HIV on ARTs seen by non-governmental facilities in high-incidence counties



Percentage of people living with HIV on ARTs seen by non-governmental facilities in high-burden counties



Source: MOH731 HIV service provision, hiskenya.org.

Leaders from CHAK, KEC, and SUPKEM, as well as their peers from other countries in the region, participated in the 2015 Consultation, and presentations by PEPFAR leaders offered them the opportunity to better understand the priorities of PEPFAR and its global partners. This provided faith-based health systems with important information for their own strategic planning efforts in anticipation of future funding priorities and opportunities.

Data from the high-incidence and high-burden counties in Kenya offer much-needed information on the scope of contributions provided by FBOs. However, such data are sorely lacking, and FBO contributions are not fully known. While there are a number of references to faith-based health systems providing a significant proportion of health services (percentages cited can range from 33 to 70, depending on the geographic location and the citation source), these claims are rarely tied to a systematic assessment or investigation.[16] In July 2015, an article in *The Lancet* series on faith-based health care highlighted the need for more robust data on the contributions of faith-based health providers. The article concluded that

> more and improved data are needed to provide support at management and policy levels on every aspect relating to how faith-based health providers (FBHPs) routinely function within their health systems. We need to move away from broad generalisations of the magnitude and character of FBOs and instead find out how different kinds of FBHPs operate within different contexts and systems. Rather than relying on basic proxies, we need to understand in a more complex manner, the interactions of management practice, organisational culture, pharmaceutical supply, cost recovery, and human resource management, and how these affect (clinical) quality, satisfaction, and use, and then how this affects access, reach to poor people, and broader goals such as universal health care.[17]

PEPFAR supports such efforts. Since the beginning of PEPFAR, data has been collected on partners' work, down to the site level. In 2013, PEPFAR began a study in Kenya to build a foundation of evidence on the provision of HIV prevention, treatment, and support services. It employed both quantitative and qualitative methods to measure the scope of FBO contributions in the three areas listed above. Efforts to

quantify the percentage of HIV services offered by faith-based facilities and health systems are long overdue, and PEPFAR will be working with UNAIDS to expand the initial analysis undertaken in Kenya. For the first time since the beginning of the epidemic, such national-level, integrated data analysis is possible through PEPFAR's support of an open source global data platform, DHIS2 (dhis2.org). To date, DHIS2 has been partially or fully implemented in 47 countries; Rwanda, Tanzania, and Uganda have all implemented DHIS2 at a national level, making such analysis possible.

PEDIATRIC HIV CARE AND PMTCT

The HIV services provided by FBOs are not limited to adults. The same analysis of HIV services in Kenya also demonstrates the substantial portion of HIV services to mothers and children provided by FBOs. Faith-based health facilities provide HIV testing and counseling (HTC) of pregnant women as part of PMTCT protocols; in high-incidence and high-burden counties, FBOs provide over 18 percent of these tests. HIV treatment services for children are even higher, with FBOs providing approximately 25 percent of treatment visits for children living with HIV/AIDS, including children who are currently on ARTs.

This is not unique to Kenya. Across sub-Saharan Africa, FBOs are the largest non-governmental provider of services to OVC, including children orphaned due to the death of their parents from HIV/AIDS.[18] However, one of the most striking findings of research into faith-based OVC programs is the percent of programs carried out by local religious communities (e.g., Christian congregations and Muslim masajid) rather than local community-based organizations (CBOs) or national religious coordinating bodies.

The same study of faith-based programs in six sub-Saharan African countries found that programs carried out at the local congregational level accounted for 82 percent of all faith-based initiatives while faith-based NGOs or national faith-based programs accounted for only 18 percent.[19] This finding supports claims that much of the faith-based response to the global HIV pandemic is undocumented because it is carried out by faith communities in local contexts that are not part of broader national programs or networks. While the scope of the services offered by these local responses cannot be

quantified, the impact of faith-based responses to HIV/AIDS becomes even larger when considering these local initiatives.

Participants at the 2015 Consultation represented strong pediatric and PMTCT programs found across East Africa. These programs were diverse in size and function, representing the capacity of FBOs to create networks that span from the local to the national to the international. The following programs, each of which was represented at the 2015 Consultation, demonstrate both high-quality pediatric and PMTCT programs and distinctive types of FBO programs:

The Continuum of Care for Persons Living with HIV/AIDS in Tanzania (CHAT):

The Continuum of Care for Persons Living with HIV/AIDS in Tanzania (CHAT) is an innovative partnership between the Evangelical Lutheran Church in America (ELCA) and the Evangelical Lutheran Church in Tanzania (ELCT). CHAT was funded by PEPFAR through USAID to support 13 palliative care teams based in Lutheran hospitals in Tanzania. Teams included a nurse coordinator, assistant, social worker, local pastor, and doctor. In turn, these teams recruited and trained home-based care volunteers in local communities.

Working collaboratively, these clinical and community programs provided a continuum of care for people living with HIV, ranging from medical care to spiritual support and bereavement counseling. In addition, the clinical teams worked with local congregations to identify vulnerable children in local communities in need of bedding, health care, nutritional services, and educational support. CHAT provided services to almost 20,000 people—more than 10,500 adults and 8,500 OVC.[20]

PEPFAR funded the CHAT program for three years while a sustainability plan was developed; during that time, the ELCA and the ELCT created partnerships between each of the 13 teams and a corresponding hospice program in the United States. In fact, the program grew after the funding period from PEPFAR ended in 2010, with seven additional palliative care programs in Tanzania and the United States participating (for a total of 20 programs). The formal partnerships continued through 2014 when the programs in Tanzania gained sufficient capacity to carry out the program independently; nonetheless, some of the partnerships have continued even past the formal termination of the program.

- *CHAT is an outstanding example of work carried out by* **National and International Religious Bodies**. The bodies are composed of local religious communities brought together in broader networks of synods, presbyteries, dioceses, or archdioceses. These national bodies provide extensive health care and social services in local communities both urban and rural, taking localized, context-specific ministries to a national scale. In addition, many of these national religious bodies are connected to international bodies. They provide mechanisms for financial and programmatic accountability, dissemination and implementation of best practices, avenues for communication and administrative support so that resources can be mobilized and channeled to the places where they are needed. Finally, national religious bodies provide a "critical mass" at a national level, allowing the wisdom, ideas, perspectives, and priorities of people at the local level to be heard. This capacity to make diverse local voices heard means that national religious bodies are important vehicles for advocacy around sound, ethical policies and practices at national and international levels.

UMMA CBO:

Umma CBO is a grassroots FBO dedicated to serving the residents of the Eastleigh informal settlement in Nairobi. It is dedicated to improving the lives of OVC and their families by

- supporting children and caregivers to establish economic empowerment initiatives;
- working with community groups to reduce the levels of stigma and discrimination against people living with HIV and their families; and
- strengthening the capacity of local CBOs to provide for the needs and rights of OVC and their households.

Some of the activities implemented by Umma CBO include

- group savings and loan programs;
- income-generating activities;
- skills-building for members of targeted CBOs to provide important services;
- sub-grants to other CBOs to provide services to OVCs and their families;
- development of a video documentary highlighting the forms, causes and effects of stigma and discrimination against people living with HIV and their families;
- and production of theatre pieces developed with community youth to sensitize the community on the issues of stigma and discrimination highlighted in the documentary.

- *Umma CBO is a **Local Grassroots Response**.* Local grassroots responses address local needs that national bodies may not see as a priority. Local grassroots responses create a structure both to address the need and to advocate for a response from national bodies. On a functional level, local grassroots responses also provide key capacities: a space for gathering and a group of willing volunteers. Because they respond quickly to local needs, these responses are trusted. Because they work directly with those whose needs are not being addressed by national networks or religious bodies, local grassroots responses are incubators for innovation. If these local grassroots responses can relate to national structures with flexibility, they offer mechanisms by which innovation can be known and replicated. Additionally, local grassroots responses are key organizations for sustainable and effective programs because they mirror local communities' priorities and offer high-value services to people at the local level. Finally, local grassroots response can be prophetic by challenging national governmental and non-governmental systems to act responsibly to those in need.

Interfaith Network of Rwanda:

The Interfaith Network of Rwanda is known by the acronym of its French name (RCLS, or Réseau des Confessions Religieuses de Lutte Contre le SIDA). RCLS includes a number of religious groups and denominations whose aim is to develop a coordinated faith-based response to HIV/AIDS. The network's programs have helped 85 percent of health facilities in Rwanda provide HTC and PMTCT services.[21] Additionally, male participation in PMTCT has risen dramatically, with 84 percent of female participants bringing their male partners with them for HTC and treatment.[22]

RCLS works with the government to mobilize communities in very remote areas that are distant from government facilities, recognizing that churches and mosques are present even in far-flung locations. The combined efforts of RCLS, the Government of Rwanda, the Rwandan Network of People Living with HIV/AIDS, and other stakeholders have drastically reduced the number of new infections there.

- *RCLS represents a **National Interfaith Network.*** National interfaith networks provide a mechanism for sharing both the distinct perspectives of a variety of religious traditions as well as their shared perspectives. They also create and sustain coordinated service delivery programs that span the divisions that sometimes occur in local communities between members of different

religious traditions; provide a structure to educate religious leaders from a variety of backgrounds on issues of common concern; use religious language and ideas to translate HIV treatment and prevention information into a style that people in local communities understand and value; and capitalize on the trust the many people place in their religious traditions and religious leaders to create a context for local communities to discuss issues that they would never share with representatives of governmental or non-governmental organizations.

Mildmay Uganda

Mildmay is an FBO that was started in Great Britain; today, in addition to the health ministries it offers in Britain, Mildmay works in Kenya, Tanzania, and Uganda, focusing much of its efforts on HIV/AIDS. Mildmay Uganda is the largest HIV service provider in central Uganda, reaching over 80,000 people per year. Through its programs, Mildmay offers HIV and other medical services to over 6,000 children and 20,000 women. Mildmay's services include a comprehensive adolescent sexual health program, specialty care programs that include an eye clinic, nutrition, physical and occupational therapy, and spiritual care.[23]

- ***International FBOs*** such as Mildmay offer an impressive array of services. Some FBOs are quite large, with programs and staff around the world. These international FBOs bridge both geographic and cultural divides around the world, bringing people of faith together in shared commitments to addressing HIV/AIDS. International FBOs can serve as key partners in national FBO programs, bringing organizational support, well-established networks, and financial resources to the table. However, care is needed to ensure that the responses, voices and cultural sensitivities of local FBOs are not lost.

MATERNAL AND CHILD HEALTH

Through their participation in the 2015 Consultation, these four programs and others like them were not only able to share promising and innovative approaches in their own work but also learn how strong pediatric and PMTCT programs supported by PEPFAR, national governments, and other global partners help improve maternal and child health services for all members of local communities.

In summarizing data on the unmet challenges of the millennium development goals in relation to HIV/AIDS and maternal health, Dr. Abraham Katana, Chief of HIV Treatment and Care for CDC-Kenya, reminded consultation participants that HIV/AIDS is one of the leading causes of child and maternal mortality, women are disproportionately affected by HIV/AIDS, and ART coverage for children is lagging behind established goals. Every day, 800 mothers die during pregnancy and childbirth and the WHO estimates that 18 percent of those deaths can be attributed to HIV/AIDS.[24] In a 2013 study in Western Kenya, HIV/AIDS related conditions were identified as an indirect, contributing factor in 45 percent of the cases of maternal mortality.[25]

PEPFAR has changed the picture in the clinical care of pregnant women. Over half of pregnant women who are living with HIV/AIDS are tested and identified because of funding and support from PEPFAR.[26] Clearly, progress is being made. Effective ART prophylaxis for PMTCT increased from 37% in 2009 to 63% in 2014 in Kenya.[27] Finally, one-third of eligible pregnant women received ARTs in 2013; less than 1 percent received ARTs during pregnancy in 2009.[28] Despite these advances, a number of challenges remain. For example, while 96 percent of women in Kenya receive antenatal care (ANC), almost 80 percent wait until their second or third trimester to initiate ANC.[29] In addition, 40 percent of HIV-positive women in Kenya reported that their last pregnancy was unplanned.[30] In a longitudinal seven year survey in Kenya, less than half of children living with HIV/AIDS under the age of two years were retained in care and only 56 percent of those over two stayed in treatment.[31]

Numbers Tell the Tale:
The percentage of HIV services for adults and children in Kenya's HIV high-incidence and high-burden counties provided by FBOs

HIV SERVICES FOR ADULTS

	HIGH-INCIDENCE	HIGH-BURDEN	HIGH-INCIDENCE/ HIGH-BURDEN
ADULT CARE			
Visits by Adults on ARTs	18.4	28.2	24.4
Adults Currently in Care	14.8	25.7	25.4
VCT			
Couples	11.7	19.4	19.3
All Test	11.9	18.6	18.1

HIV SERVICES FOR CHILDREN

	HIGH-INCIDENCE	HIGH-BURDEN	HIGH-INCIDENCE/ HIGH-BURDEN
PMTCT			
Tests	18.5	18.9	18.2
PEDIATRIC CARE			
Visits by Children on ARTs	25.0	24.2	24.2
All Peds Currently in Care	23.2	22.9	23.0

PREVENTION WITH ADOLESCENTS LIVING WITH HIV/AIDS

FBOs that have been at the forefront of services for children living with HIV/AIDS are now working to provide HIV prevention services for those children who are growing into adolescence. Nicholas Makau, Director of the Lea Toto program at Children of God Relief Institute—Nyumbani, presented at the Consultation on his organization's efforts to address the needs of adolescents living with HIV/AIDS. Lea Toto serves over 3,000 children living with HIV/AIDS in eight informal settlements across Nairobi. The program offers HIV primary care services to these adolescents and extensive psychosocial support services to them and their families. Mr. Makau identified a number of challenges that the adolescents at Lea Toto face, including:

- defaulting on ART treatment;
- the need to address sexual issues and relationships;
- academic support;
- coping with HIV status after disclosure;
- drug or alcohol use, especially how it impacts sexual behaviors and increases risk of transmission; and
- the importance of creating transition into adult clinical care.

In order to address these challenges, Lea Toto developed a targeted adolescent program that combines HIV clinical care with support services. The program has four core elements.

- *Mentorship.* Adolescents are provided an adult mentor, eighty percent of whom are people living with HIV. Most of the mentors at Lea Toto work in the corporate or NGO sector in Nairobi and many of them grew up in the same informal settlements where Lea Toto works. Whenever possible, mentors include former Lea Toto participants who have successfully transitioned into adult clinical care and are living positively with HIV.

- *Peer Groups.* Peer groups allow adolescents to create or strengthen social networks with other young people living with HIV/AIDS and recognize they are not alone. The peer group program involves educational, life-skills, and social activities.

- *Social Events.* Lea Toto offers specific social events such as talent nights, sports activities, and field trips. These activities provide a welcome respite from home and school and they also build trust between the adolescents themselves and with their mentors.

- *Adolescent Clinic.* Lea Toto maintains a distinct clinical calendar for adolescents. This allows clinic staff to address sexual and reproductive health, support ART adherence, and develop a clinical relationship in which young people begin to address their own health needs and behaviors.

In 2014, PEPFAR sponsored a series of workshops with 160 adolescents living with HIV/AIDS who are part of the Lea Toto program. The workshops assessed adolescents' needs and perceptions related to HIV prevention, sexual health, economic challenges and opportunities, and educational needs and resources. The findings reveal opportunities for building partnerships to help support adolescents as well as urgent needs for HIV prevention education to help young people negotiate sexual beliefs and behaviors.

Economic and Educational Resources: Young people growing into adulthood in informal settlements face a number of challenges. Identifying much-needed resources in their community for education and economic empowerment and bringing those resources to the table to collaborate offers a model for community-driven programs. The Lea Toto workshops revealed interesting characteristics about the organizations in the informal settlements that young people identified as most trusted:

- Participants named 73 most-trusted organizations across the eight informal settlements where Lea Toto works.

- FBOs were named more frequently than any other type of organization (including governmental programs) as community resources and most-trusted organizations.

- Kenyan organizations are more trusted than are international NGOs and FBOs for adolescents in the informal settlements.

HIV Prevention and Sexual Health Education**:** As part of the workshops, 25 statements about HIV and sexual health were read aloud to participants. The statements were designed to assess knowledge of HIV transmission and sexual health as well as the health beliefs of the participants. Each participant responded to the statement with "Agree," "Disagree," or "Uncertain." If greater than 90 percent of participants answered in the same way consensus was achieved. Participants did not reach consensus in 15 statements across three categories:

1. Different opinions about sexual behaviors and beliefs:

The variety of opinions expressed by workshop participants revealed differences in perceptions about what exactly counts as sex. In turn, this leads to uncertainty about what counts as sexual behavior. In addition, there were different opinions about appropriate sexual behavior for young men and young women. These differences impacted the ways in which young women and men viewed themselves and others.

What is sex? How do I define it?

STATEMENT: Kissing is sex.
RESPONSES: 63% agree, 34% disagree, 3% uncertain

STATEMENT: Sex without penetration is not real sex.
RESPONSES: 48% agree, 28% disagree, 24% uncertain

How should boys and girls act?

STATEMENT: Girls never pressure boys to have sex, pressure always comes from boys.
RESPONSES: 13% agree, 63% disagree, 24% uncertain

STATEMENT: Girls are not supposed to negotiate for condom use.
RESPONSES: 3% agree, 76% disagree, 22% uncertain

STATEMENT: It's more important for a girl to be a virgin when she gets married than for a guy.
RESPONSES: 23% agree, 54% disagree, 23% uncertain

2. Uncertainty about HIV transmission risk and whether to disclose HIV status:

In some instances workshop participants showed an impressive level of knowledge about HIV transmission, but in other instances commonly held misconceptions demonstrated the need for further education about condoms and risk behaviors. In addition, responses to the statement on disclosure revealed the need for support in helping young people to decide whether they should disclose their HIV status to friends.

What behaviors can transmit HIV and/or lead to unwanted pregnancy?

STATEMENT: Condoms have pores.
RESPONSES: 33% agree, 31% disagree, 37% uncertain

STATEMENT: One can't be infected with HIV if s/he has sex for the first time.
RESPONSES: 2% agree, 83% disagree, 15% uncertain

STATEMENT: One can't be infected with HIV is s/he has only one sexual partner.
RESPONSES: 6% agree, 71% disagree, 23% uncertain

STATEMENT: Anal sex cannot lead to HIV infection.
RESPONSES: 5% agree, 68% disagree, 27% uncertain

Should I disclose my HIV status?

STATEMENT: One should not share her/his status with friends.
RESPONSES: 51% agree, 22% disagree, 27% uncertain

3. Uncertainty about moral teachings and sexual behavior:

Participants were trying to identify their own moral perspectives about sexual expression. Participants' responses revealed that adolescents in the Lea Toto program are trying to make sense of their HIV status, their sexual feelings, their moral and religious worldviews, and social norms. Such efforts are difficult for any young person but the challenges are exacerbated for adolescents living with HIV/AIDS.

What are my moral beliefs about sex?

STATEMENT: Sex is immoral.
RESPONSES: 3% agree, 84% disagree, 13% uncertain

STATEMENT: If I am in a loving committed relationship, it is okay to have sex.
RESPONSES: 31% agree, 56% disagree, 13% uncertain

STATEMENT: It is healthy to think about sex.
RESPONSES: 41% agree, 51% disagree, 9% uncertain

STATEMENT: Abstaining too long is abnormal.
RESPONSES: 6% agree, 84% disagree, 10% uncertain.

In response to the findings from the workshops, PEPFAR has provided funds to Lea Toto to expand their adolescent program, complementing the existing elements with clear and correct information, enhanced activities to address sexual and reproductive health education, educational/vocational support, and economic empowerment. The enhanced program is being piloted in 2015 with full implementation across all eight Lea Toto sites in 2016.

FROM GLOBAL TO LOCAL: FAITH-BASED HEALTH SYSTEMS AND DELIVERY NETWORKS

Effective health and community systems are created and sustained when effective clinical programs are supplemented by strong ancillary services such as supply chain mechanisms, health workforce education, and community-based service delivery, outreach, and retention programs. In East Africa, FBOs are essential providers of these types of programs. 2015 Consultation participants represented the many programs that contribute to health and community systems strengthening, including those detailed below.

Supply Chain Mechanisms**:** The Mission for Essential Drugs and Supplies (MEDS) is a partnership between CHAK and the KEC that has developed and supported an impressive supply chain that covers all of Kenya others parts of the region. MEDS provides medicines, supplies, and procurement and quality assurance services to more than 1,800 health facilities in Kenya, including private, faith-based, and public facilities. The organization also serves over 20 facilities outside of Kenya in Eastern and Central Africa.[32] MEDS has worked to improve its supply chain capabilities over the last five years with medicines and supplies provided to clinical sites within 24 hours to sites within 60 kilometers of Nairobi and within 48 hours for any other location. [33]

The Ecumenical Pharmaceutical Network (EPN) was initially supported by the World Council of Churches (WCC), and CHAK provided office space to the organization. Today, EPN has grown to encompass 81 faith-based member organizations from more than 30 countries committed to providing quality pharmaceutical services to increase access to medicines and improve health. EPN institutions are committed to the delivery of just and compassionate quality services by focusing on four strategic areas: 1) access to and rational use of medicines; 2) HIV/AIDS care and treatment; 3) professionalization of pharmaceutical services; and 4) pharmaceutical information sharing.

MEDS, EPN, and other supply chain programs managed by FBOs across East Africa help ensure that essential drugs and medical supplies are delivered quickly in a cost-effective manner.

Health Workforce Education: Faith-based health systems offer licensed clinical and health workforce education programs across sub-Saharan Africa. For example, 17 medical training colleges and universities are member institutions of the CHAK network. All of these provide nursing education, with six offering degree programs and the other 11 offering diploma programs. Kenya Methodist University is the first private university in Kenya to offer the Bachelor of Medicine and Bachelor of Surgery degrees at its Meru campus, with Maua Methodist Hospital serving as the primary teaching hospital. CHAK's medical training programs produce well-trained graduates; of the institutions with graduates receiving the highest scores on diploma examinations, eight of the top 10 were CHAK institutions. Seven CHAK hospitals are accredited to provide internship education for medical students, and in 2012, these hospitals provided internship training for medical doctors. With funding from CDC through PEPFAR, CHAK has implemented a Pre-Service Education Strengthening Program to integrate HIV clinical education into medical training colleges and institutions.

In Uganda, Mildmay has trained over 30,000 health care professionals in both degree and diploma programs in health care management, medical laboratory technology, pediatric care, and child counseling. Mildmay also provides technical assistance and capacity building for staff from both

governmental and civil society organizations through specific training initiatives and a set of short courses. In addition to Mildmay's leadership in health workforce education in Uganda, the Uganda Catholic Medical Bureau has twelve medical education training facilities and one laboratory training facility.

Health Systems Strengthening: The faith-based health systems represented at the 2015 Consultation are all active members of the African Christian Health Association Platform (ACHAP). ACHAP brings together 30 national-level faith-based networks providing services in 28 countries across sub-Saharan Africa to establish technical working groups, share resources, and provide ongoing training and technical assistance. This network fills a vital role to support mentorship and capacity building in administration, governance, fiscal management, data management, and service delivery. ACHAP staff provided leadership at the 2015 Consultation, and representatives from ACHAP member networks helped select topics and content.

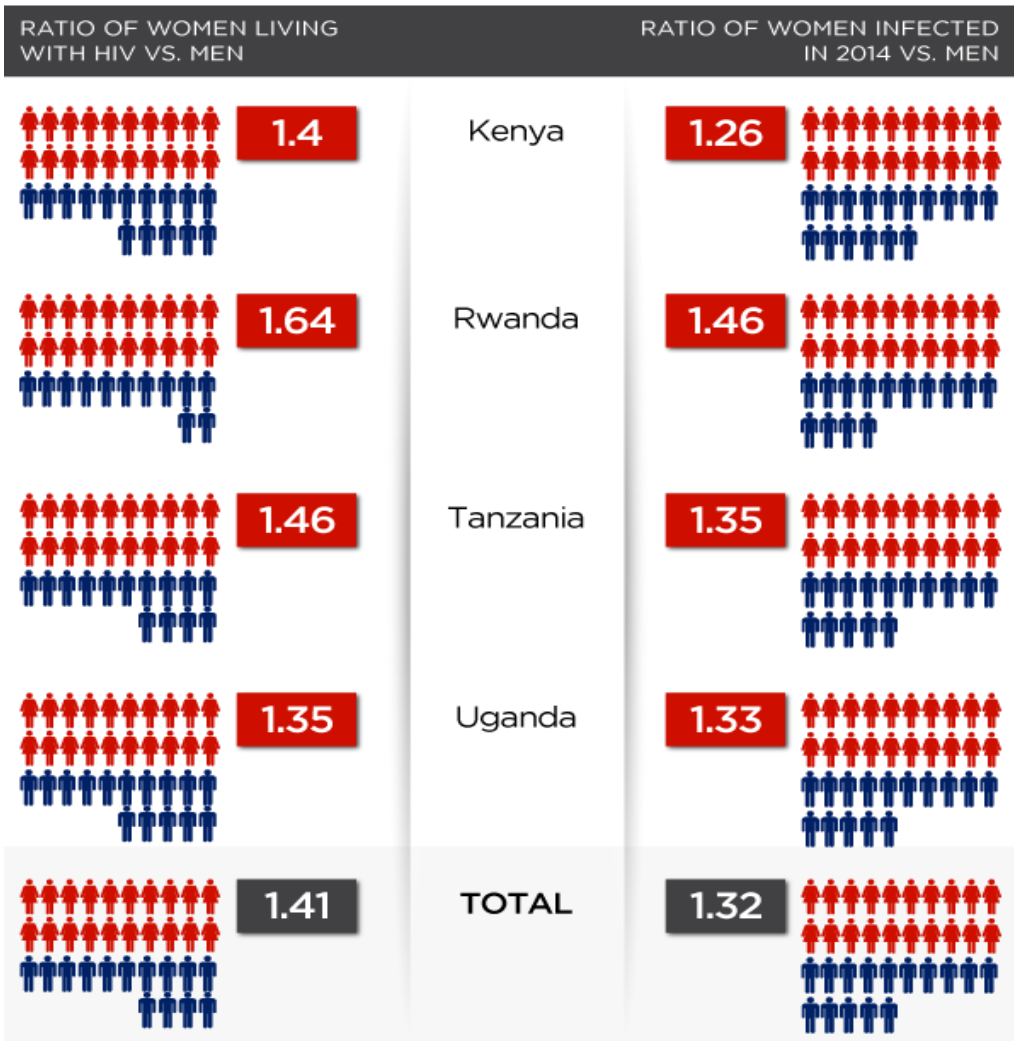
CHAK receives funds from CDC through PEPFAR to carry out the CHAK HIV/AIDS Project (CHAP). One of CHAP's objectives is health systems strengthening by strengthening leadership, governance, finance, and grants management systems; increasing collaboration between CHAP-funded facilities and county governments; improving patient care by offering appropriate care to patients in CHAP facilities, and integrating community and outpatient clinical services with inpatient hospital programs. [34]

Community Systems Strengthening: CHAP leadership realizes that strong health systems rely on strong, responsive, resilient community systems. With this in mind, CHAP has initiated an innovative, comprehensive community-based program to encourage adherence to ARTs. The program achieves impressive results: with over 92 percent of patients enrolled in CHAP facilities receiving ART, the 12-month retention rate was an impressive 98 percent.[35] Such results are possible because of strong community support systems comprised of community health workers, psychosocial support staff, and peer mentors. The community health team ensures a smooth referral into treatment for those who receive a positive HIV test result, offers treatment preparation sessions for people beginning ARTs, helps ensure ART adherence through counseling, addresses psychosocial needs; supports patients in the disclosure of their HIV status, follows up on patients who fail to keep appointments, and conducts home visits that allow for more in-depth assessments. CHAP has developed an innovative treatment support model that integrates efforts between nursing staff in clinical settings and treatment and adherence support in the community.

Pressing Challenges: Gender and Key and Vulnerable Populations

HIV/AIDS, GENDER, AND RELIGION

Globally, women shoulder a disproportionate share of HIV infection; Kenya, Rwanda, Tanzania, and Uganda are no exceptions.

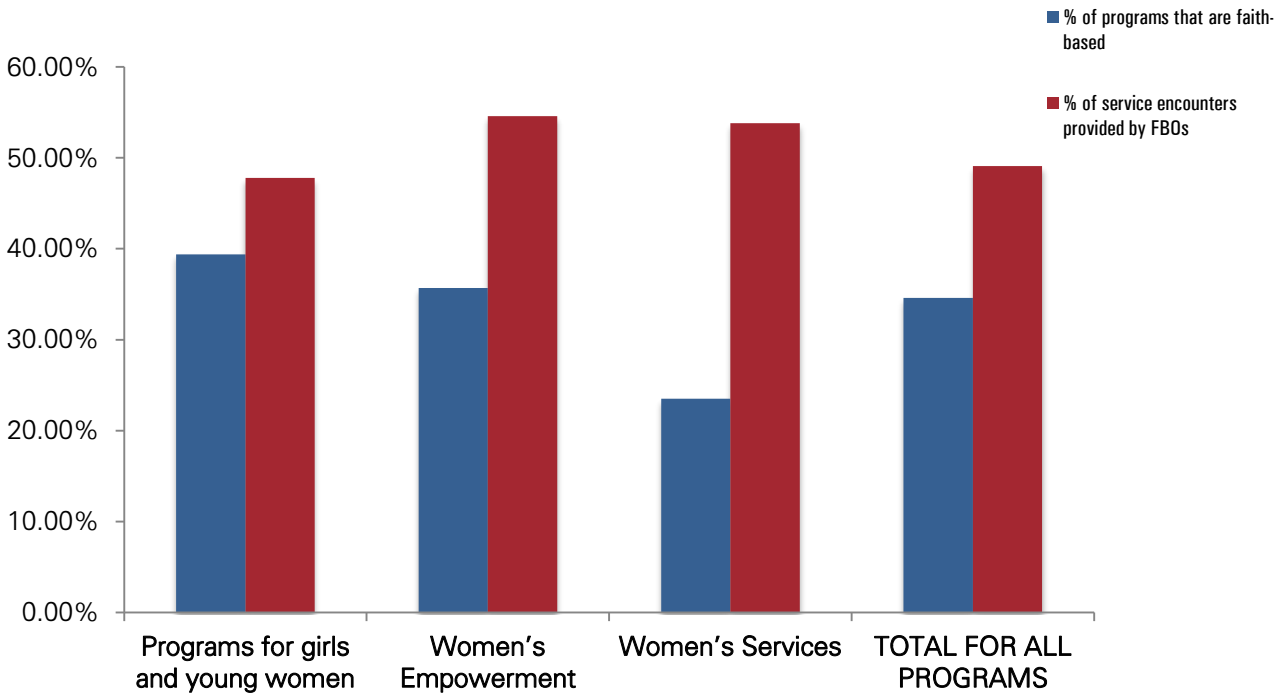


Source: UNAIDS, 2014

A variety of social-structural forces such as gender norms and cultural teachings impact women's vulnerability to HIV infection. PEPFAR and its global partners have made lowering new cases of HIV among young women and girls a top priority. This cannot be accomplished simply by providing clinical services, though they are essential; rather, cultural norms that underwrite and support discrimination and inequity must be addressed.

To support such efforts, PEPFAR has launched a number of new initiatives, including the DREAMS Partnership. DREAMS—Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe—is a public-private partnership between PEPFAR, the Nike Foundation, and the Bill and Melinda Gates Foundation to reduce HIV incidence in sub-national areas among adolescent girls and young women. The program is providing over $210 million to countries to implement a core package of evidence-based interventions to address the drivers that directly and indirectly increase girls' HIV risk, including poverty, gender inequality, sexual violence, and lack of education. The DREAMS partnership will be implemented in 10 countries across sub-Saharan Africa, including Kenya, Tanzania, and Uganda, in collaboration with UNAIDS and other partners.[36]

FBOs as partners in these efforts: FBOs are important providers of services to address the social-structural factors that disproportionately affect women. Such services are particularly important in resource-poor settings such as informal settlements. Though comprehensive data on these services in informal settlements are lacking, a 2011 PEPFAR-funded study of psychosocial support services provided by FBOs and non-religious CBOs in the Mukuru settlement of Nairobi revealed that FBOs provide just under half of all services for women, young women, and girls—more than any other single sector and almost as much as governmental, private, and civil society programs combined.[37]



Community partnerships to address gender issues: Beginning in 2013, PEPFAR supported the implementation of a community-based initiative in Nakuru County, Kenya that brought together religious leaders, leaders of local FBOs and CBOs, and psychosocial staff for HIV clinical programs.[38] Participants created teams in their local community and identified the most pressing social-structural factors that create vulnerability for HIV infection for some people and cause some people living with HIV to drop out of clinical care. One of the teams developed a community action plan to work with women in their local community to

- help women living with HIV to improve their nutritional status;
- empower women to initiate income generating activities;
- increase awareness of HIV/AIDS and the importance of preventive and treatment adherence measures; and
- reduce community stigma of HIV/AIDS.

Collectively, the group led nutrition and gardening training sessions for participants in support groups for women living with HIV/AIDS. They also trained these same groups to seek loans through microfinance institutions to start small businesses. Another key aspect of the program is to provide sexual education to community members. They continue to support women in their community through ongoing support groups. PEPFAR continues to develop programs that build the capacity of FBOs to address gender inequity and social-structural factors that make some communities more vulnerable to HIV infection. The program that began in Nakuru County in 2013 has been expanded into Nairobi County and will be implemented in Kisumu County in 2016.

When the story gets difficult: Using sacred texts to discuss gender

Reverend Nyambura Njoroge and Reverend Pauline Njiru help lead a number of HIV initiatives for the WCC. At the 2015 Consultation, Revs. Njoroge and Njiru demonstrated to participants a method for reading Biblical texts developed by the WCC. The demonstration, part of a workshop entitled, *Gender and HIV: A Shared Responsibility*, walked participants through the story of the rape of Tamar, a passage found in 2 Samuel 13, a part of scripture sacred to both Christians and Jews. The passage is difficult to hear. It tells the story of the rape of King David's daughter Tamar by her half-brother Amnon.

By taking participants through the story, Revs. Njoroge and Njiru showed how scriptural narratives can offer an entry point into discussion on sensitive subjects such as gender-based violence, cultural attitudes of masculinity and femininity, and abuses of power. Starting such discussions through an analysis of scriptural story can help faith communities identify challenges, opportunities, and common commitments in their own contemporary context to support gender equity and challenge violence against women.

RELIGION AND KEY AND VULNERABLE POPULATIONS

PEPFAR 3.0 clearly identifies the challenge and necessity of providing high quality services for vulnerable and key populations:

> Overcoming the barriers that prevent key Populations from receiving treatment and care is more than a challenge, it is a necessity. In many settings, key populations are at higher risk for acquiring HIV, but are often the least likely to obtain HIV services. Now more than ever, people who inject drugs, sex workers, and men who have sex with men face stigma and discrimination. Human rights among lesbian, gay, bisexual, and transgender (LGBT) people in certain parts of the world are increasingly under threat, creating additional barriers to key populations accessing services. If any one of our populations is left behind, we are all left behind and we will not control the epidemic.[39]

Religious belief may contribute to stigmatization and discrimination of key and vulnerable populations, including sex workers, MSM, and PWID, and religious teaching may be used to support harsh laws and policies. Some FBOs offer exemplary services to key and vulnerable populations but a number of them struggle to provide comprehensive HIV prevention services, especially related to sexual activity or drug use. Still others are unable to provide these services because doing so would conflict with the interpretation of teachings of the religious tradition that supports them (e.g., condom use). Finally, some FBOs actively work to advocate for laws and social policies that are a barrier to evidence-informed prevention interventions such as specific MSM programs. In short, FBO contributions have challenges in creating and supporting HIV prevention programs focused on sexual behavior and drug use.

The 2015 Consultation provided a context for frank discussion on the challenges FBOs face in providing HIV services to the following key and vulnerable populations:

- **MSM:** Although many countries do not maintain data on national-level HIV prevalence among MSM, a 2012 study that aggregated data from over 2200 peer-reviewed studies and surveillance reports found that HIV prevalence among MSM was at least three times higher than that in the population-at-large in every region of the world.[40] In many parts of the world where PEPFAR supports programming, religious teachings and social norms contribute to stigma for MSM. Religious teachings are invoked to support criminalization of same-sex sexual expression and some religious leaders have provided a theological framework to support the positions of the politicians who pass such laws.

- **Sex workers**: Various FBOs offer programs that specifically address sex workers' needs, focusing on psychosocial support and short-term economic assistance. Most of these programs concentrate on female sex workers and only a handful of FBOs work with male and transgender sex workers. In fact, religion has been a motivating factor in violence against male sex workers.[41]

- **PWID**: Drug use correlates with increased risk of HIV infection and HIV disease progression for people living with HIV.[42] Injection drug use presents additional risk of HIV infection because shared syringes offer a direct of route of transmission for HIV. Drug treatment services are not widely available in many parts of the world, and so any treatment provided by FBOs helps fill gaps in care.

All of these communities are associated with high HIV prevalence rates (for a map of HIV prevalence rates for key populations in select sub-Saharan African countries, see Appendix II). In addition, members of these communities experience high levels of stigma and discrimination, regularly face imprisonment, and have limited access to comprehensive, non-judgmental, and accessible HIV prevention, treatment, and support services. Although religion may contribute to stigmatization and criminalization for these communities, religious belief may also serve as the foundation for compassionate, non-judgmental, and comprehensive responses. PEPFAR is committed to working with religious leaders and FBOs that offer such responses.

These challenging, complex issues were addressed at the 2015 Consultation through breakout sessions on FBOs and Key and Vulnerable Populations. The sessions offered participants the chance to hear from members of these communities with facilitators moderating the discussions that followed as a number of perspectives emerged. Representatives of LGBTI communities highlighted the lack of religious leaders lending their voices in support of social justice for sexual minorities; these representatives were clear that such voices were critical to change public opinion and to foster support and social acceptance. In addition, these representatives also reminded participants that members of LGBTI communities were already part of their congregations and masajid and that LGBTI people were looking to their faith communities to offer a place of hospitality and welcome in a culture where they often faced discrimination.

Participants discussed the sensitive issue of religious teachings on sexuality as they debated among themselves the extent to which the theological positions of religious communities drove discrimination, stigma, and barriers to care and treatment. Some participants offered examples of religious texts being used to condone discrimination. Others wondered how to find a way forward when religion sets forth a value system that names same-sex expression as sinful while LGBTI communities affirm same-sex expression as natural and positive. Representatives of FBOs providing health and psychosocial services asked an essential question: were religious beliefs hindering key and vulnerable populations from accessing services and were those beliefs perpetuating stigma and suffering?

As they examined the issue, FBO representatives struggled with the realization that services of some FBOs may exclude key and vulnerable populations and contribute to stigma. In an effort to build consensus that FBOs should offer their services to anyone in need, participants returned to religious teachings to articulate a core message: people of faith are called to welcome the stranger into their midst and to treat everyone with compassion and dignity. As they worked to name the implications of this teaching for HIV services, some participants wondered whether identifying groups such as sex workers and MSM as key populations actually contributes to the problem by creating an "us versus them" mentality.

As the conversation moved from a discussion of these complex issues to focus on the responsibilities of FBOs, a consensus began to emerge. Despite differing moral perspectives, participants could affirm the importance of stopping HIV transmission and recognized that sexual minorities must have access to comprehensive and effective HIV prevention, treatment, and support services in order to lower the rate of new HIV infections. For this to happen, some participants called on PEPFAR to carry out further research on the impact of religion on access to services for key and vulnerable populations. Are members of these communities reluctant to seek care at a FBO facility? Do they experience discrimination or stigmatization from religious communities or FBHPs? What are the barriers in accessing care for these communities and how can those barriers be addressed and eliminated? Others asked PEPFAR to continue to offer opportunities for dialogue and discussion as they described the importance of hearing from people most affected: "People react differently because of lack of knowledge or ignorance," they said. "We need to listen to one another."

Making the case

The 2015 Consultation offered an opportunity for frank discussions on a number of sensitive topics including religious teachings on gender and the challenges that FBOs face in working with key and vulnerable populations. Religious leaders and representatives of FBOs at the 2015 Consultation offered strong perspectives on these issues. This is what they said:

REVEREND CANON GIDEON BYAMUGISHA

Reverend Canon 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. Reverend Byamugisha found out he was living with HIV, soon after his wife became ill. His colleagues were largely supportive but pleaded with him 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 Reverend Byamugisha's singular decision to grow into a broader response, but in 2002, 42 other religious leaders added their voices to his to found ANERELA+, which in 2006 became INERELA+: the International Network of Religious Leaders Living with or Personally Affected by HIV/AIDS. In his presentation at the 2015 Consultation, Reverend Byamugisha observed,

> "Public health researchers put up a slide showing the key populations. It says, 'sex worker, men who have sex with men' etc. But the religious leaders are saying 'we told you. We told you that these are the behaviors that put people at risk.' We need to change the language—to redefine those who are most at risk without alienating them. Those most at risk are:
>
> - Those people who lack accurate information on how HIV spreads.
> - Those people who are fatalistic or pessimistic on HIV/AIDS—their attitude makes them vulnerable.
> - Those who lack appropriate skills for protection.
> - Those who lack services—accessible, non-stigmatizing services. For example, they want counseling or medicine, but they're judged so they don't come back.
> - Those who lack supporting environments that makes safe behavior common and routine.
>
> 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? We have data from behavioral scientists and biomedical researchers, but we don't have a lot of data that is looking at what makes people of faith do less than they are supposed to do to reduce stigma and shame and denial and discrimination and inaction of AIDS.
>
> **We need to focus on FBOs operating in most-at-risk communities**
>
> We need to focus on FBOs operating in most-at-risk communities. 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 sex workers, MSM, and 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 also as members of supportive communities, including faith communities. Religious leaders simply must deal with the reality that their communities include members of key and vulnerable populations." ❞

HIS GRACE BISHOP PAUL YOWAKIM AND FATHER MENA ATTWA

Bishop Paul is the leader of the Coptic Orthodox Church in Kenya, serving as the General Bishop for Evangelism and Mission in East Africa. One of Coptic's many contributions in the FBO sphere is Coptic Hospital, located in Nairobi, Kenya. The HIV program at Coptic provides prevention, treatment, and support services to thousands of people living with HIV in two facilities in Nairobi and in a comprehensive program in rural Western Kenya. Across these three programs, Coptic provides over 125,000 HIV treatment visits each year.

"We have almost 1500 orphans here in Kenya we provide for, and we have two community schools in Zambia. All over Africa, we have programs for widows and orphans. In Nairobi, we have a program for sex workers. We help to find jobs for women and help them to live healthy lives. We have a "street kids" program to help young men get an education and stay with their families. The work that we do with these groups has expanded our ministry.

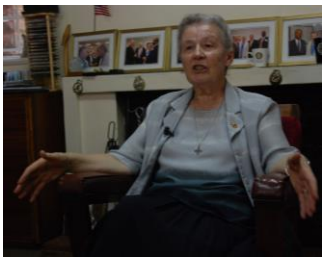
I feel God sent us a mission here to help the community, and we are so happy to be part of the work in God's creation."

Father Mena Attwa serves as the Director of Coptic Hospital in Nairobi, and he believes that the innovative outreach program to sex workers is a crucial element in the response to HIV within his community.

"The outreach program started informally—we would go out in the evening and speak to sex workers and give them information about our clinical services and let them know they were welcome to receive services there. Some women drop in from time to time but they don't receive regular care from us. That's okay—we stay in relationship with them to the degree they want. But there's a group of sex workers who now receive regular, ongoing services through Coptic. They receive spiritual and psychosocial support and we sponsor a weekly fellowship for the women and any other sex workers who want to attend.

When God opens the door for you to attend to both the physical and the spiritual you have to be able to provide in both aspects. Working with this community is giving me a real-life experience of the importance of both and it's nice to be part of that."

SISTER MARY OWENS, IBVM



Sister Mary Owens is the Executive Director of the Children of God Relief Institute—Nyumbani. Sister Mary has been part of the organization since it was founded by Father Angelo D'Agostino SJ, MD in 1992. She worked with Father D'Agostino to establish the various programs of Nyumbani: Nyumbani Home, Nyumbani Village, Lea Toto, and the Nyumbani Laboratory. Following Father D'Agostino's untimely death in 2006, Sister Mary became Executive Director, a position she holds to this day.

"Recently, I was at an adolescent gathering and I heard terms that I hadn't heard before. This is the effect of peer pressure. The young people told me that sometimes they "take a drug holiday," which means, of course, "I stopped taking my antiretrovirals." And because of peer pressure, other young people say, "OK, I'll take a drug holiday as well." And the young people

tell me of stigma and misinformation and the way it is communicated. They told me that in HIV education sessions at school the main message is "AIDS kills." And so for the young people in our program the message is, "I'm going to die." And, of course, that means that they are caught in secrecy because if any of their age-mates or their schoolmates learn that they have the virus they ask, "Oh, so you're going to die soon, where's your grave?"

"The stigma has to be eradicated. HIV is a medical condition—that's all it is. But I am afraid that a high percentage of people don't see it like that."

Early on, we had to take the government of Kenya to court because our children were being excluded from pre-primary education. Our children came up against terrible stigma in school. Stigma is what needs to be eradicated. It keeps parents from bringing their children in for testing and care. The child comes just that bit too late and they pass away. And we know that the majority of children who don't get access to care and treatment right from the point of delivery, nearly 50 percent of them will pass away before the age of two.

Without stigma, parents would say "It's OK to take my child to Lea Toto and get all the care that my child needs without the neighbors stigmatizing me, discriminating against me, or telling stories it would be just like any other medical condition." So the stigma has to be eradicated. HIV is a medical condition—that's all it is. But I am afraid that a high percentage of people don't see it like that. It's just a medical condition.

At the LGBTI session that was held at the Consultation, I asked myself, "Some of our children will have a different sexual orientation than the majority of people and can we help?" It just hit me. We're focused so much on HIV/AIDS, but now, can we help? So that is a question mark I'm carrying away from this Consultation because we're bound to have some who have a different orientation. And of course, here in Kenya and Africa, talking about sexuality is still very taboo but it's something that I'm carrying from this conference. ❞

ABDALLA BADHRUS

Abdalla Badhrus is the Program Manager for Health and Harm Reduction Services for the Muslim Education and Welfare Association (MEWA) in Mombasa, Kenya. MEWA provides a spectrum of services to people using drugs, from low-threshold interventions such as outreach and syringe exchange to detoxification and treatment programs. MEWA provides specific residential and day treatment programs for women and men and has adapted the 12 steps model of recovery into Milati Islami (Path to Peace) to focus on teachings and practices familiar to people who practice Islam.

❝ People who are using drugs are human beings—they are human beings! But so many people don't treat people who use drugs as fully human. They believe that those who are using drugs should have no rights. People say, "If you see a snake and a drug user, first kill the drug user." Often for women drug users, there is a lot of stigma. Among the community, when a woman takes drugs, it is like they are lost, they cannot come back. And because of this, it is not easy for women to access services. When they are out and about people just think, "Oh, they are just women, they are sex workers, they are very bad people, they have done a lot of very bad things. They're supposed to be home with their children." Because society doesn't offer them the services, we don't give them the care they need these same women are used and abused. So it's very, very important for us also to think about gender.

I remember when we were doing a meeting in 2003 with people who use drugs and the women at the meeting were asking, "You have been supporting men for a long time. There is no treatment for females. There is no drug treatment center especially for females in Kenya." So we said, "Let us try and help you." The next day, female drug users came with their luggage. Some of them came with their babies [one of them a small, two-week old girl]. And then in offering detox, we saw that two weeks is not enough. The women who came had so many needs: sexual and reproductive health, rehabilitation, food for their children, shelter, and clothes. So we said, "What can we do now?" We started collecting donations between ourselves. Everyone [donated some money] and rented a small house just next to our center. We started learning and learning and learning. Today we offer a host of specific services for women drug users.

"It's very, very important for us also to think about gender."

Through PEPFAR, we have reached a lot of people. You know, before we were only doing a very, very small program with minimum funding. But when PEPFAR came, we extended our net from Kilifi to Mombasa. Because of PEPFAR, a lot of people are getting our services, we are reaching many people."

CHURCH WORLD SERVICE

Throughout the world today, LGBTI communities continue to suffer from discrimination and persecution. The Church World Service works to create a safe space for LGBTI persons, providing both resettlement for LGBTI refugees and protection to those still facing the fear of persecution. Since 1990, CWS has partnered with the U.S. Department of State to operate a center in Nairobi, Kenya, that serves refugees and those seeking asylum (including, but not limited to, LGBTI persons). CWS has begun to identify and cultivate relationships between civil society groups focused on refugee rights and LGBTI human rights. Through a grant provided in 2014 by the Arcus foundation, CWS has sought to build links between faith communities and LGBTI rights organizations in both Kenya and South Africa, creating a network of advocates for LGBTI rights in the local community with the aim of improving protection for LGBTI refugees.

"It makes such a difference to have a friendly provider who treats you with dignity."

CWS recognizes that the psychosocial, spiritual, and health needs of those seeking asylum can be exceptionally challenging. They work hand-in-hand with caring churches, organizations, and individuals to provide help and homes to refugees. Through addressing psychosocial and physical trauma, CWS works to build a welcoming community for uprooted people so that they can fashion a better future.

In June 2015, a group of sex workers and LGBTI refugees who have worked with CWS staff discussed their perceptions of FBOs:

"For general health services we [LGBTI refugees] will go to a faith-based clinic but for sexual and reproductive health services, we would rather go to a friendly clinic because that's where we feel comfortable. Faith-based health providers need to be pro-active in sending a message that they are friendly. They could have a sign that says everyone is welcome here. And the staff need to be trained to act friendly toward us.'

'If I go to a faith-based clinic and I know it's a faith-based clinic, I'll be afraid of the bias they have. I probably won't disclose [my health condition], I'll probably not tell them exactly why I'm there until I meet someone who is friendly.

‘It makes such a difference to have a friendly provider who treats you with dignity. There is one staff member at [a particular faith-based clinic]. She treats sex workers with warmth and dignity. The sex workers know and like her. She’s the only person there that they trust. When she’s working, sex workers will come to that clinic. But when she’s not, they will not go. It makes such a difference. ”

Strengthening through partnerships

LOCAL, REGIONAL, AND NATIONAL PARTNERSHIPS

All of the countries represented at the 2015 Consultation have strong ecumenical and interfaith networks that fulfill two essential roles. First, they support stronger, integrated health system. Second, they build effective platforms to advocate for strong HIV programs, equitable policies equity, universal health access, and transparency and accountability in funding and management.

Kenya: Since 2009, CHAK, KEC, and SUPKEM have strengthened their partnership through a Memorandum of Understanding (MOU) signed by all three organizations and officials with the Government of Kenya. At that signing, James Ole Kiyiapi, the Permanent Secretary in the Ministry of Medical Services said, "With signing of this MOU, we now have a partnership framework that will enable the government to subsidize the efforts of our partners." Representing the National Conference of Catholic Bishops, John Cardinal Njue called the partnership a unique initiative to carry on the healing ministry of our traditions. Abdulghafur El-Busady of SUPKEM spoke of the importance of the agreement for focusing each network "on making it easier for our people to access health services."

Tanzania: The Christian Social Services Commission (CSSC) and the National Muslim Council of Tanzania collaborate on a variety of initiatives. Through 2013, PEPFAR supported a capacity-building and health systems strengthening initiative with the CSSC serving as the project lead for the private sector and faith-based sector. The project focused on strengthening the health workforce, improving data collection and management, and developing an advocacy platform.[43]

Uganda: Together, the Uganda Catholic Medical Bureau, Uganda Muslim Medical Bureau, Uganda Orthodox Medical Bureau and Uganda Protestant Medical Bureau operate almost 900 health facilities in Uganda, 86 percent of which are in rural areas. They comprise over 75 percent of the not-for-profit private sector facilities in the country.[44] These networks have been sources of stability during periods of governmental and civil unrest in Uganda, helping assure that essential health services continue to be provided. They serve people in remote rural areas and help catalyze and sustain initiatives at the grassroots.[45]

Rwanda: Interfaith partnerships to address HIV/AIDS have been ongoing in Rwanda for a number of years. RCLS supports collaboration between Christians and Muslims seeking health services through a number of programs. The network works in coordination with Le Bureau des Formations Médicales Agréées du Rwanda to help ensure that medical supplies are provided to faith-based health facilities. With funding from PEPFAR through USAID and support from IMA World Health, an international FBO, RCLS has worked with Christian pastors and Muslim imams to publish sermons that support sound maternal and child health policies and practices.[46]

These ecumenical and interfaith networks play an essential role in advocacy efforts to sustain and strengthen the global response to HIV/AIDS in four ways.

1. They hold important leadership roles within the coordinating mechanisms of civil society to establish coordinated plans and set strategic objectives.

2. They call for transparency and accountability within government and civil society, providing a clear message in support of universal health coverage and equity in services.

3. They educate religious leaders and countless people of faith within their own traditions about sound HIV/AIDS programs and about the ways that religious teachings and religious practice can support such programs. In doing so, they challenge religiously motivated stigma and discrimination.

4. They forge strong partnerships across the globe and provide platforms for other people of faith to advocate to the governmental, multi-lateral, and civil society programs to continue funding for essential HIV/AIDS services.

INTERNATIONAL PARTNERSHIPS

As the only cosponsored Joint Programme of the United Nations, UNAIDS is a tangible example of a collaborative, multisectoral response to a complex and multi-faceted issue. UNAIDS draws on the expertise of its 11 cosponsors—the UN Refugee Agency (UNHCR), UNICEF, the World Food Programme, the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the United Nations Office on Drugs and Crime, UN Women, the International Labour Organization, UNESCO, the World Health Organization, and the World Bank—and a largely field based Secretariat. Inclusion of affected communities is at the heart of UNAIDS' modus operandi—it is the only UN entity with civil society represented on its governing body.

In a speech to faith leaders in 2013 UNAIDS Executive Director Michel Sidibé said:

> "We are together, at the right time and at the right gathering, to forge tremendous change in the world. We share a bold and noble dream of global justice and peace. We may use different words, and work in different ways, but this is our common vision and our audacious goal: to end human suffering and to protect hope and dignity. I am convinced we can get there together.
>
> Over three decades of the AIDS response, I can say with confidence that we have learned precious lessons that are relevant to all who fight for equity, dignity, justice and peace. AIDS has shown that we can change the world when we put human beings—in their irrevocable, God-given dignity—at the centre of our action. The AIDS response has demonstrated the power of bringing those most marginalized to the tables where decisions and policies are made. AIDS has demonstrated the power of engaging a broad alliance of civil society partners to address the challenges of HIV, but also to raise awareness and demand action for issues and communities otherwise silenced in mainstream society.
>
> Yes, we scaled up HIV prevention, treatment, care and support services to millions of people—but these were many of the people who were easiest to reach. It will be much harder to reach those still in need—the ones whose lives are hanging in the balance because they remain hidden, or marginalized, or criminalized. It will require a mass mobilization of communities to demand HIV treatment, to address the stigma, discrimination, gender inequity and punitive laws that are so often the barriers to people coming forward for testing, or coming back to receive their results, or even access HIV treatment where it is now available. This requires an even greater commitment to equity, inclusiveness, human dignity and faith. This is why, more than ever before, we must strengthen the alliances between organizations of people living with and affected by HIV and religious communities and leaders. This is essential to ending stigma and discrimination and improving access to health and dignity for all.
>
> Our common commitment to the poor will be a critical force to make sure that the funding needed to reach people with HIV testing and treatment is sustained amid the current fiscal crisis. Over the years you have generated an essential dialogue in faith communities about HIV, sexuality, stigma, discrimination and rights. Now it is time to push boundaries on issues of sexuality, stigma and rights. You must be barricades against exclusion.

> We must not take our foot off the pedal now. We must redouble our efforts. When what we look for is justice, I will refuse silence. We must advocate for those who are still waiting for access to HIV treatment. If we don't pay now as a global community to finish the task we have started, then we will pay forever—both financially and in human lives. We cannot let shifts in the geopolitical climate throw us off our course or drive a wedge between us. Today we must join our strengths again, take control and influence the trajectory of our journey. To borrow your language, "We must go the extra mile." We will travel father together than alone."

In its most recent five-year strategy (2011-2015), UNAIDS has built on the principles outlined in the 2010 UNAIDS Framework for FBO Partnership, by committing to:

- Work with families, communities and FBOs and strengthen community and social welfare systems to ensure continuous access to treatment and supplies for vulnerable and socially excluded populations—and to recognize and support caregivers.
- Strengthen FBOs in expanding their pivotal role in the community; in integrating HIV prevention, care and support; and in steadily addressing stigma and discrimination.[47]

UNAIDS will measure these commitments by marking progress toward the following key result: Country partners in the global South will drive and implement human rights–based approaches to HIV prevention, treatment, care and support and give priority to effective interventions, with the engagement of parliamentarians and opinion-shapers such as FBOs, youth networks and women's rights networks.

Moving forward, as part of the *Fast-Track* strategy, UNAIDS will continue to deepen the partnership with FBOs and their networks to facilitate an expansion of community-based and facility-based care as an essential component of rapid service delivery scale-up. This includes support to document models of good policy and practice in service delivery and to address key issues at the community level, such as stigma and discrimination towards people living with HIV as well as transforming gender norms and ending gender-based violence.

The Global Fund to Fight AIDS, Tuberculosis and Malaria**:** In December 2014, Mark Dybal, the Executive Director of the Global Fund wrote:

> "Faith communities play a fundamental role in addressing health challenges around the world. For decades–even before many bilateral and multilateral institutions were established–these organizations have been providing lifesaving prevention, care and treatment in a holistic way to serve the needs of a person. In fact, many hospitals and clinics around the world can trace their roots back to missionaries and churches. Faith leaders and institutions have been critical, as well, in addressing stigma and educating communities about health. With a commitment to serving the poorest and hardest-to-reach populations, and with years of trust built up among the people they serve, members of the faith community are integral to the sustainability of global health programs.
>
> Importantly, the faith community has played a critical role in addressing the HIV/AIDS, tuberculosis and malaria epidemics in areas with the greatest need and fewest resources. To ensure the investments of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the world's largest public health financier, have long-term impact, we are committed to continuing strong partnership with this important group of stakeholders."

Since its founding, the Global Fund has funded 61 grants to FBOs as prime recipients in 28 countries totaling over $900 million. In addition, FBOs have received more than $500 million in additional funding as sub-recipients in 73 countries.[48]

Recommendations and next steps

At the 2015 Consultation, faith-based leaders from across East Africa heard from presenters and offered their own wisdom and insights on some of the most challenging aspects of the HIV/AIDS response: serving children, young women and girls, and other key and vulnerable populations. They discussed key priorities of PEPFAR, UNAIDS, and other global partners to fast track the hard-won progress made over the last few decades. They shared their innovative faith-based programs working with adolescents living with HIV/AIDS, PWID, sex workers, and MSM and discussed the need to attend to cultural norms in relation to gender inequities. LGBTI community members shared their unique experiences in East Africa, which began important and difficult dialogues that are essential for finding common ground. Participants saw ways in which their tireless efforts in pediatric HIV care and PMTCT can improve maternal and child health services for everyone in local communities. They heard about the importance of religious voices in local, national, and global advocacy efforts, and they gained useful tools for effectively communicating the work they do across their own networks. At the end of the three days together, participants left with more than updated program knowledge; they left with renewed optimism on how they, along with PEPFAR and other global partners, could move forward together.

At the closing session, participants gathered to draft a set of recommendations to guide the activities of FBOs, PEPFAR, UNAIDS, and all other partners as we enter the next critical stage of the global response:

1. Leverage the trust that has developed between FBOs and local communities to build strong, more comprehensive, all inclusive, integrated HIV prevention efforts built not on stigmatization but on unconditional love.

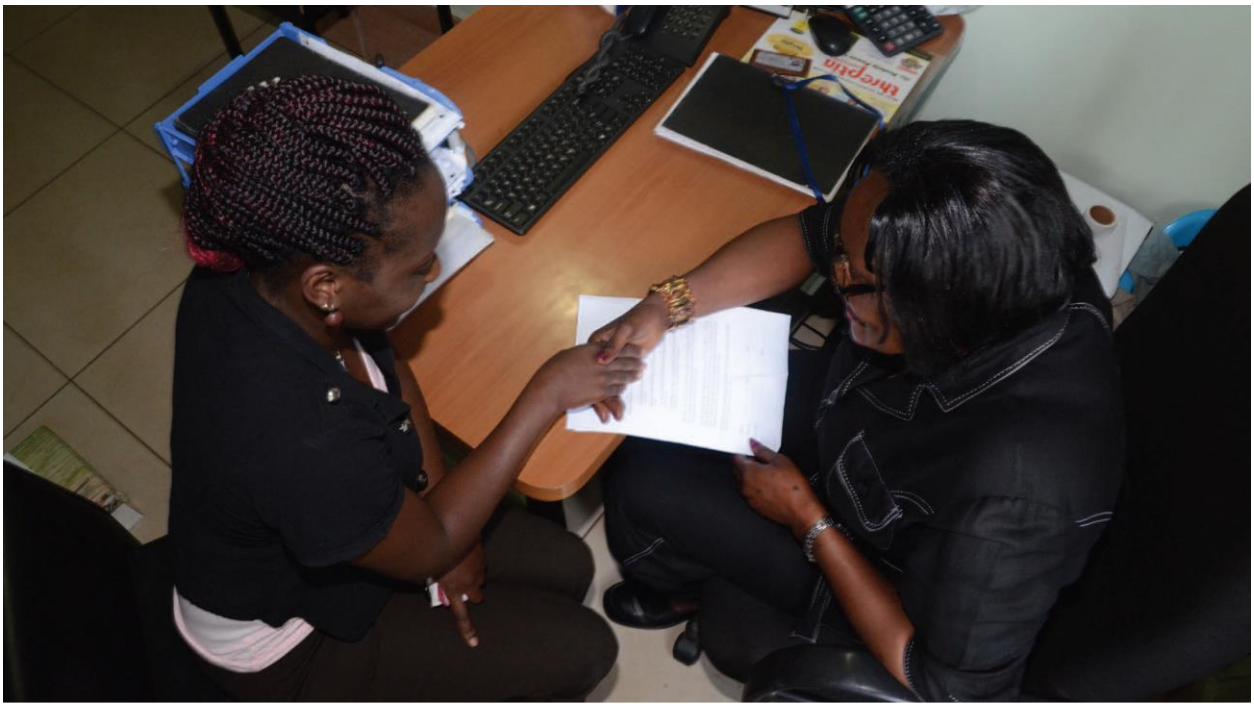
   Those efforts should move beyond a focus on individual behavior to include family, congregational, and community-based initiatives. Further, they should advance theological perspectives grounded in human rights and social justice. Specific HIV prevention initiatives should be targeted toward your people with emphasis on adolescent girls and young women. Interventions that focus on those entering or within marriage or stable relationships remain relevant. Finally, marginalized, hard-to-reach, key and vulnerable populations should be included in program design, implementation, monitoring, and evaluation.

2. Develop the capacity for FBOs to advocate for improved health care for all citizens and hold governments accountable.

   FBOs should be empowered to be the voice of reason advocating for all citizens including marginalized and hard-to-reach populations, thus ensuring that governments build and sustain adequate health facilities, distribute resources equitably, and develop sound long-term strategies for improving health systems—both in faith-based and government sectors.

3. Maximize the existing organizational infrastructure of faith-based health systems to reach communities impacted by HIV, including vulnerable and hard-to-reach populations, people in steady relationships, key populations, youth, those culturally marginalized, those from remote geographical areas, and people of all genders.

   Faith-based health systems provide a significant proportion of the health services in East Africa. Those systems have the capacity to reach both urban and rural communities that can surpass that of other health systems. Religious leaders should be mobilized to provide HIV testing, counseling, and treatment to hard-to-reach populations. FBOs should provide leadership to develop, administer, and analyze population health surveys that reach all populations. FBOs, governments, and civil society organizations should work together to make HIV programs sustainable as funding from outside donors shifts. FBOs should provide services in a non-discriminatory and non-judgmental, client-centered manner.



4. Strengthen the capacities of FBOs to develop proper systems and tools for gathering, sharing, and utilizing data for critical decision making and holistic advocacy at all levels including: key populations, gender-based violence, HIV/AIDS, and sensitive/affirming religious messages.

   FBOs should be equipped to understand the language, perspectives, and priorities of funders and other partners so that they can make a stronger case for funding. This should include building a stronger evidence base on the contribution of FBOs to service delivery. Additionally, FBOs should work to ensure that HIV awareness and prevention messages are integrated into religious life and practice by referencing HIV in corporate liturgies prayers, and sermons. This will encourage local religious communities to see HIV prevention and care not as the specialized work of health or social service professional, but as the shared responsibility of people of faith gathered together.

5. Strengthen communities' input and investment into FBO administration and programming.

   The work of FBOs can be sustained and strengthened when it aligns with community priorities. Such alignment can be encouraged by soliciting community involvement in program administration through community advisory boards. Additionally, faith-based health systems should build or foster strong community ties in order to put referral mechanisms in place. These mechanisms should lower barriers to accessing service for people coming from the community into the health system and for people going back into the community from the health system. FBOs and faith communities should be equipped to implement relevant programs in the community while PEPFAR provides services to build capacity. Religious leaders should be empowered to remind families about PMTCT programs; advocate for comprehensive HIV services for everyone, including people with physical or developmental disabilities; and address stigma and discrimination in health care settings and at the community level.

6. Develop and make widely available mechanisms to support the organizational development of FBOs.

   FBOs would benefit strongly from greater participation in organizational and technical support services provided by funders and other partners. This is particularly true in the areas of human resources, supply chain management, financial accountability and development, and training. National data management systems should be upgraded to capture FBO contributions in national and global statistics and data should be analyzed to better understand the characteristics of local epidemics. PEPFAR should educate FBOs on new PEPFAR tools as they are developed and on priorities as they change.

7. Increase FBOs' capacities to advocate, and to develop and implement effective programs including effective systems for monitoring, evaluation, and learning.

   Capacity building should focus on FBOs' mechanisms to improve the quality and scope of their programs. These mechanisms should include: providing skills- building and training; disseminating best practices with support to replicate them; prioritizing evidence-based data utilization to inform policy decisions and program sustainable initiatives; and developing and supporting more robust monitoring and evaluation mechanisms that tie indicators to service improvement.

8. Expand FBO networks by bringing in new or previously unaffiliated FBOs and engaging other religious traditions.

   Create a genuinely broad task force or interfaith network in areas where the virus is, while maintaining rigorous epidemiological surveillance to monitor for changes in HIV incidence in other areas. Once the network is built, offer capacity building strategies that enhance skills and knowledge for effective advocacy. Work with these interfaith networks to develop tools that promote accountability, transparency, and increased impact. In these activities both key populations and FBO/religious leaders will take into consideration the perspectives of both parties in hopes of reaching consensus on shared commitments. This will result in convergence of a common advocacy agenda for greater health. Expand faith-based outreach that could extend effectiveness of health facility programming at the community level, finding synergies between the medical and the spiritual components.

9. Hold ineffective FBOs accountable.

   Not all FBOs are effective in their work. Some lack capacity and resources to do the work they aspire to; others use religion to promote stigma and shame rather than care and compassion. Mechanisms should be developed to address these circumstances. The capacity-building recommendations listed above could be offered to FBOs lacking capacity and resources. FBOs that actively use religion to promote stigma and shame should be held accountable by FBOs endeavoring to offer strong HIV prevention, treatment, and support services. Increase the capacity of FBOs to deal with hard-to-reach groups and increase the mutual sensitivity of FBOs and key population communities to extend HIV services to key populations by making faith-based programs more available. In such efforts, the common goal will be to promote human dignity for all in the context of HIV/AIDS. Conduct theological audits with a view of analyzing and documenting which theologies are enhancing life and which ones are life-threatening in the context of HIV/AIDS. Develop strategies that enhance opportunities where life-promoting interpretations of religious traditions are carried out.

10. Offer leadership development initiatives to better equip the next generation of religious leaders and leaders of FBOs.
    Leadership development is as important as organizational development. Therefore, it is critical to provide platforms for current leaders to share their knowledge, expertise, and wisdom and to create mechanisms at both individual and organizational levels for mentoring. At the individual level, mentoring would allow emerging leaders to work with well-respected and highly effective senior leaders for an extended period of time. At the organizational level, mentoring would pair established, successful FBOs with new and/or promising FBOs in order for staff to share best practices.

As PEPFAR carefully examines the impact of its programs and investments and works to leverage the experience and expertise of all partners, FBOs and the leadership of the faith community in providing HIV prevention, care, and treatment services will continue to be a cornerstone of the program. In addition, faith leaders have an increasingly important role in advocating for the social, political, and programmatic changes that will ensure that we can reach all of those who need HIV services, leaving no one behind. This is essential to not only sustain but also expand the programs that we have built together over the last decade. Otherwise, the gains we have made toward controlling the HIV epidemic might well be lost.

These recommendations, which resulted from thoughtful and hearty discussion on a range of challenging and difficult topics, reflect the commitment and dedication of the participants of the 2015 Consultation to strengthening and enhancing collaboration between faith-based organizations, donors, multilateral organizations, governments, private partners, and each other.

The meeting underscored the need to ensure that the hard work of reducing the impact of HIV and ultimately ending the epidemic continues. PEPFAR and UNAIDS will work closely with 2015 Consultation participants and other faith-based stake holders to review and respond to the concerns raised and ideas presented during the event. This careful consideration will improve our collective capacity to provide the very best possible service to all of those who are in need.

It is our intention that the hard work we did together, and our mutual and steadfast dedication to the process will inform how PEPFAR, UNAIDS, and others forge stronger partnerships with our faith-based collaborators going forward.

Notes

[1] For further information on the scope of services provided by FBOs, see pp.18-31 and Appendix I.
[2] Olivier, J. & Wodon, Q. (2012). Layers of evidence: Discourse and typologies of faith-inspired community responses to HIV/AIDS in Africa. In J. Olivier and Q. Wodon (Eds.), *Strengthening the Evidence for Faith-Inspired Engagement in Africa, Vol. 3: Mapping, Cost, and Reach to the Poor of Faith-Inspired Health Providers in Sub-Saharan Africa* (pp. 25-51). Washington, DC: The World Bank.
[3] Tomkins, A., Duff, J., Fitzgibbon, A., Karam, A., Mills, E.J., Munnings, K., . . .Yugi, P. (2015). Controversies in faith and health care. *The Lancet.* Faith-based health care series article 2. July 7, 2015, 1-10. doi: 10.1016/S0140-6736(15)60252-5.
[4] UNAIDS. (2015). *Understanding fast track. Accelerating action to end the AIDS epidemic by 2030*. Geneva, Switzerland: Author, p. 6. Retrieved from http://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf.
[5] UNAIDS. (2014). *Fast track: Ending the AIDS epidemic by 2030*. Geneva, Switzerland: Author. Retrieved from http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf.
[6] UNAIDS. (2014). *Implications of the start study data: Questions and answers*. Geneva, Switzerland: Author, p. 3. Retrieved from http://www.unaids.org/sites/default/files/media_asset/2015_Implications_of_the_START_study_data_en.pdf.
[7] Office of the U.S. Global AIDS Coordinator. (2014). *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*. Washington, DC: Author. Retrieved from http://www.pepfar.gov/documents/organization/234744.pdf.
[8] For further information on the substantive roles of FBOs in the care of orphans and vulnerable children (OVC), see United Nations Children's Fund & World Conference of Religions for Peace. (2004).
[9] U.S. Department of State. (2005). *The President's emergency plan for AIDS relief: Community and faith-based organizations.* Report to Congress mandated by Report 108-599, accompanying H.R. 4818. Washington, DC: Author. Retrieved from http://www.state.gov/documents/organization/54420.pdf
[10] These amounts were calculated by analyzing the annual country and regional operating budgets approved by PEPFAR. See http://www.pepfar.gov/countries/cop/index.htm for further information on budgetary data gathered from the annual country and regional operating plans.
[11] Office of the U.S. Global AIDS Coordinator. (2014), p. 7.
[12] Baird, J., Isbell, M., and Siringi, S. (2014). *Kenya HIV Prevention Revolution Road Map.* Nairobi: National AIDS Control Council. Retrieved from http://www.nacc.or.ke/images/documents/Final.pdf.
[13] For further information on HIV infection rates for each high incidence and/or high burden county see Appendix I.
[14] For a discussion of various types of faith-based organizations and networks see U.S. President's Emergency Plan for AIDS Relief, 2012.
[15] These percentages were calculated using the master list of faith-based facilities in each county. HIV service provision data for each facility was disaggregated from the MoH 731 database available in the hiskenya.org platform.
[16] Olivier & Wodon. (2012).
[17] Olivier, J., Tsimpo, C., Gemignani, R., Sojo, M., Coulombe H., Dimmock, F., . . . Wodon, Q. (2015). Understanding the roles of faith-based health care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *The Lancet.* Faith-based health care series article 1. July 7, 2015, p. 8. doi:10.1016/S0140-6736(15)60251-3.
[18] United Nations Children's Fund & World Conference of Religions for Peace. (2004). *Study of the response y faith-based organizations to orphans and vulnerable children.* New York: Authors. Retrieved from http://www.unicef.org/media/files/FBO_OVC_study_summary.pdf.
[19] *Ibid.*, p. 10.

[20] For a data summary and description of the CHAT program, see the February 2010 report of the Federation of Hospices of Sub Saharan Africa. Retrieved from http://www.globalpartnersincare.org/sites/default/files/public/gpc/Quarterly/February_2010_Quarterly.pdf.
[21] Kagoyire, B. (2012). Best practices from FBOs: Sustained community-level HIV/AIDS response in Rwanda. Presentation at *PEPFAR Consultation on the Role of Faith-Based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS*. Limuru, Kenya.
[22] Kagoyire, B. (2012).
[23] For further information on the types of services provided by Mildmay and the numbers of people served see http://www.mildmay.org/overseas/uganda/.
[24] Katana, A. (2015). The Connections Among PMTCT, Pediatric HIV and Maternal Child Health Services. Presentation at *Building on Firm Foundations: The 2015 Consultation on Strengthening Partnerships Between Faith-Based Organizations and PEPFAR to Build Capacity for Sustained Responses to HIV/AIDS.* Limuru, Kenya.
[25] Desai, M., Phillips-Howard, P., Odhiambo, F., Katana, A., Ouma, P., Hamel, M.J., . . . Laserson, K. (2013). An Analysis of Pregnancy-Related Mortality in the KEMRI/CDC Health and Demographic Surveillance Systems in Western Kenya. PLoS One 8 (7): e68733. doi: 10.1371/journal.pone.0069733.
[26] Katana. (2015).
[27] 2015 Global Plan Progress Report
[28] UNAIDS. (2014). *2014 Progress Report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.* Geneva: Author. Retrieved from http://www.unaids.org/sites/default/files/documents/JC2681_2014-Global-Plan-progress_en.pdf.
[29] National AIDS Control Council. (2012). *Kenya AIDS Indicator Survey.* Nairobi: Kenya Ministry of Health.
[30] Katana. (2015).
[31] *Ibid.*
[32] For further information on MEDS see http://www.meds.or.ke/who_we_are.html.
[33] For further information on MEDS see http://www.meds.or.ke/who_we_are.html.
[34] Christian Health Association of Kenya. (2014). CHAK HIV/AIDS Project Transforming Lives: Health Systems Strengthening. Nairobi: Author.
[35] CHAK HIV/AIDS Project (2014). CHAP Treatment Adherence Support Guide. Nairobi: Christian Health Association of Kenya.
[36] For further information on the DREAMS Initiative see http://www.pepfar.gov/partnerships/ppp/dreams/index.htm.
[37] Interfaith Health Program. (2012). *Mukuru on the move: A directory of health assets in Mukuru Kwa Njenga, Kwa Reuben, and Lunga Lung – three communities in Nairobi, Kenya.* Atlanta: Author. Retrieved from http://ihpemory.org/wp-content/uploads/2014/07/2010-MUKURU-COMMUNITY-HEALTH-ASSETS-DIRECTORY-COMPLETE-with-indices-and-introduction-2.pdf.
[38] Interfaith Health Program. (2015). *Faith, health, and development: Collaborating for sustainable HIV community care.* Atlanta: Author. Retrieved from http://ihpemory.org/wp-content/uploads/2015/02/FHCLDP-Report_Tab_Final.pdf.
[39] Office of the U.S. Global AIDS Coordinator. (2014), p. 9.
[40] Beyrer, C., Baral, S.D., van Griensven, F., Goodreau, S.M., Chariyalertsak, S., Wirtz, A., and Brookmeyer, R. (2012). Global epidemiology of HIV infection in men who have sex with men. *The Lancet, 380* (9839), 367-377.
[41] Blevins, J. & Irungu, P. Different ways of doing violence: Sexuality, religion, and public health in the lives of same-gender-loving men in Kenya. *Journal of the American Academy of Religion.* Accepted for publication. Forthcoming, 2015.
[42] Kader R., Govender R., Seedat S., Koch J.R., Parry, C. (2015). Understanding the impact of hazardous and harmful use of alcohol and/or other drugs on ARV adherence and disease progression. PLoS ONE 10(5): e0125088. doi:10.1371/journal. pone.0125088.
[43] For further information on this initiative see http://pdf.usaid.gov/pdf_docs/PA00JZH7.pdf

[44] Kagimu M. (2013). FBO and government partnerships – the experience of Uganda. *2013 Biennial Meeting of the African Christian Health Association Platform*. Lusaka, Zambia. Retrieved from http://www.ihmaidsministry.org/Docs/PMTCTreport_-_final_-_Consultation_on_the_Global_Plan_Report_-_as_of_04apr13.pdf.

[45] Orach, S. (2009). Is religion relevant for health care in Africa in the 21st century?—The Uganda Experience. *When Religion and Health Align: 2009 Conference of the African Religious Health Assets Programme.* Cape Town, South Africa. Retrieved from http://www.irhap.uct.ac.za/downloads/Wed_Orach_paper.pdf.

[46] Chand, S. and Singirankabo, I. (2009). Christians and Muslims promoting maternal and child health: A sermon/khutbah guide based on the Holy Bible and the Holy Qu'ran. Windsor, MD: IMA World Health. Retrieved from http://imaworldhealth.org/wp-content/uploads/2014/06/Rwanda_Muslim_Khutbah_Sermon_Guide_-_English.pdf.

[47] UNAIDS. (2010). *Getting to zero: 2011-2015 strategy United Nations Joint Programme on HIV/AIDS.* Geneva, Switzerland: Author. Retrieved from http://www.unaids.org/en/resources/documents/2010/20101221_JC2034_UNAIDS_Strategy.

[48] Friends of the Global Fights Against AIDS, Tuberculosis, and Malaria. (2014). *A critical partnership: The lifesaving collaboration between the global fund and faith-based organizations.* Washington, DC: Author. Retrieved from http://theglobalfight.org/wp-content/uploads/FBO_FINAL_121514.pdf.

References

Baird, J., Isbell, M., and Siringi, S. (2014). *Kenya HIV Prevention Revolution Road Map*. Nairobi: National AIDS Control Council. Retrived from http://www.nacc.or.ke/images/documents/Final.pdf.

Beyrer, C., Baral, S.D., van Griensven, F., Goodreau, S.M., Chariyalertsak, S., Wirtz, A., and Brookmeyer, R. (2012). Global epidemiology of HIV infection in men who have sex with men. *The Lancet*, *380* (9839), 367-377.

Blevins, J. & Irungu, P. Different ways of doing violence: Sexuality, religion, and public health in the lives of same-gender-loving men in Kenya. *Journal of the American Academy of Religion.* Accepted for publication. Forthcoming, 2015.

Chand, S. and Singirankabo, I. (2009). Christians and Muslims promoting maternal and child health: A sermon/khutbah guide based on the Holy Bible and the Holy Qu'ran. Windsor, MD: IMA World Health. Retrieved from http://imaworldhealth.org/wp-content/uploads/2014/06/Rwanda_Muslim_Khutbah_Sermon_Guide_-_English.pdf.

Christian Health Association of Kenya. (2014). CHAK HIV/AIDS Project Transforming Lives: Health Systems Strengthening. Nairobi: Author.

CHAK HIV/AIDS Project (2014). CHAP Treatment Adherence Support Guide. Nairobi: Christian Health Association of Kenya.

Desai, M., Phillips-Howard, P., Odhiambo, F., Katana, A., Ouma, P., Hamel, M.J., . . . Laserson, K. (2013). An Analysis of Pregnancy-Related Mortality in the KEMRI/CDC Health and Demographic Surveillance Systems in Western Kenya. PLoS One 8 (7): e68733. doi: 10.1371/journal.pone.0069733.

Friends of the Global Fights Against AIDS, Tuberculosis, and Marlaria. (2014). *A critical partnership: The lifesaving collaboration between the global fund and faith-based organizations.* Washington, DC: Author. Retrieved from http://theglobalfight.org/wp-content/uploads/FBO_FINAL_121514.pdf.

Interfaith Health Program. (2012). *Mukuru on the move: A directory of health assets in Mukuru Kwa Njenga, Kwa Reuben, and Lunga Lunga – three communities in Nairobi, Kenya.* Atlanta: Author. Retrieved from http://ihpemory.org/wp-content/uploads/2014/07/2010-MUKURU-COMMUNITY-HEALTH-ASSETS-DIRECTORY-COMPLETE-with-indices-and-introduction-2.pdf.

Interfaith Health Program. (2015). *Faith, health, and development: Collaborating for sustainable HIV community care.* Atlanta: Author. Retrieved from http://ihpemory.org/wp-content/uploads/2015/02/FHCLDP-Report_Tab_Final.pdf.

Kader R., Govender R., Seedat S., Koch J.R., Parry, C. (2015). Understanding the impact of hazardous and harmful use of alcohol and/or other drugs on ARV adherence and disease progression. PLoS ONE 10(5): e0125088. doi:10.1371/journal. pone.0125088

Kagimu M. (2013). FBO and government partnership—the experience of Uganda. *2013 Biennial Meeting of the African Christian Health Association Platform*. Lusaka, Zambia. Retrieved from http://www.ihmaidsministry.org/Docs/PMTCTreport_-_final_-_Consultation_on_the_Global_Plan_Report_-_as_of_04apr13.pdf.

Kagoyire, B. (2012). Best practices from FBOs: Sustained community-level HIV/AIDS response in Rwanda. Presentation at *PEPFAR Consultation on the Role of Faith-Based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS*. Limuru, Kenya.

Katana, A. (2015). The Connections Among PMTCT, Pediatric HIV and Maternal Child Health Services. Presentation at *Building on Firm Foundations: The 2015 Consultation on Strengthening Partnerships Between Faith-Based Organizations and PEPFAR to Build Capacity for Sustained Responses to HIV/AIDS.* Limuru, Kenya.

National AIDS Control Council. (2012). *Kenya AIDS Indicator Survey.* Nairobi: Kenya Ministry of Health.

Olivier, J., Tsimpo, C., Gemignani, R., Sojo, M., Coulombe H., Dimmock, F., . . . Wodon, Q. (2015). Understanding the roles of faith-based health care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *The Lancet.* Faith-based health care series article 1. July 7, 2015, p. 8. doi:10.1016/S0140-6736(15)60251-3.

Olivier, J., & Wodon, Q. (2012). Layers of evidence: Discourse and typologies of faith-Inspired community responses to HIV/AIDS in Africa. In J. Olivier and Q. Wodon (Eds.), *Strengthening the Evidence for Faith-Inspired Engagement in Africa, Vol. 3: Mapping, Cost, and Reach to the Poor of Faith-Inspired Health Providers in Sub-Saharan Africa* (pp. 25-51). Washington, DC: The World Bank.

Tomkins, A., Duff, J., Fitzgibbon, A., Karam, A., Mills, E.J., Munnings, K., . . .Yugi, P. (2015). Controversies in faith and health care. *The Lancet.* Faith-based health care series article 2. July 7, 2015, 1-10. doi: 10.1016/S0140-6736(15)60252-5

Office of the U.S. Global AIDS Coordinator. (2014). *PEPFAR 3.0 – Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*. Washington, DC: Author. Retrieved from http://www.pepfar.gov/documents/organization/234744.pdf.

Orach, S. (2009). Is religion relevant for health care in Africa in the 21st century?—The Uganda Experience. *When Religion and Health Align: 2009 Conference of the African Religious Health Assets Programme.* Cape Town, South Africa. Retrieved from http://www.irhap.uct.ac.za/downloads/Wed_Orach_paper.pdf.

UNAIDS. (2015). *Understanding fast track. Accelerating action to end the AIDS epidemic by 2030*. Geneva, Switzerland: Author, p. 6. Retrieved from http://www.unaids.org/sites/default/files/media_asset/201506_JC2743_Understanding_FastTrack_en.pdf.

UNAIDS. (2014a). *90-90-90 – An ambitious treatment target to help end the AIDS epidemic*. Geneva, Switzerland: Author. Retrieved from http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf.

UNAIDS. (2014b). *2014 Progress Report on the Global Plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive.* Geneva: Author. Retrieved from http://www.unaids.org/sites/default/files/documents/JC2681_2014-Global-Plan-progress_en.pdf.

UNAIDS. (2014c). *Fast track: Ending the AIDS epidemic by 2030*. Geneva, Switzerland: Author. Retrieved from http://www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf.

UNAIDS. (2014d). *Implications of the start study data: Questions and answers*. Geneva, Switzerland: Author, p. 3. Retrieved from http://www.unaids.org/sites/default/files/media_asset/2015_Implications_of_the_START_study_data_en.pdf.

UNAIDS. (2010). *Getting to zero: 2011-2015 strategy United Nations Joint Programme on HIV/AIDS.* Geneva, Switzerland: Author. Retrieved from http://www.unaids.org/en/resources/documents/2010/20101221_JC2034_UNAIDS_Strategy

United Nations Children's Fund & World Conference of Religions for Peace. (2004). *Study of the response by faith-based organizations to orphans and vulnerable children.* New York: Authors. Retrieved from http://www.unicef.org/media/files/FBO_OVC_study_summary.pdf.

U.S. Department of State. (2005). *The President's emergency plan for AIDS relief: Community and faith-based organizations.* Report to Congress mandated by Report 108-599, accompanying H.R. 4818. Washington, DC: Author. Retrieved from http://www.state.gov/documents/organization/54420.pdf.

U.S. President's Emergency Plan for AIDS Relief. (2012). *A firm foundation: The PEPFAR consultation on the role of faith-based organizations in sustaining community and country leadership in the response to HIV/AIDS*. Washington, DC: Author, pp. 23-25. Retrieved from http://www.pepfar.gov/documents/organization/195614.pdf.

Zigon, J. (2009). Morality and HIV/AIDS: A comparison of Russian orthodox church and secular NGO approaches. *Religion, State, and Society* 37(3), 311-325.

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Selected participants and organizations were interviewed or videotaped in order to provide background information and compelling examples of the important work of FBOs. Without their insights and stories, this document would consist only of empty statistics.

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Dr. Mimi Kiser	Emory University, Interfaith Health Program
Rev. Dr. William Kopwe	Christian Council of Tanzania (CCT)
Ms. Esther Kwamboka	St. Paul's University
Ms. Susan Landskroener	Emory University, Interfaith Health Program
Mr. Ikeny Loyelei	AIC Lokichoggio Health Centre
Mr. Nicholas Makau	Children of God Relief Institute
Rev. Nicta Lubaale Makiika	Organisation of African Instituted Churches (OAIC)
Dr. Simon Megiroo	Evangelical Lutheran Church in Tanzania
Dr. Esther Mombo	St. Paul's University
Mr. Michael Mugweru	Africa Christian health Associations Platform
Dr. Barbara Namata Mukasa	Mildmay Uganda
Mr. Christian T. Musenga	The Face
Ms. Jacinta Mutegi	Kenya Conference of Catholic Bishops
Dr. Zablon Bundi Mutongu	St. Paul's University
Dr. Maryann Mwangi	St. Paul's University
Mrs. Doris Mwarey	Africa Christian health Associations Platform
Dr. Samuel Mwenda	Christian Health Association of Kenya (CHAK)
Dr. Henry Mwesezi	Uganda Episcopal Conference
Mrs. Imelda Sembe Namayi	National Council of Churches of Kenya
Mr. Stephen Ngugi	Christian Aid
Mrs. Nkatha Njeru	Catholic Medical Mission Board, Kenya Office
Dr. Catherine Njigua	Christian Health Association of Kenya (CHAK)
Rev. Pauline Njiru	World Council of Churches - EHAIA
Rev. Dr. Nyambura Njoroge	World Council of Churches
Ms.. Florence Nyaoke	Gay Kenya Trust (G.K.T.)
Pastor Rebecca Nzuki	The Salvation Army
Dr. Peter Okaalet	Okaalet and Associates
Mr. Kennedy Olango	MAAYGO
Ms. Maureen Ong'ombe	Independent Consultant
Sister Mary Owens	Children of God Relief Institute—Nyumbani
Mr. Thomas Paul	Kenya Conference of Catholic Bishops (KCCB)
Ms. Marie Tunu Ramtu	Church World Service
Ms. Renee Saunders	U.S. Centers of Disease Control and Prevention
Dr. Fredrick Sawe	KEMRI/WRP
Rev. Canon MacDonald Sembereka	MANERELA+
Dr. Kennedy Serrem	Catholic Medical Mission Board, Kenya Office
Mr. Lattif Shaban	Supreme Council of Kenya Muslims (SUPKEM)
Dr. Douglas Shaffer	Office of the U.S. Global AIDS Coordinator and Health Diplomacy

Ms. Asina Shenduli	National Muslim Council of Tanzania
Mr. Kevin Shuffstall	U.S. Department of Defense
Mr. Ignace Singirankabo	Rwanda Interfaith Council on Health (RICH)
Ms. Angeline Yiamiton Siparo	Catholic Medical Mission Board, Kenya Office
Mrs. Sally Smith	Joint United Nations Programme on HIV/AIDS
Mr. Dean Surbey	Rollins School of Public Health, Emory University
Ms. Sandra Thurman	Office of the U.S. Global AIDS Coordinator and Health Diplomacy
Mr Eric Willy Uwimana	Rwanda Interfaith Council on Health (RICH)
Rev. Dr. Joseph Wandera	St. Paul's University
Mr. Vance Whitfield	Cardno Emerging Markets
His Grace Bishop Paul Yowakim	Coptic Orthodox Church

Consultation Agenda

Goal:
To identify, describe, and strengthen the distinctive contributions of faith-based organizations in support of sustained, effective, country-led responses to HIV/AIDS in collaboration with PEPFAR.

Objectives:

1. Discuss progress made on responding to key recommendations developed at the 2012 PEPFAR Consultation with Faith-Based Organizations
2. Identify and define the essential elements required to build the capacity of faith-based organizations to support a sustained response to HIV/AIDS.
3. Identify and describe innovative faith-based models for working with hard-to-reach and vulnerable communities.
4. Describe the ways in which a strengthened response for PMTCT and pediatric HIV can support maternal and child health programs.
5. Describe and define the ways in which gender impacts the risk for HIV infection and access to HIV services for women and men.
6. Describe challenges and opportunities for faith-based organizations to work with key populations.
7. Define the priorities and strategies that inform PEPFAR's global efforts.
8. Define the role of faith-based organizations and faith leaders in advocacy for universal access to HIV services.
9. Develop a set of key recommendations to guide efforts to build partnerships between faith-based organizations and PEPFAR into the future.
10. Develop strategies for faith-based organizations to effectively communicate with diverse audiences.

Host:

Professor Joseph Galgalo, Vice Chancellor, St. Paul's University

Consultation Conveners:

St. Paul's University; Emory University, Interfaith Health Program

MONDAY, APRIL 13

Participants arrive and check-in over the course of the day

6:00 PM Outdoor Reception
7:00 PM Blessing and Dinner
7:30 PM Dinner Session

Greetings
John Blevins, Associate Professor, Emory University, Interfaith Health Program
Esther Mombo, Professor, St. Paul's University, Interfaith Program on HIV and Social Justice
Vice Chancellor Joseph Galgalo, St. Paul's University

Musical Entertainment
St. Paul's University Choir, *Rev. Dr. Zebedi Muga, Director*

Background and Progress Made on Implementing Recommendations from the 2012 Consultation *Sandra Thurman,* Chief Strategy Officer and Acting Principal Deputy Director
Office of the U.S. Global AIDS Coordinator & Health Diplomacy

Question/Answer and Comments from Participants

9:00 PM Adjourn

TUESDAY, APRIL 14

8:30 AM Morning Prayer

8:40 AM PLENARY ONE: Building the Capacity of Faith-Based Organizations in Support of Their Essential Role in the Global Fight Against HIV/AIDS
Presenter: René Berger, Kenya Office, USAID

- Essential Partners: The Distinctive Contributions of FBOs to HIV Prevention, Treatment, and Care
- Mechanisms to Improve Monitoring and Evaluation
- Improving Data Management Systems
- Tracking Service Provision

10:30 AM Tea Break

11:00 AM PLENARY TWO: Valuing Every Human Life: Faith-Based Organizations and Those Who Are Vulnerable and Hard to Reach

- Making the Faith-Based Case for Services for Those Most Vulnerable
  Reverend Canon Gideon Byamugisha
- Working with Commercial Sex Workers
  Bishop Paul Yowakim, Coptic Hospital
- Working with People who Use Drugs
  Abdalla Badhrus, Program Manager for Health and Harm Reduction Services, Muslim Education and Welfare Association
- Working with HIV-Positive Adolescents
  Nicholas Makau, Lea Toto Program Director, Children of God Relief Institute
- Working with LGBT Communities
  Marie Tunu Ramtu, Church World Service

Summarizing the Key Issues
Esther Mombo, St. Paul's University, Interfaith Program on HIV & Social Justice

1:00 PM Blessing and Lunch

2:00 PM Concurrent Sessions (participants will be able to attend two of three)

2:00- 3:30 Concurrent Session One

Session One: The Connections Among PMTCT, Pediatric HIV, and Maternal and Child Health Services
Presenter: Dr. Abraham Katana, Chief of HIV Treatment and Care, Division of Global HIV/AIDS, Centers for Disease Control & Prevention, Kenya

Facilitator: Douglas Shaffer, Chief Medical Officer, Office of the U.S. Global AIDS Coordinator & Health Diplomacy

Session Two: Gender and HIV/AIDS: A Shared Responsibility Between Women and Men
Presenters: Dr. Nyambura Njoroge & Reverend Pauline Njiru, World Council of Churches

Session Three: FBOs and Key Populations: Questions, Challenges, and Opportunities
Panel comprised of representatives of key population groups
Presenter: Marie Tunu Ramtu, Church World Service
Facilitators: Esther Mombo & Gideon Byamugisha

3:30 PM — Tea Break

4:00 PM — Concurrent Sessions Continued, *Concurrent Session Two*
Sessions listed above are repeated and participants will attend a second session of their choice

5:30 PM — Adjourn

6:30 PM — Interfaith Worship Service

7:00 PM — Dinner

WEDNESDAY, APRIL 15

8:00 AM — Morning Prayer

8:10 AM — Reports from the Concurrent Sessions
Presenters: Maureen Ong'ombe, Esther Kwamboka, and Mimi Kiser

8:45 AM — PLENARY THREE: PEPFAR 3.0: Right Thing, Right Place, Right Time
Presenter: Kevin M. De Cock, M.D., Country Director, U.S. Centers for Disease Control and Prevention, Kenya

9:15 AM — PLENARY FOUR: The Role of Religious Leaders and FBOs in Advocacy: A Strong Partner in Civil Society and a Prophetic Voice of Accountability
Presenters: Reverend Canon MacDonald Sembereka, Executive Directory, MANERELA+;
Sandra Thurman, Chief Strategy Officer and Acting Principal Deputy Director, Office of the U.S. Global AIDS Coordinator & Health Diplomacy;
Sally Smith, Community Mobilization Adviser, UNAIDS

10:30 AM — Tea Break

11:00 AM — PLENARY FIVE: Moving Forward Together: An Enduring Partnership Between PEPFAR and Faith-Based Partners
Facilitators: Peter Okaalet, Maureen Ong'ombe

- Developing Key Recommendations: Evaluating 2012 Recommendations and Identifying Need for Additional Recommendations
- Finalizing Set of Key Recommendations from the 2015 Consultation

12:45 PM Final Thoughts, Acknowledgements, Closing Prayer

1:00 PM Consultation Adjourns

Following the adjournment, participants will gather in front of the Jumuia Conference Centre for a group photo.

Lunch

Following lunch, participants are free to depart. Those who pre-registered will re-convene for the Institute

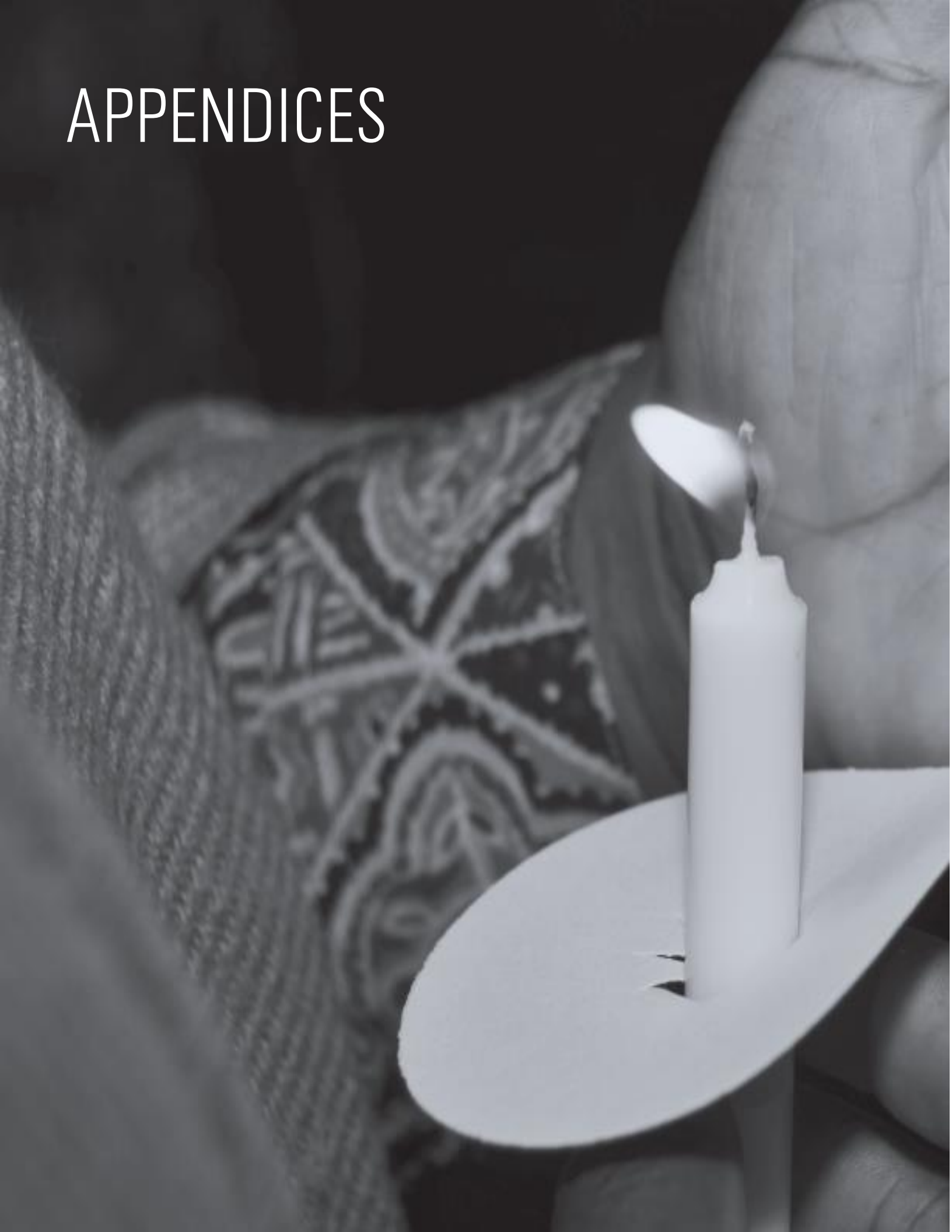
2:00-5:00 PM Optional Post-Consultation Institute
Telling Your Story: How Faith-Based Organizations Communicate Their Messages
Presenters: Veronica Davison, Acting Director for Public Affairs & Communication Office of the U.S. Global AIDS Coordinator & Health Diplomacy;
Karyn DeLuca, Communications Specialist, Interfaith Health Program, Emory University;
Andres Ilves, Founder and Principal, Ilves International

1. Not Just for Funders: How FBOs Can Use Data to Demonstrate Impact to Their Own Constituents
   FBOs often describe their work through story telling. Funders, however, require quantifiable measures and demonstrable outcomes. This module will help participants understand how to use the data required by funders to communicate impact to their core supporters and constituents. It will also highlight the importance of FBOs building their capacity to monitor activities and evaluate outcomes/outputs/impact.

2. A Human Face: How to Share Stories of People Impacted by the Work of FBOs
   This module will provide skills to help participants develop and publish effective narratives of the work of their organization. Such narratives can be effective in putting a "human face" on numbers and data.

3. The Right Platform: Print, Internet, and Social Media as Platforms for FBOs
   This module will help participants assess their communication platforms (print, web-based, etc.), identify new communications strategies, and gather resources to implement those strategies.

APPENDICES



APPENDIX I:

Summary Data for all High-Incidence and High-Burden Counties in Kenya

The data on the percentage of HIV services provided by faith-based facilities were derived from an analysis of existing data from two national-level data platforms in Kenya. The first data platform (ehealth.or.ke), maintained by the Ministry of Health in Kenya, contains information on all registered health facilities in the nation. A list of all health facilities in each county was generated along with a subset of all facilities identified as faith-based facilities. Any facilities thought to be faith-based but not listed as such were tagged. If they could be verified as faith-based (e.g., through the organization's website) they were added to the list of faith-based facilities. After the facilities master list was compiled, the second data platform was employed. This platform (hiskenya.org) contains data on health service delivery across Kenya. The MOH 731 database on the hiskenya.org platform contains summary data on HIV health services indicators developed through National AIDS and STI Control Programme (NASCOP) in Kenya. Using the hiskenya.org platform, aggregate county-level data on HIV services were generated. These data were compared to data generated through pivot tables on the faith-based facilities in each county. The percentages listed in the report are cumulative for services delivered from 2012-2014. In the county-specific information that follows, the data on incidence rank, burden rank, new infections, and number of people living with HIV comes from the *HIV Prevention Revolution Roadmap* (2014).

This analysis drew from and carried forward work funded by PEPFAR in 2013 through the Interfaith Health Program at the Rollins School of Public Health at Emory University. That work analyzed HIV service delivery in every county in Kenya with one year of data (the only data available in the hiskenya.org platform at the time). For further information on this work, see Essential Partners: The Scope of Contributions of Faith-Based Health Systems to HIV Prevention, Treatment, and Support in Kenya at http://ihpemory.org/publications/ihp-reports/.

▲HIGH–INCIDENCE COUNTIES

1. Homa Bay County
   - **High Incidence. Rank: 1** (15,003 new infections. 2.98% incidence. 14.8% of national new cases)
   - **High Burden. Rank: 2** (159,970 people living with HIV; Prevalence: 25.7%)
   - **% of services provided by FBOs**
     - Adult: 19.5% of people living with HIV on ARTs receive services from FBOs
     - VCT: 7.0% of HTC provided by FBOs
     - PMTCT: 17.2% of HTC in pregnant women provided by FBOs
     - Pediatric: 8.0% of services to children on ARTs provided by FBOs
   - **13.3% of all health facilities that provide ART services are faith-based**
   - **65.6% of all faith-based health facilities provide ART services**
     - *10 existing faith-based health facilities are not currently providing ART services:*
     - 6 CHAK (3 Dispensaries, 3 Health Centres)
     - 4 KEC (1 Dispensary, 2 Health Centres, 1 Med. Clinic)

2. Siaya County
   - **High Incidence. Rank: 2** (12,059 new infections. 2.47% incidence. 11.9% of national new cases)
     High Burden. Rank: 4 (128,568 people living with HIV; Prevalence: 23.7%)
   - **% of services provided by FBOs**
     - Adult: 10.5% of people living with HIV on ARTs receive services from FBOs
     - VCT: 10.9% of HTC provided by FBOs
     - PMTCT: 8.6% of HTC in pregnant women provided by FBOs
     - Pediatric: 38.1% of services to children on ARTs provided by FBOs
   - **12.2% of all health facilities that provide ART services are faith-based**
   - **94.1% of all faith-based health facilities provide ART services**
     - *1 existing faith-based health facility is not currently providing ART services:*
     - CHAK Dispensary

3. Kisumu County

- **High Incidence. Rank: 3** (12,645 new infections. 2.13% incidence. 12.5% of national new cases)
  High Burden. Rank: 3 (134,826 people living with HIV; Prevalence: 19.3)
- **% of services provided by FBOs**
  - Adult: 20.9% of people living with HIV on ARTs receive services from FBOs
  - VCT: 12.6% of HTC provided by FBOs
  - PMTCT: 16.3% of HTC in pregnant women provided by FBOs
  - Pediatric: 18.7% of services to children on ARTs provided by FBOs
- **18.4% of all health facilities that provide ART services are faith-based**
- **78.9% of all faith-based health facilities provide ART services**
  - *4 existing faith-based health facilities are not currently providing ART services:*
  - 1 CHAK (1 Dispensary)
  - 3 KEC (1 Dispensary, 1 Health Centre, 1 Med. Clinic)

4. Migori County

- **High Incidence. Rank: 4** (8,292 new infections. 1.56% incidence. 8.2% of national new cases)
  High Burden. Rank: 5 (88,405 people living with HIV; Prevalence: 14.7%)
- **% of services provided by FBOs**
  - Adult: 25.5% of people living with HIV on ARTs receive services from FBOs
  - VCT: 7.8% of HTC provided by FBOs
  - PMTCT: 9.9% of HTC in pregnant women provided by FBOs
  - Pediatric: 15.4% of services to children on ARTs provided by FBOs
- **19.2% of all health facilities that provide ART services are faith-based**
- **53.6% of all faith-based health facilities provide ART services**
  - *13 existing faith-based health facilities are not currently providing ART services:*
  - 8 CHAK (4 Dispensaries, 2 Health Centre, 2 Medical Clinic)
  - 5 KEC (2 Dispensaries, 2 Health Centre, 1 Medical Clinic)

5. Kisii County

- **High Incidence. Rank: 5** (5,976 new infections. .76% incidence. 5.9% of national new cases)
- **High Burden. Rank: 20** (63,715 people living with HIV; Prevalence: 8%)
- **% of services provided by FBOs**
  - Adult: 8.9% of people living with HIV on ARTs receive services from FBOs
  - VCT: 2.4% of HTC provided by FBOs
  - PMTCT: 5.6% of HTC in pregnant women provided by FBOs
  - Pediatric: 9.4% of services to children on ARTs provided by FBOs
- **5.9% of all health facilities that provide ART services are faith-based**
- **70.6% of all faith-based health facilities provide ART services**
  - *5 existing faith-based health facilities are not currently providing ART services:*
  - 2 CHAK (1 Dispensary, 1 Nursing Home)
  - 3 KEC (2 Dispensaries, 1 Medical Clinic)

6. Nyamira County

- **High Incidence. Rank: 6** (2,507 new infections. .59% incidence. 2.5% of national new cases)
- **High Burden. Rank: 3** (134,826 people living with HIV; Prevalence: 19.3%)
- **% of services provided by FBOs**
  - Adult: 4.4% of people living with HIV on ARTs receive services from FBOs
  - VCT: 7.2% of HTC provided by FBOs
  - PMTCT: 9.6% of HTC in pregnant women provided by FBOs
  - Pediatric: 3.8% of services to children on ARTs provided by FBOs
- **22.2% of all health facilities that provide ART services are faith-based**
- **93.8% of all faith-based health facilities provide ART services**

- *1 existing faith-based health facility is not currently providing ART services:*
- 1 CHAK (1 Dispensary)

7. Turkana County

- **High Incidence. Rank: 7** (3,141 new infections. .59% incidence 3.1% of national new cases)
- **Medium Burden. Rank: 11** (44,736 people living with HIV; Prevalence: 7.6%)
- **Services**
  - Adult: 59.6% of people living with HIV on ARTs receive services from FBOs
  - VCT: 59.1% of HTC provided by FBOs
  - PMTCT: 55.8% of HTC in pregnant women provided by FBOs
  - Pediatric: 56.1% of services to children on ARTs provided by FBOs
- **85%% of all health facilities that provide ART services are faith-based**
- **41.5% of all faith-based health facilities provide ART services**
  - *24 existing faith-based health facilities are not currently providing ART services:*
  - 10 CHAK (10 Dispensaries)
  - 14 KEC (13 Dispensaries, 1 VCT Programme)

8. Bomet County

- **High Incidence. Rank: 8** (1,965 new infections. .44% incidence. 1.9% of national new cases)
- **Medium Burden. Rank: 16** (27,989 people living with HIV; Prevalence: 5.8%)
- **% of services provided by FBOs**
  - Adult: 38.7% of people living with HIV on ARTs receive services from FBOs
  - VCT: 16.3% of HTC provided by FBOs
  - PMTCT: 17.2% of HTC in pregnant women provided by FBOs
  - Pediatric: 33.0% of services to children on ARTs provided by FBOs
- **20.0% of all health facilities that provide ART services are faith-based**
- **50.0% of all faith-based health facilities provide ART services**
  - *3 existing faith-based health facilities are not currently providing ART services:*
  - 1 CHAK (1 VCT)
  - 1 KEC (1 Dispensary)
  - 1 Other (1 VCT)

9. Nakuru County

- **High Incidence. Rank: 9** (4,326 new infections. .4% incidence. 4.3% of national new cases)
- **High Burden. Rank: 7** (61,598 people living with HIV; Prevalence: 5.4%)
- **% of services provided by FBOs**
  - Adult: 12.5% of people living with HIV on ARTs receive services from FBOs
  - VCT: 18.7% of HTC provided by FBOs
  - PMTCT: 40.0% of HTC in pregnant women provided by FBOs
  - Pediatric: 16.3% of services to children on ARTs provided by FBOs
- **8.1% of all health facilities that provide ART services are faith-based**
- **21.8% of all faith-based health facilities provide ART services**
  - *43 existing faith-based health facilities are not currently providing ART services:*
  - CHAK (14 Dispensaries, 3 Health Centre, 2 Medical Clinics)
  - KEC (4 Dispensaries, 2 Health Centres)
  - Other (12 Dispensaries, 2 Health Centres, 3 Medical Clinics)
  - SUPKEM (1 Dispensary)

▲HIGH–BURDEN COUNTIES

1. Nairobi County
   - **Med. Incidence. Rank: 35** (3,414 new infections. .13% incidence. 3.4% of national new cases)
   - **High Burden. Rank: 1** (177,552 people living with HIV; Prevalence: 6.8)
   - **% of services provided by FBOs**
     - Adult: 47.3% of people living with HIV on ARTs receive services from FBOs
     - VCT: 38.4% of HTC provided by FBOs
     - PMTCT: 26.5% of HTC in pregnant women provided by FBOs
     - Pediatric: 50.7% of services to children on ARTs provided by FBOs
   - **23.9% of all health facilities that provide ART services are faith-based**
   - **54.5% of all faith-based health facilities provide ART services**
     - *55 existing faith-based health facilities are not currently providing ART services:*
     - 19 CHAK facilities (9 Dispensaries, 2 Health Centres, 8 Medical Clinics)
     - 18 KEC facilities (9 Dispensaries, 2 Health Centres, 5 Medical Clinics, 1 Nursing Home, 1 hospital)
     - 16 Other Faith-Based (3 Dispensaries, 4 Health Centres,8 Medical Clinics, 1 hospital)
     - 2 SUPKEM (1Dispensary, 1 Medical Clinic)

2. Homa Bay County
   - **High Incidence. Rank: 1** (15,003 new infection. 2.98% incidence. 14.8% of national new cases)
   - **High Burden. Rank: 2** (159,970 people living with HIV; Prevalence: 25.7%)
   - **% of services provided by FBOs**
     - Adult: 19.5% of people living with HIV on ARTs receive services from FBOs
     - VCT: 7.0% of HTC provided by FBOs
     - PMTCT: 17.2% of HTC in pregnant women provided by FBOs
     - Pediatric: 8.0% of services to children on ARTs provided by FBOs
   - **13.3% of all health facilities that provide ART services are faith-based**
   - **65.6% of all faith-based health facilities provide ART services**
     - *10 existing faith-based health facilities are not currently providing ART services:*
     - 6 CHAK (3 Dispensaries, 3 Health Centres)
     - 4 KEC (1 Dispensary, 2 Health Centres, 1 Med. Clinic)

3. Kisumu County
   - **High Incidence. Rank: 3** (12,645 new infections. 2.13% incidence. 12.5% of national new cases)
     High Burden. Rank: 3 (134,826 people living with HIV; Prevalence: 19.3%)
   - **% of services provided by FBOs**
     - Adult: 20.9% of people living with HIV on ARTs receive services from FBOs
     - VCT: 12.6% of HTC provided by FBOs
     - PMTCT: 16.3% of HTC in pregnant women provided by FBOs
     - Pediatric: 18.7% of services to children on ARTs provided by FBOs
   - **18.4% of all health facilities that provide ART services are faith-based**
   - **78.9% of all faith-based health facilities provide ART services**
     - *4 existing faith-based health facilities are not currently providing ART services:*
     - 1 CHAK (1 Dispensary)
     - 3 KEC (1 Dispensary, 1 Health Centre, 1 Med. Clinic)

4. Siaya County

- **High Incidence. Rank: 2** (12,059 new infections. 2.47% incidence. 11.9% of national new cases)
  High Burden. Rank: 4 (128,568 people living with HIV; Prevalence: 23.7%)
- **% of services provided by FBOs**
  - Adult: 10.5% of people living with HIV on ARTs receive services from FBOs
  - VCT: 10.9% of HTC provided by FBOs
  - PMTCT: 8.6% of HTC in pregnant women provided by FBOs
  - Pediatric: 38.1% of services to children on ARTs provided by FBOs
- **12.2% of all health facilities that provide ART services are faith-based**
- **94.1% of all faith-based health facilities provide ART services**
  - *1 existing faith-based health facility is not currently providing ART services:*
  - 1 CHAK Dispensary

5. Migori County

- **High Incidence. Rank: 4** (8,292 new infections. 1.56% incidence. 8.2% of national new cases)
  High Burden. Rank: 5 (88,405 people living with HIV; Prevalence: 14.7%)
- **% of services provided by FBOs**
  - Adult: 25.5% of people living with HIV on ARTs receive services from FBOs
  - VCT: 7.8% of HTC provided by FBOs
  - PMTCT: 9.9% of HTC in pregnant women provided by FBOs
  - Pediatric: 15.4% of services to children on ARTs provided by FBOs
- **19.2% of all health facilities that provide ART services are faith-based**
- **53.6% of all faith-based health facilities provide ART services**
  - *13 existing faith-based health facilities are not currently providing ART services:*
  - 8 CHAK (4 Dispensaries, 2 Health Centre, 2 Medical Clinic)
  - 5 KEC (2 Dispensaries, 2 Health Centre, 1 Medical Clinic)

6. Kisii County

- **High Incidence. Rank: 5** (5,976 new infections. .76% incidence. 5.9% of national new cases)
- **High Burden. Rank: 20** (63,715 people living with HIV; Prevalence: 8%)
- **% of services provided by FBOs**
  - Adult: 8.9% of people living with HIV on ARTs receive services from FBOs
  - VCT: 2.4% of HTC provided by FBOs
  - PMTCT: 5.6% of HTC in pregnant women provided by FBOs
  - Pediatric: 9.4% of services to children on ARTs provided by FBOs
- **5.9% of all health facilities that provide ART services are faith-based**
- **70.6% of all faith-based health facilities provide ART services**
  - *5 existing faith-based health facilities are not currently providing ART services:*
  - 2 CHAK (1 Dispensary, 1 Nursing Home)
  - 3 KEC (2 Dispensaries, 1 Medical Clinic)

7. Nakuru County

- **High Incidence. Rank: 9** (4,326 new infections. .4% incidence. 4.3% of national new cases)
- **High Burden. Rank: 7** (61,598 people living with HIV; Prevalence: 5.4%)
- **% of services provided by FBOs**
  - Adult: 12.5% of people living with HIV on ARTs receive services from FBOs VCT: 18.7% of HTC provided by FBOs
  - PMTCT: 40.0% of HTC in pregnant women provided by FBOs
  - Pediatric: 16.3% of services to children on ARTs provided by FBOs
- **8.1% of all health facilities that provide ART services are faith-based**
- **21.8% of all faith-based health facilities provide ART services**
  - *43 existing faith-based health facilities are not currently providing ART services:*

- CHAK (14 Dispensaries, 3 Health Centre, 2 Medical Clinics)
- KEC (4 Dispensaries, 2 Health Centres)
- Other (12 Dispensaries, 2 Health Centres, 3 Medical Clinics)
- SUPKEM (1 Dispensary)

8. Kakamega County

- **Low Incidence. Rank: 43** (327 new infections. .02% incidence. .3% of national new cases)
- **High Burden. Rank: 8** (57,952 people living with HIV; Prevalence: 5.9%)
- **22.3% of ART services are provided by FBOs**
- **% of services provided by FBOs**
  - Adult: 21.1% of people living with HIV on ARTs receive services from FBOs
  - VCT: 30.6% of HTC provided by FBOs
  - PMTCT: 40.0% of HTC in pregnant women provided by FBOs
  - Pediatric: 5.7% of services to children on ARTs provided by FBOs
- **11.9% of all health facilities that provide ART services are faith-based**
- **65.6% of all faith-based health facilities provide ART services**
  - *13 existing faith-based health facilities are not currently providing ART services:*
  - 2 CHAK (2 Dispensaries)
  - 2 KEC (2 Dispensaries)
  - 9 Other (6 Dispensaries, 1 Health Centre, 1 Medical Clinic, 1 Other Hospital)

9. Mombasa County

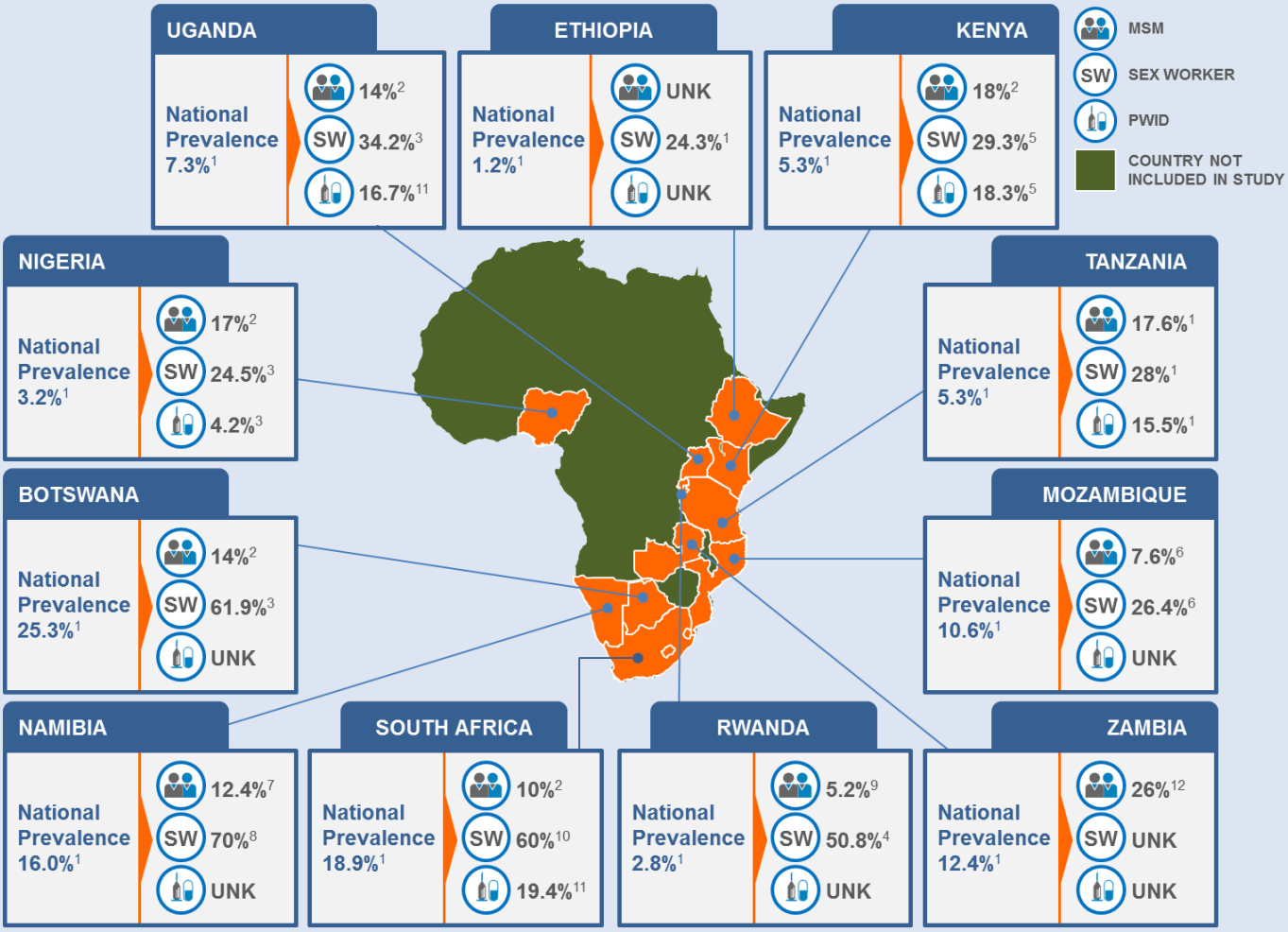
- **Medium Incidence. Rank: 18** (4,326 new infections. .4% incidence. 4.3% of national new cases)
- **High Burden. Rank: 9** (53,700 people living with HIV; Prevalence: 5.3%)
- **% of services provided by FBOs**
  - Adult: 52.3% of people living with HIV on ARTs receive services from FBOs
  - VCT: 12.2% of HTC provided by FBOs
  - PMTCT: 20.1% of HTC in pregnant women provided by FBOs
  - Pediatric: 33.5% of services to children on ARTs provided by FBOs
- **11.9% of all health facilities that provide ART services are faith-based**
- **46.7% of all faith-based health facilities provide ART services**
  - *8 existing faith-based health facilities are not currently providing ART services:*
  - 2 CHAK (1 Dispensary, 1 Medical Clinic)
  - 4 KEC (1 Dispensary, 1 Health Programme, 1 Medical Clinic, 1 Nursing Home)
  - 2 Other (1 Medical Clinic, 1 Nursing Home)

10. Kiambu County

- **Medium Incidence. Rank: 17** (3,027 new infections. .26% incidence. 3.0% of national new cases)
- **High Burden. Rank: 10** (46,656 people living with HIV; Prevalence: 3.8%)
- **% of services provided by FBOs**
  - Adult: 34.6% of people living with HIV on ARTs receive services from FBOs
  - VCT: 14.8% of HTC provided by FBOs
  - PMTCT: 15.8% of HTC in pregnant women provided by FBOs
  - Pediatric: 18.9% of services to children on ARTs provided by FBOs
- **29.6% of all health facilities that provide ART services are faith-based**
- **17.6% of all faith-based health facilities provide ART services**
  - *67 existing faith-based health facilities are not currently providing ART services:*
  - 20 CHAK (16 Dispensaries, 1 Health Centres, 3 Medical Clinics)
  - 21 KEC (12 Dispensaries, 2 Medical Clinics, 3 Health Centres, 4 Other Hospitals)
  - 25 Other (12 Dispensaries, 7 Health Centres, 1 Health Program, 3 Medical Clinics, 2 Other Hospitals)
  - 1 SUPKEM (! Health Centre)

APPENDIX II:
HIV prevalence of key populations in select countries in sub-Saharan Africa

NOTE: Data on HIV prevalence for MSM, Sex Workers, and PWID are not complete. Many governments do not gather epidemiological data on HIV disease for these communities in their countries. All HIV prevalence data cited in the figure are drawn from peer-reviewed sources or from data platforms and program reports of organizations that are recognized leaders in the global response to HIV. Whenever possible, data is drawn from the same source: 2014 HIV prevalence data compiled by UNAIDS (all country level prevalence is from UNAIDS). However, UNAIDS reports no data for key populations for many countries. In such instances, other data sources have been used. When more than one 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.



1 Joint United Nations Programme on HIV/AIDS. (UNAIDS) Prevalence data, 2014. (http://aidsinfo.unaids.org).
2 United Nations Joint Programme on HIV/AIDS. (2014). The gap report. Geneva, Switzerland: Author.
3 Joint United Nations Programme on HIV/AIDS. (UNAIDS) Prevalence data, 2013. (http://aidsinfo.unaids.org).
4 Joint United Nations Programme on HIV/AIDS. (UNAIDS) Prevalence data, 2011. (http://aidsinfo.unaids.org).
5 National AIDS Control Council. (2014). Kenya AIDS progress report: Progress towards zero. Nairobi: Author.
6 Conselho Nacional de Combate ao HIV e SIDA. (2014). Global AIDS response progress report: Mozambique country report. Maputo: Author.
7 Ministry of Health and Social Services. Global AIDS response progress reporting 2013. Windhoek: Author.
8 UNAIDS Namibia. (2011). Sex work and HIV in Namibia: Review of the literature and current programmes. Windhoek: UNFPA Namibia and UNAIDS Namibia.
9 Binagwaho, A. (2009). Exploring HIV Risk Among MSM in Kigali, Rwanda. Chapel Hill, NC: MEASURE Evaluation.
10 South African National AIDS Council. (2013). National strategic plan for HIV prevention, care and treatment for sex workers. Pretoria, South Africa: Author.
11 Harm Reduction International. (2014). The global state of harm reduction 2014. London: Author.
12 Mwansa, C.C. & Musonda, M.L.K. (2014, July). Sexual risk behaviors of gay and MSMs in Zambia. Poster session presented the International AIDS Conference. Melbourne, Australia

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