

# Faith and HIV in the Next Decade: Mobilizing Religious Communities to End the HIV Epidemic

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## CONTRIBUTORS' STATEMENT

*We all hope that the 2020s will be the last decade of the HIV and AIDS epidemic—that by 2030 HIV and AIDS will no longer be threats to public health. Religious leaders and institutions have key roles to play if the global effort to end the epidemic is to succeed. Meaningful and engaged strategic planning can help ensure that those key roles are played effectively, and that religious leaders and institutions are strong helpful partners in ending the HIV epidemic.*

*"When religious communities agree on a common cause, they can successfully transcend the confines of their doctrines."*

*-Rev. Phumizile Mabizela*

*The opinions and recommendations contained in this paper represent the collective contributions of this group of individuals. They do not necessarily represent the policies or positions of the organizations with which these individuals are associated.*

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## PREFACE

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We are a group of individuals committed to mobilizing religious communities in the fight against HIV and AIDS. We share the world's hope that the 2020s will be the last decade of the epidemic—that by 2030 HIV and AIDS will no longer be threats to public health. We believe that religious institutions and faith-based organizations have key roles to play if the global effort to end the epidemic is to succeed. With the hope of ensuring that those roles are played well, we have developed a set of strategic recommendations for religious leaders and institutions and other faith-based organizations about how best to mobilize religious communities in the fight against HIV and AIDS during the 2020s. These recommendations include: (1) the establishment of national targets for HIV outcomes of local religious communities and for the reduction of societal stigma; (2) a substantial capacity-building program for local religious leaders using materials that are culturally relevant in their local contexts; (3) close engagement between religious and secular institutions in the planning and execution of multi-year initiatives; and (4) advocacy at all levels for universal access to HIV prevention and treatment services.

Our recommendations are the result of a several month online consultation process. Early in the process, we took an informal poll among ourselves about the impact of religion during the first four decades of the HIV epidemic. Of the 34 responses, more than two-thirds thought that religion had been both helpful and harmful. During the fifth decade of the HIV epidemic, we must take many more helpful actions and many fewer harmful actions. We hope that in 2030, the overwhelming response to the same question will be that religion has been very helpful in ending the HIV epidemic.

It has been ten years since the development of the UNAIDS Strategic Framework for Partnership with Faith-Based Organizations. Our recommendations largely reinforce the key elements of that framework. Perhaps the greatest difference is our emphasis on building capacity within local religious communities and the role of national interreligious coalitions in establishing quantitative targets that are aligned with the UNAIDS Fast Track strategy.

We began this initiative before the gravity of the COVID-19 pandemic became apparent. Our recommendations have not changed, but the context for implementing them has changed dramatically. Public health systems are stressed to the breaking point. The global economy has been shaken, and the poor and marginalized have suffered the most. Many countries are racked by unprecedented social and political unrest. The global institutions that have shaped the response to both HIV and COVID-19 are being weakened by national rivalries. The future feels very uncertain.

But in the midst of this uncertainty, there is still certainty about HIV. The HIV epidemic is not yet over, and a dramatically strengthened religious response will be required to end it.

*"Faith and HIV in the Next Decade' responds to a call from Georgetown colleague Maeve McKean during a September 2019 dialogue—to link continuing, creative research that moves ahead of scientific and social changes to collective action, that truly draws on shared wisdom and energy to bring about change. The vastly diverse religious communities worldwide have vital roles to play during the 2020s, combining care and compassion with a grounded appreciation for lived realities. Mobilization to address HIV has already brought public health and religious communities closer together, recalibrating understandings and moral compasses on both sides. This strategy highlights the path for a continuing journey in the decade ahead."*

*-Katherine Marshall*

## SUMMARY

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Religious leaders and institutions have been a vital part of the global response to HIV and AIDS since the early days of the epidemic. However, the faith-based response to HIV must be scaled up significantly if we are to end the HIV epidemic by 2030. The faith-based response must be strong enough to achieve the following success criteria:

- People who actively participate in religious communities meet or exceed the HIV epidemiological targets for the general population;
- Religiously affiliated HIV prevention and treatment centers provide services without stigma, discrimination, or risk of criminal prosecution;
- People living with HIV or at risk of HIV infection who wish to be members of a religious community participate in a religious community that affirms their value as human beings; and
- In high-burden countries and regions, local religious communities are significantly more helpful than harmful in addressing stigma related to HIV.

A coordinated interfaith strategy will be required to meet these criteria by 2030. The key elements of the strategy include:

- strong advocacy by prominent religious leaders to raise awareness and stimulate global action to end the HIV epidemic;
- mobilization and empowerment of local religious leaders and communities, both to ensure good HIV outcomes for members and to reduce societal stigma related to HIV;
- coordination of national HIV initiatives through interreligious coalitions that set targets for the faith-based response and track actions designed to achieve the targets;
- widespread training for religious leaders based on materials that are culturally relevant and in local languages;
- active engagement with other authorities in planning and execution of national and international HIV strategies;
- advocacy at all levels for universal access to HIV prevention and treatment services that are free of stigma, discrimination, or risk of criminal prosecution; and
- expansion of the body of scientific evidence about the effectiveness of faith-based interventions in the HIV epidemic.

These elements are embodied in a set of recommended actions and activities for a variety of religious institutions and faith-based organizations, as well as secular organizations involved in the response to HIV and AIDS.

Near-term activities that will lay a solid foundation for executing the strategy during the rest of the 2020s include:

- issuing a strong interfaith statement of advocacy and commitment on World AIDS Day;
- analyzing the impact of religion in countries that have achieved Fast Track targets;
- promoting the sharing of HIV experiences among local religious communities;
- engaging with UNAIDS in strategic planning before the UN High-Level Meeting on Ending AIDS in June 2021; and
- encouraging increased dialogue between national interreligious coalitions and people living with HIV or at risk of HIV infection.

## FOUR DECADES OF FAITH AND HIV

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We are nearing the end of the fourth decade of the HIV and AIDS epidemic. What began in the 1980s as a mysterious deadly disease that ravaged certain population groups had become a global epidemic in the 1990s, with frightening levels of new infections and deaths. In the 2000s and 2010s, thanks to one of the greatest humanitarian efforts in history, the rates began to decline, and HIV infection has become a manageable medical condition. We now have the scientific knowledge and medical tools to bring the epidemic under control and ultimately bring it to an end.

But we are not there yet. As of the end of 2019, almost 33 million people have died from AIDS-related causes, there are 38 million people living with HIV, and new infections and deaths continue. In 2015, UNAIDS launched an ambitious program with the ultimate goal of ending the HIV epidemic by the year 2030. The Fast Track program established global targets for the year 2020 as a key milestone, expressed as 90-90-90: 90% of the people living with HIV know their status, 90% of those are receiving treatment, and 90% of those have achieved viral suppression. We now know that we will fall short of the Fast Track goals. As of the end of 2019, we have achieved 81-82-88 globally, which means that only a little more than half of the people living with HIV have achieved viral suppression, and the rates of new HIV infections have remained much higher than expected. Some countries and cities are likely to achieve the Fast Track goals by 2020, but globally we will fall short. And for some vulnerable and marginalized populations, the current state of the epidemic is much worse than for the general population.

In 2020, the global HIV response has also been impacted by the COVID-19 pandemic. We do not yet know the full extent of the impact, but there are indications that fear of infection by this new virus, as well as COVID-19 prevention measures, have made it more difficult for people to access their HIV medications. The economic impact of COVID-19 will also likely set us back, both through its effects on the vulnerable and marginalized and by weakening the global financial commitment to ending HIV.

Heading into the fifth decade, we even see risks of a resurgence. A global sense of complacency has led to continued shortfalls in the funding needed to ensure that the medical tools are available for all who need them. There is a risk of a major bulge of new infections among young people, and social issues like stigma and discrimination continue to be significant barriers. In fact, whether or not the 2020s are the last decade of the HIV epidemic will depend largely on how well we deal with related social issues.

Religious institutions and faith-based organizations have been a significant part of the global response to AIDS and HIV since the earliest days of the epidemic. Faith-based hospitals and clinics are an important component of the public health infrastructure in many countries. Local religious communities of all traditions have been providing care to people living with HIV for decades. Faith-based relief and development organizations have launched major projects to combat HIV. Religious leaders have been strong advocates, both locally and globally, for universal access to HIV prevention and treatment services and have been influential in promoting international humanitarian initiatives to fight HIV.

But the religious response to HIV has not always been helpful. Some religious leaders have described HIV infection as divine punishment for immoral behavior. Religious doctrine has sometimes been used to justify judgmental attitudes toward people living with HIV or toward marginalized and vulnerable

*"As a religious leader living with HIV, I witnessed the powerful transformation within religious leaders and communities over the past 30 years from resistors to transformers."*

*-Rev. Christo Greyling*

populations at risk of HIV infection. The resulting stigma and discrimination have been significant barriers to access for many people who need HIV prevention and treatment services.

To be sure, there have been important faith-based initiatives to address stigma and discrimination, including the promotion of dialogue between religious leaders and those who have felt judged by religion, as well as strong actions against stigma and in favor of universal access by many religious leaders and communities. But there have not been enough. If religious institutions and faith-based organizations are

*"The HIV/AIDS pandemic, TB, and COVID-19 have underlined the fact that we live in one world and that our destiny is dependent on how we take care of one another on a global scale."*

*-Dr. Renier Koegelenberg*

to play a significant role in addressing the social drivers of the HIV epidemic, then we will need to take many fewer of the harmful actions and many more of the helpful ones.

Looking ahead to the next, and hopefully last, decade of the HIV epidemic, religious institutions and faith-based organizations have three distinct capabilities with the potential for dramatically affecting the global effort to end the HIV epidemic:

- Local religious communities are strong communities of caring. Members are concerned about the health and well-being of all and will do what they can to help. They meet regularly, providing opportunities to share information and concerns. Their leaders hold positions of trust and authority, giving them significant influence on public attitudes.
- Religious institutions have broad geographic reach and long-term presence. Local religious communities are ubiquitous and their organization into national and international structures provides opportunities for large-scale projects and initiatives.
- Religious leaders can serve as a global conscience. Based on shared sacred values of respect for all human beings, protection of the vulnerable, and inclusion of the marginalized, religious leaders can be the voice the world needs to hear.

The strategic recommendations contained in this report are intended to help all religious leaders and communities fully reach their potential to help the world finally bring an end to the HIV epidemic.

# STRATEGIC PLAN FOR THE NEXT DECADE

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The strategic plan embodied in this document has seven key elements:

- **Specific success criteria for the religious response to HIV in the 2020s.** These five criteria address the key results that the religious response must achieve, including improved HIV outcomes as well as significant reduction in stigma and discrimination.
- **Strong advocacy by prominent religious leaders to raise awareness and stimulate global action to end the HIV epidemic.** Prominent religious leaders and interreligious coalitions must continue to raise awareness that the HIV epidemic is not over and to advocate strongly for universal access to HIV prevention and treatment services, free from stigma, discrimination, and fear of criminal prosecution.
- **Mobilization and empowerment of local religious leaders and communities.** Local religious communities play a vital role in two areas: improving the HIV outcomes of their members, and reducing HIV-related stigma among members and within the wider community.
- **Coordination of national HIV initiatives through interreligious coalitions.** National religious institutions and interreligious coalitions should ensure that the response is as interfaith as possible, establish national targets for the faith-based response, and work closely with other national institutions planning and executing national strategies.
- **Widespread training for religious leaders based on materials that are culturally relevant, scientifically correct, and in local languages.** Although many local religious communities have already implemented effective HIV programs, many more will require training, materials, and other resources in order to implement the strategy effectively.
- **Active engagement with other authorities in planning and executing national and international HIV strategies.** National and international strategies are most effective when they include all stakeholders, including religious institutions and faith-based organizations. When these national HIV strategies include activities by religious organizations, it is important to ensure that those activities are adequately funded.
- **Expansion of the body of scientific evidence about the effectiveness of faith-based interventions in the HIV epidemic.** The response of faith-based organizations to the HIV epidemic, like the response of secular organizations, must be grounded in scientific evidence, and religious institutions and faith-based organizations must contribute to data gathering and analysis.

*"We now have a map to guide our concerted efforts for the next decade as we work together more effectively toward a world without HIV."*

*-John Blevins*

## *Goals and Success Criteria*

The goal of this strategic plan is to mobilize the power of religious communities to contribute substantially to ending the HIV epidemic by 2030. If we are successful:

- **In 2030, HIV and AIDS will no longer be threats to public health, globally and within all regions and demographic groups.** This goal is shared by all partners in the global response to the HIV and AIDS epidemic. It is the primary goal that we all hope to achieve: that the 2020s are the last decade of the epidemic. And it is a goal that applies overall, including vulnerable and marginalized populations. By 2030, no one will have been left behind.
- **Religious leaders, communities, institutions, and other faith-based organizations are strong partners in the global response to the HIV epidemic.** This goal reflects the distinct contributions that faith-based actors can and should make in the global response to HIV—not only through prevention, treatment, care, and support—but also by addressing the social drivers, such as stigma and discrimination. If the 2020s are to be the last decade of the epidemic, then faith-based actors must be strong, trusted, and helpful partners.

We believe that it will be impossible to achieve the first goal without also achieving the second goal.

How will we know if the strategy has been successful and we have achieved the second goal? We suggest the following five criteria:

- **People who actively participate in religious communities meet or exceed the HIV epidemiological targets for the general population.** There are two primary epidemiological targets for the general population in 2030: 95-95-95 on the treatment cascade, and an incidence/prevalence ratio below 0.03. There may be some religious communities that do not achieve these targets in 2030. However, if the faith-based response is successful, there will be enough religious communities that exceed the targets to offset those that do not.
- **Religiously affiliated HIV prevention and treatment centers provide services grounded in scientific evidence and reflective of best practices without stigma, discrimination, or risk of criminal prosecution.** Achieving the epidemiological targets for the general population will require universal access to HIV prevention and treatment services delivered in the best possible way. In contexts where stigma, discrimination, laws, and policies are barriers to accessing HIV services, religious institutions should be on the forefront in overcoming the barriers and providing services to all who need them.
- **People living with HIV, or at high risk of HIV infection, who wish to be members of a religious community participate in a religious community that welcomes them and affirms their value as human beings.** Different religious communities meet the needs of their members differently. In the context of the HIV epidemic, it is important that people living with HIV, or at high risk of HIV infection, be able to find religious communities that affirm their value as human beings and address their spiritual needs with dignity and respect.
- **In high-burden countries and regions, local religious communities are significantly more helpful than harmful in addressing stigma related to HIV.** Local religious leaders and communities have a significant effect on the attitudes of their members and of the wider community. In the context



of the HIV epidemic, this effect may sometimes be helpful in reducing societal stigma, or the effect may sometimes be harmful, or it may be neutral. If stigma is to be reduced significantly, then we will need many more helpful local religious communities than harmful ones.

- **Many more people perceive religious leaders, communities, institutions, and other faith-based organizations as helpful partners in the global and national response to HIV and AIDS than perceive them as barriers to ending the epidemic.** Although, in some sense, public perception should not matter as long as the goals are achieved, the faith-based response to the HIV epidemic will be more effective if the perception matches the reality and if the contributions of the faith-based response are recognized as helpful.

Given the current state of knowledge, it is difficult or impossible to track some of these criteria and to set appropriate targets. As discussed later in this document, several research questions must be addressed in order to be able to measure these criteria.

*"At the end of the day it is preaching and worship and ordained and lay collaboration that will make the difference. After almost 40 years, those are what people living with and at risk for HIV still seek—faith communities where we are welcomed and supported and loved."*

*-Jesse Milan, Jr.*

## Recommendations

Our strategic plan is expressed as recommendations to various types of religious institutions and faith-based organizations that are part of the global response to HIV and AIDS. The diversity of these institutions prevents a simple classification. Nonetheless, for the purposes of these strategic recommendations, it is helpful to identify broad categories that play different roles in the strategy.

**Local religious communities:** Local religious communities include informal and formal communities that encourage and support worship and spirituality for their members. Studies have shown that, in many high-burden countries, a very large fraction of the population worships regularly in such communities, giving organized religious communities and institutions an especially influential role.

**National and international religious communities:** National and international religious communities are the hierarchical levels of organizations that include many local religious communities. Different religious communities may be organized at different levels with differing degrees of control, influence, or autonomy.

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

**National and international interreligious coalitions:** Interreligious coalitions bring together representatives of different religious traditions for dialogue and joint action. Different coalitions have different scope and reach, both theologically and geographically.

In presenting our strategic recommendations, we will use this classification scheme to identify specific audiences for different recommendations.

### Local Religious Communities

Local Religious Communities have played a significant role in the faith response to HIV throughout the four decades of the epidemic. That role must be scaled up substantially if we are to end the HIV epidemic in the next decade. Studies have consistently shown that large fractions of the population of most countries regularly participate in the activities of local religious communities, often attending services on a weekly basis. That fact alone represents a significant leverage point in the battle against HIV.

*"We can influence communities through their faith leaders whom they trust and believe."*

*-Nkatha Njeru*

We recommend that local religious communities in high-burden countries focus on three areas in response to the HIV epidemic.

First, develop programs to improve the HIV outcomes of members. The details of such programs will differ depending on the local context, but effective programs generally include three main elements:

- **Provide accurate information about HIV and AIDS to members of the local religious community.** Unfortunately, even in high-burden areas, many people do not have sufficient accurate and scientifically correct information about HIV and AIDS. A good information campaign can take many forms, including weekly messages, information materials, discussion groups, and social media communications. It is especially important to counter false information.

- **Provide support for members living with HIV.** Provide clear messages during weekly gatherings that infection with HIV is a medical issue and that proper medical treatment enables a long and productive life. Proper medical treatment includes knowing one's status, adhering to medical protocols, and ultimately achieving viral suppression. Depending on the societal context, it may also be important to remind members that they should not rely exclusively on faith healing. Different approaches may be best for different groups of people: men, women, young people, children, pregnant mothers, as well as members who have been marginalized. For many people, counseling services and support groups can be very helpful.
- **Educate and empower members to prevent HIV transmission.** Educate members about all methods of preventing HIV transmission, including mutual abstinence, viral suppression through treatment, condoms, medical male circumcision, pre- and post-exposure prophylaxis, ARV treatment for pregnant and breastfeeding women, and sterile needles, among others. Knowledge about all methods will help members make wise and safe decisions to avoid either becoming infected with HIV or transmitting HIV to someone else.

Second, address the social drivers of the HIV epidemic openly. Again, the details will depend on the social context of the religious community. We recommend the following at a minimum:

- **Frequently and repeatedly deliver clear messages about the inherent dignity and worth of all human beings.** Messages from religious leaders about the importance of treating all people with dignity and respect can significantly reduce stigmatizing attitudes. Importantly, these messages must include people of other religious traditions as well as marginalized populations at risk of HIV infection, such as men who have sex with men, sex workers, and people who inject drugs.

*"We won't end the HIV epidemic by 2030 if we don't address the social issues, and we can't solve the social issues without strong action from religious communities."*

*-Dr. David Barstow*

- **Speak openly about societal practices and domestic issues that increase the risk of HIV infection.** Some issues are common in many societies, such as gender-based violence. Other issues may be relevant in localized contexts, such as female genital mutilation or child marriage.
- **Actively engage with marginalized populations.** Stigmatizing attitudes can often be broken down through personal communication among members of local religious communities, people living with HIV, and marginalized populations including men who have sex with men, sex workers, and people who inject drugs. Local religious communities can encourage such communication in a variety of ways, including personal testimonies at weekly gatherings or facilitated discussion groups. It is vital that the communication occur in a non-threatening and non-judgmental setting.

Third, work actively with other HIV organizations within the community. We recommend the following actions and activities:

- **Work with other local religious communities to develop youth-friendly centers where young people can have open discussions about life skills.** Young people face many challenges as they mature into adulthood. The opportunity to discuss these challenges in non-threatening environments can help them understand the challenges and make wise decisions. These support groups should be led by trained facilitators with possibilities for peer-led or peer-to-peer discussions. It can also be helpful to conduct these discussion groups in an interfaith setting which young people may find less threatening.

- **Establish partnership activities with religious and secular organizations in the local community.** Ending the HIV epidemic requires joint effort from religious leaders and other community-based organizations, learning institutions, and health departments. They must combine their efforts together in the fight against HIV. Partnership activities could include public forums for awareness, testing campaigns, and advocacy events, as well as a referral system to ensure that all community members find HIV service providers that are appropriate to their individual circumstances.

It is important to note that many local religious communities already implement many of these actions and activities. In many other cases, however, it will be important to provide training to the leaders of the local religious communities in order to ensure that the actions and activities are implemented effectively. Widespread training is one of the key elements of this strategy and is discussed later in this document.

### *National Religious Initiatives*

During the next decade of the HIV epidemic, most of the global response to the epidemic will be coordinated and implemented by the national leadership of high-burden countries. It is important that

*"National governments, multilateral organizations, and non-government partners in the AIDS fight at national and local levels have a great deal to gain from including religious leaders and faith-based organizations in national strategies and HIV and AIDS prevention, treatment, and care programs."*

*-Jimmy Kolker*

the faith-based response within a country be well integrated with other elements of its national strategy. Two types of religious institutions are especially important in this national integration: national religious communities and national interreligious coalitions.

One important role of national religious communities is to support and empower their affiliated local religious communities. We recommend that national religious communities implement the following three actions and activities in order help their local religious communities implement effective HIV programs:

- **Provide training and materials for local religious leaders and communities.** The training and materials may include guidance about how to develop and implement effective HIV programs at the local level, as well as suggestions for how to deal with challenging social and spiritual complexities. Peer-to-peer training can be very effective. Material should be made available in local languages.
- **Track the actions and activities of local religious communities as they address the HIV epidemic.** Develop a simple mechanism for affiliated local religious communities to provide information about the key elements of the local response, such as training, messaging at weekly gatherings, support groups, testing campaigns, educational campaigns, and outreach to marginalized populations. Collect this information and produce national summaries on a regular basis.
- **Study and analyze the interaction between religious doctrine and public health.** The nature of the HIV epidemic forces us to reflect deeply about the interaction between religious doctrine and public health. It is important for religious leaders to study this interaction and to develop approaches that promote public health in ways that are consistent with their religious traditions. These approaches should be shared with affiliated local religious leaders.

Many high-burden countries already have national interreligious coalitions that have been heavily involved in the national HIV response. If a country does not already have an active interreligious coalition, we strongly recommend that the leaders of diverse religious traditions get together to form one. In order to be effective, the coalition must represent a large majority of the national population that participates regularly in the activities of religious communities. Once formed, such bodies can play several roles.

First, they can coordinate HIV initiatives across religious traditions. Such coordination involves two primary activities:

- **Develop guidelines for local religious communities that reflect the national context and that cross religious boundaries.** There are many elements of an HIV response that can be used effectively by different religious traditions. For example, guidelines might cover interventions such as support groups to help people living with HIV remain on treatment, testing campaigns to encourage members to know their HIV status, and educational materials about HIV prevention methods. Different religious traditions might implement the guidelines differently, but consistent guidelines across traditions will help ensure that the national interfaith response is effective and also make it easier to track the aggregated response of local religious communities.
- **Set national targets for the religious response to HIV and work with national religious communities to track the HIV activities of local religious communities.** National interreligious coalitions are well positioned to set national targets for the faith-based response to HIV. Such targets could include the number of religious leaders who have been trained or the number of local religious communities that implement the recommendations described in this report. It will be very helpful if the targets and tracking are both done as consistently as possible across religious traditions.

Second, national interreligious coalitions can raise public awareness and address complex social and cultural issues. In particular, we recommend two kinds of actions and activities:

- **Develop an HIV information and awareness campaign that includes diverse religious traditions.** The campaign would include information and educational materials, resources on the internet, materials for interfaith social media, periodicals, and a repository for official documents of various national religious organizations. Awareness events could include essay contests; public forums; and faith-based events with resource persons who would guide and counsel the audience on testing, prevention, and treatment of HIV. The campaign should specifically address stigma and discrimination and other social issues that increase the risk of HIV infection, such as gender-based violence. Depending on the societal context, it may be important to emphasize the importance of evidence-based medical treatment for HIV.
- **Facilitate dialogue between national religious leaders and networks of people living with HIV or at risk of HIV infection.** Stigmatizing attitudes can often be broken down through personal communication. National interreligious coalitions can provide platforms and venues to encourage mutually respectful dialogue between religious leaders and leaders of populations that have often felt judged and rejected by religious institutions, including marginalized populations such as men who have sex with men, sex workers, and people who inject drugs. Such dialogues will help ensure that the national faith-based response to HIV addresses the needs of those most affected by the disease.

Third, national interreligious coalitions can provide a unified voice for interaction with the public and with other national organizations. In particular, we recommend the following:

- **Ensure that religious organizations are appropriately included in planning activities and funding decisions made at the national level.** National strategies are most effective when they include all stakeholders, including religious and faith-based organizations. When these national HIV strategies include activities by religious organizations, it is important to ensure that those activities are adequately funded.
- **Advocate for laws and policies to ensure universal access to HIV prevention and treatment services.** Universal access to HIV prevention and treatment services is vital to ending the HIV epidemic by 2030. Sometimes barriers to universal access are simply the lack of resources, but often the barriers are caused by societal attitudes (fear of stigma and discrimination) or by laws and policies (fear of criminal prosecution). Religious leaders of all traditions should be at the forefront of finding ways to overcome these barriers. Depending on the cultural and legal context, different approaches may be appropriate. For example, when fear of criminal prosecution is a barrier, the most effective approach might be the repeal of problematic laws, or the establishment of sanctuary zones, or the implementation of harm reduction policies.
- **Facilitate interfaith dialogue about public policy issues related to the HIV epidemic.** There are sometimes strong disagreements among religious leaders about public policy issues. National religious coalitions can be a helpful context in which to discuss the issue, the disagreement, and the effect of different positions on the HIV epidemic. It may not always be possible to agree on policy issues, but it should always be possible to respectfully discuss them, allowing individuals to reach their own conclusions.

Note that several of these recommendations must be seen as recommendations to secular leaders, as well as recommendations to religious leaders. In some cases, effective engagement may require the development of new modes of interaction between secular and religious leaders and institutions.

### *Faith-Based Relief and Development Organizations*

Faith-based organizations have been on the front lines of fighting HIV since the early days of the epidemic. For example, many hospitals and clinics that provide HIV services in high-burden countries are affiliated with religious traditions and faith-based organizations. If we are to end the epidemic by the year 2030, these faith-based organizations must continue to be on the front lines. In addition, faith-

*"The involvement of religious communities is key to achieving universal health coverage. They are one of the very few organizations closest to the most vulnerable populations in the field."*

*-Jean-François de Lavison*

based organizations can provide support to local religious leaders and can help address the social drivers of the HIV epidemic.

Many faith-based relief and development organizations are already playing these roles very effectively. We recommend the following actions and activities for faith-based organizations that do not already have HIV programs in high-burden countries:

- **Develop policies and procedures for faith-based hospitals and clinics to ensure that HIV prevention and treatment services are provided to all who seek them without stigma, discrimination, or fear of criminal prosecution.** Several international public health organizations

have articulated guidelines for best practices in providing HIV services in medical settings, including best practices for reducing stigma and discrimination. These guidelines should be followed by all hospitals and clinics, including faith-based ones. In situations where laws present barriers to access, faith-based organizations can be instrumental in developing ways to overcome those barriers.

- **Work closely with community-based organizations.** Faith-based relief and development organizations often have access to expertise and materials that are unavailable to health workers in the wider community. Sharing the expertise will help ensure that community health workers on the front lines have the skills and resources to perform their tasks. In addition, faith-based organizations should participate in other community-based HIV activities, such as awareness and testing campaigns, referral programs, and discussion or support groups.
- **Participate in governmental policymaking about social, political, and economic issues.** Ensure that policymakers are aware of the implications of their policy choices on the future of the HIV epidemic and promote universal access to HIV prevention and treatment services.

### *Interfaith Advocacy*

Faith-based advocacy is most effective if it is done through interfaith initiatives that cross religious traditions. Some of these initiatives, especially those related to public policy, must be done at the national level. For example, several of the recommendations given earlier for national interreligious coalitions are focused on advocacy at the national level.

Advocacy at the international level is critical to ensuring that the global response to HIV continues, and even strengthens, in order to end the HIV epidemic by 2030. We recommend the following actions and activities for prominent religious leaders and interreligious coalitions:

*"To be a faith leader, a religious leader, a spiritual leader, and an individual involved in responding to HIV/AIDS is to take God's call to live and lead faithfully in service to our shared humanity."*

*-Marsha Martin*

- **Develop a strong statement of advocacy and commitment endorsed by prominent religious leaders from a broad range of traditions.** The religious response to the HIV epidemic is driven by sacred values that are shared by a broad range of religious traditions, such as a commitment to relieve human suffering and a responsibility to reach out to the marginalized and to protect the vulnerable. A public statement by prominent religious leaders about these values, together with a commitment to action and perseverance, would be a powerful tool for advocacy and solidarity as we work together to end the HIV epidemic.
- **Take every opportunity to raise awareness and spread key messages about the HIV epidemic.** Key messages include: (1) the HIV epidemic is not over and the world has a moral obligation to persevere until it is over; (2) universal access to HIV prevention and treatment services is a central requirement to ending the epidemic; and (3) our success in ending the HIV epidemic by 2030 will also depend on how effectively we address the social drivers, including not only stigma, discrimination, and gender-based violence, but also structural issues, such as poverty, malnutrition, racism, and gender inequality.
- **Maintain periodic, structured, and active consultative ties between international public health policy organizations and international interfaith and interreligious organizations.** Periodic, structured, and active consultative relationships between international organizations (such as the

United Nations system, and especially WHO and UNAIDS) and religious institutions (such as the World Council of Churches, the Vatican, INERELA+, Religions for Peace, and other faith-inspired constituencies) can ensure open communication and collaboration on public health programmatic recommendations and public health policy for broader acceptability and implementation at national levels and towards the elimination of HIV and AIDS by 2030.

Finally, there is an important role for religious leaders and faith communities in developed countries. In particular, we recommend the following actions and activities:

- **Develop HIV and AIDS awareness programs for use by local religious communities in high-income countries.** The HIV epidemic has faded from public consciousness, with many people believing that the epidemic is already over. Appropriate messaging by local religious leaders—on World AIDS Day, for example—can serve as a reminder of the need and the obligation to help end the epidemic by 2030. This is especially important in developed countries that contribute financially to the global HIV response, in order to ensure that the world has the global political will and the financial resources to persevere in the fight against HIV.
- **Advocate for continued participation in international bodies that are vital to the global response to HIV.** Developed countries have been instrumental in the global effort to fight HIV and AIDS, through both multinational organizations such as the Global Fund and through bilateral initiatives such as PEPFAR. Historically, religious leaders have been influential in launching and sustaining such programs. Similar advocacy will be vital if the world is to work collectively to end the HIV epidemic by 2030.

*"Faith has played a tremendous role in all pandemics. Many who have lost hope through these crises have found hope in their faith and belief. We wish to acknowledge faith leaders and faith communities for the role that they have played in keeping the light on in times of darkness. 2020 is no different and our wish is for health, love and wellness for all."*

*-Nuraan Osman*



## Implementation

### Measuring Success

In order to evaluate success, it is helpful to understand our proposed criteria in quantitative terms.

- **People who actively participate in religious communities meet or exceed the HIV epidemiological targets for the general population.**

Our targets for 2030 are based on the epidemiological targets for the general population: 95-95-95 on the treatment cascade, and an incidence/prevalence ratio below 0.03. Prior to 2030, it may be more useful to look at “people who actively participate in religious communities” as a demographic category within the general population: Are the data for this demographic group better, worse, or similar to the data for the general population?

- **Religiously affiliated HIV prevention and treatment centers provide services grounded in scientific evidence and reflective of best practices without stigma, discrimination, or risk of criminal prosecution.**

Religiously affiliated HIV prevention and treatment centers should publish data on whether they are meeting national and international standards.

- **People living with HIV, or at high risk of HIV infection, who wish to be members of a religious community participate in a religious community that welcomes them and affirms their value as human beings.**

One way to measure this would be through surveys of the general population. It would be useful to correlate this with other measures of societal stigma related to HIV.

- **In high-burden countries and regions, local religious communities are significantly more helpful than harmful in addressing stigma related to HIV.**

The focus of this criterion is on the effect that local religious communities have on societal stigma related to HIV, which in turn has an effect on HIV outcomes both generally and among marginalized populations. Although not explicitly stated in the criterion, it will continue to be important to measure societal stigma, and we would expect to see a correlation between measures of this criterion and measures of societal stigma.

The most difficult part of tracking this criterion involves identifying characteristics of local religious communities that are either helpful, harmful, or neutral with respect to HIV-related stigma. As described later in this document, this will require considerable research. Pending the results of the research, we suggest that our recommendations for local religious communities be used as a starting point: To the degree that a local religious community has implemented the recommendations, it can be considered helpful.

*"The faith sector can be a huge force for good in ensuring that we end AIDS as a global health threat. It is time that we utilize this force, equipping faith leaders, using the assets of the faith sector, and recording and measuring the impact."*

*-Lyn van Rooyen*

Assuming the identification of appropriate characteristics, we suggest separating the general population into four categories: (a) those who do not participate in a local religious community; (b) those who participate in a local religious community that exhibits helpful characteristics; (c) those who participate in a local religious community that exhibits harmful characteristics; and (d) those who participate in a local religious community that exhibits neutral characteristics. The ratio of (b) to (c) corresponds to this success criteria. However, the effect of helpful religious communities on overall societal stigma probably corresponds more closely to the absolute values of (b) and (c), rather than their ratio.

- **Many more people perceive religious leaders and institutions and faith-based organizations as helpful partners in the global and national response to HIV and AIDS than perceive them as barriers to ending the epidemic.**

This is essentially an opinion poll. However, three different groups might have significantly different opinions: (a) people living with HIV or at risk of HIV infection; (b) people directly involved in the response to the HIV epidemic; and (c) the general population.

It is not yet possible to measure and track these criteria. Some criteria will only require adaptation or extension of existing data gathering mechanisms. Others will require answering significant research questions, as described later in this document.

### *Building Capacity*

Local religious communities play a vital role in this strategic plan. We believe that a substantial training effort will be required in order for them to play this role effectively. Although many local religious communities have already implemented effective HIV programs, many more will require training, materials, and other resources in order to implement the recommendations effectively.

*"Poorly equipped faith communities do damage; well-equipped faith communities are powerfully helpful in mitigating the effects of HIV."*

*-Doug Fountain*

We recommend that national religious communities take primary responsibility for building capacity in their affiliated local religious communities. This would involve developing suitable materials and organizing and operating the training process. It would be best if the training and material were provided in local languages used by affiliated local religious communities.

Fortunately, national religious communities do not need to start from scratch! There are already several good AIDS and HIV training programs for faith leaders. Many of these would require only minor adaptations to fit different religious traditions and different national societal contexts. It would also be very helpful to facilitate widespread sharing of the experiences among affected communities in different countries and regions so that all local religious communities can take advantage of what has been learned in other places.

Although we recommend that national religious communities take primary responsibility, there is also an important role for national interreligious coalitions. Specifically, our first recommendation for national interreligious coalitions involves the development of "guidelines for local religious communities that reflect the national context and that cross religious boundaries." We recommend that the national religious coalition develop these guidelines before the national religious communities develop their training materials. This will ensure a degree of consistency across religious traditions within the country, which

will strengthen the overall faith response and also facilitate tracking the actions and activities of the local religious communities in a way that is consistent across religious traditions.

We expect that building the needed capacity will ultimately require a substantial investment in training over a several-year period. Traditional approaches, such as multi-day in-person workshops, may be too expensive to provide training to hundreds of thousands of religious leaders. Therefore, it will be necessary to adapt existing material to less costly approaches, such as online classes with interactive discussions.

### *Tracking Progress*

We recommend that national interreligious coalitions take primary responsibility for setting targets for the aggregated response of local religious communities to the HIV response. For example, 75% might be an appropriate target for the number of local religious communities that have effective HIV programs. If 25% of the local religious communities already have effective HIV programs, then a secondary target of training an additional 10% of the local religious leaders each year would reach the 75% target in about five years.

Tracking progress toward targets on actions and activities should be based on data provided by national religious communities about their training programs and about the HIV programs of their affiliated local religious communities. However, the data should be reported nationally only on an aggregated basis, without identifying differences in the response by different religious traditions, in order to prevent misuse of the data to attack specific religious traditions.

Although national interreligious coalitions should take the lead in tracking actions and activities, progress toward the success criteria should be tracked by independent organizations to ensure objectivity. For example, epidemiological studies could identify “members of local religious communities” as a demographic group within the general population. Similarly, surveys of the general population could include questions about HIV programs at local religious communities of which they are members. When gathering information through such surveys, the data should not be associated with specific religious traditions. Instead, the data should be associated with specific actions and activities, such as message topics during worship services or the existence of support groups.

If the HIV programs of local religious communities are effective, then there should be a correlation between progress made toward the targets set by the national interreligious coalitions and data measured by independent national surveys. For example, as the number of local religious communities with support programs for members living with HIV increases, there should be a corresponding improvement in the HIV outcomes of members of local religious communities as measured by epidemiological studies. Similarly, if a large fraction of the national population are members of local religious communities with strong stigma reduction programs, there should be a corresponding reduction in the overall national level of societal stigma as measured by independent programs.

## *Research Agenda*

There has already been considerable research into the effect of religion and religious institutions on the global response to the HIV and AIDS epidemic. We expect such research to continue. We also expect continued research on the effects of societal stigma on the HIV and AIDS epidemic.

Here, we suggest three lines of research that are particularly relevant to the strategy described above.

### **The overall effect of religious institutions on national HIV and AIDS initiatives**

It is widely believed that religious institutions have a significant effect on the HIV and AIDS response in many countries. Qualitative data has provided us with a depth of understanding about the complexity of religions' roles in HIV and AIDS initiatives. Yet, existing data does not provide definitive results about the magnitude of the effect, and further research could show where and when the effect has been cumulatively positive or negative. The goal of this line of research is to develop more definitive answers.

Research along this line could focus primarily on two questions:

- What has been the role and impact of religion and religious institutions in national programs that have been successful?
- What has been the role and impact of religion and religious institutions in national programs that have not yet proved successful?

Answering these questions will involve analyzing national programs that have been active for several years, long enough to determine their degrees of success. For example, several African countries appear to be headed toward achieving the UNAIDS Fast Track targets by 2020. If religious institutions have played a decisive role in these successes, it would confirm expectations that religious institutions must be vital and positive partners. Alternatively, if these programs have been successful despite low, or even negative, involvement by religious institutions, then it may be necessary to reevaluate our understanding of the importance of religion and religious institutions in the global AIDS response. Likewise, if analysis of not-yet-successful programs shows a weak or negative involvement of religious institutions, it would suggest that a stronger, positive involvement of religious institutions might have helped the program be more successful.

### **The effect of local religious communities on the HIV epidemic**

Studies have shown that, in many countries with a high HIV burden, large fractions of the population worship regularly, suggesting that these worship activities may have a significant effect on the HIV epidemic. However, there is little data about the degree of that effect, and even whether the effect on the epidemic has been helpful or harmful. Such data would be very useful in determining the best ways to mobilize local religious communities to help end the HIV epidemic by 2030.

Research along this line could focus primarily on the following questions:

- How many local religious communities in high-burden countries or regions have active HIV programs? What are the characteristics of these programs?
- What characteristics of local religious communities have a positive effect on HIV outcomes of their members, and what characteristics have a negative effect?
- What characteristics of local religious communities tend to reduce HIV-related societal stigma, and what characteristics tend to increase or perpetuate societal stigma?

Answering these questions will involve identifying specific characteristics and correlating them with specific HIV outcomes and with different types of stigma. For example, if a religious community actively supports members living with HIV, then it is likely that the religious community will have a positive effect on HIV outcomes of its members. On the other hand, if many members of a local religious community believe that AIDS is punishment for immoral behavior, then it is likely that the religious community has a negative effect on HIV outcomes of members living with HIV and that the religious community increases or perpetuates AIDS-related stigma.

### **The effect of specific faith-based interventions on the HIV epidemic**

It has been notoriously difficult to measure the impact of specific faith-based initiatives on the HIV epidemic. We have numerous studies with stories and anecdotal evidence, but relatively few with quantitative data. For example, such quantitative data would confirm (or deny) the effectiveness of the recommendations given in this document. The recommendations represent our collective wisdom and experience, but additional research is needed to gather more evidence about their effectiveness.

Research along this line could focus primarily on three types of question:

- What are the effects of specific faith-based interventions on the HIV outcomes of people affected by the intervention?
- What are the effects of specific faith-based interventions on HIV-related societal stigma, either among members of the religious community or in the wider community?
- What are the effects of specific faith-based interventions on different key characteristics of local religious communities that are related to the HIV epidemic?

Based on the results of this research, it may be appropriate to adjust the strategic recommendations in order to ensure we are following the most effective path toward achieving our success criteria by 2030.

*"This strategy pushes us all to find out what is working and commit to doing that as best we can—these are the steps toward the goal of ensuring that the 2020s are the last decade of the HIV and AIDS epidemic."*

*-Olivia Wilkinson*

## NEXT STEPS

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Our strategic recommendations are intended to ensure that the fifth decade of the HIV epidemic is the last and that religious institutions and other faith-based organizations play a strong role in bringing the epidemic to an end. In preparation for implementing the recommendations, we suggest six near-term initiatives to be completed before the UN High-Level Meeting on Ending AIDS in June 2021.

**1. Review the success criteria and strategic recommendations with diverse constituencies.**

Discuss the strategy and rationale with other faith-based organizations, international HIV agencies, non-governmental organizations, civil society, and affected populations, revising the success criteria and strategic recommendations as appropriate and identifying partnership opportunities.

**2. Issue a strong interfaith statement of advocacy and commitment.**

World AIDS Day in 2020 is a good opportunity for prominent religious leaders to issue a joint statement of advocacy and commitment to ending the HIV epidemic.

**3. Establish a baseline for the religious response to HIV.**

Develop preliminary answers to questions such as the following: (1) What was the role of religious institutions and faith-based organizations in cities and countries that have achieved the Fast Track targets? (2) Are HIV outcomes of members of local religious communities generally better, worse, or the same as the HIV outcomes of the general population? (3) In high-burden countries, how many local religious communities have active HIV programs? In the limited time available, it will not be possible to develop precise answers, but even general estimates will help validate our recommendations and improve our planning.

**4. Collect a list of best practices for HIV programs at local religious communities.**

Many local religious communities have accumulated many years of experience with effective HIV programs. Sharing this experience broadly will help other local religious communities initiate and strengthen their own HIV programs and will contribute to the development of a list of best practices for HIV programs of local religious communities.

**5. Engage in international planning activities.**

UNAIDS has already begun its strategic planning for the five years from 2021 through 2026. Religious leaders and institutions and other faith-based organizations should be as actively engaged in that process as possible and should be prepared to make commitments about actions and activities such as those that we are recommending.

**6. Strengthen the response of national interreligious coalitions.**

During the next year, it would be very helpful for national interreligious coalitions to focus their HIV activities in three areas: (1) respectful dialogue with people living with HIV or at risk of HIV infection; (2) establishment of national aggregated targets for training and for the actions and activities of local religious communities; and (3) active engagement with secular and community-based organizations in planning and execution of national HIV strategies.

# GUIDELINES AND PRINCIPLES

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In developing our recommendations, we have tried to follow these guidelines and principles. We believe they should also be followed by those who adopt the recommendations.

- **Focus on ending the HIV epidemic by 2030.** While there are many areas and issues where advocacy and action by religious leaders and communities are very important, our recommendations will focus on ending the HIV epidemic in the next decade. In some cases, the recommended actions and activities may help directly and immediately. In other cases, they may help indirectly or over a longer time frame. In all cases, it is important to understand how the actions and activities will help end the HIV epidemic in the next decade.
- **Address social issues directly.** Religious leaders and communities have significant influence over societal attitudes, not only among their members, but also in society at large. This influence can be used to address the social issues that are key drivers of the HIV epidemic, such as stigma and gender-based violence. Religious communities and institutions from different traditions in different contexts may have different strengths and may emphasize different approaches, but silence is not an option.
- **Actively and respectfully engage with marginalized populations.** It is critically important that religious leaders and communities work closely with people living with HIV and with members of populations that are at increased risk of HIV infection. There must be no “us vs. them”—we are all part of the response and must work together with mutual respect at all levels, including program design and implementation.
- **Work with young people.** One of the key risks of the next decade is that there will be a youth bulge in new HIV infections. Religious communities and institutions can play a significant role in educating and empowering young people to prevent HIV transmission. In addition, during the next decade, leadership of the religious response to HIV and AIDS must ensure young people’s participation in planning, decision-making, evaluating, and innovating so that the response will continue beyond the next decade.
- **Develop strong partnerships with all sectors.** The actions of religious institutions and faith-based organizations in the global response to HIV and AIDS will be strongest and most effective if done in close partnership with all sectors, including government agencies, non-governmental organizations, private organizations, and civil society, and at all levels, from global organizations to local communities. During the next decade, much of the work will be led by groups at the national level, and religious institutions must be actively involved in developing and implementing national strategies, including coordination of different religious institutions with different strengths and approaches.
- **Emphasize community-level activities.** A strong lesson from the first four decades of the HIV epidemic is that community-based responses are often the most effective. This may require local religious communities to adapt their approaches to the local circumstances and to coordinate their activities with other community-based initiatives.
- **Be informed by and contribute to scientific evidence.** There is a growing body of scientific evidence about the effectiveness of various social interventions in the response to HIV and AIDS. Such data are vitally important in helping to shape the faith-based response to the epidemic. In addition, it is important for religious institutions and faith-based organizations to contribute to such data.

- **Be as interfaith and interreligious as possible.** The religious response to HIV and AIDS will be most effective if it is broadly inclusive of diverse religious traditions. Recent examples of successful interreligious activity in public health contexts have demonstrated that this is possible. While doctrinal differences may lead different religious traditions to support different approaches, all evidence-based interventions that successfully contribute to ending the HIV epidemic by 2030 should be welcomed. The contribution of religious institutions and faith-based organizations to ending the HIV epidemic by 2030 will be significantly more effective if we are able to work together and speak with a common voice.
- **Respect doctrinal differences.** The nature of the HIV epidemic forces us to reflect deeply about the interaction between religious doctrine and public health. However, despite doctrinal differences, different religious traditions can still be encouraged and expected to make their unique successful contribution to the HIV response. It is neither appropriate nor realistic to expect or require significant changes in doctrine during the time frame of the next decade of the epidemic.



## PERSONAL STATEMENTS

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Contributors to Faith and HIV in the Next Decade provide personal reflections on the document and consultation process, considering the future of faith engagement in the HIV epidemic and the broader integration of faith perspectives in global health policy.

"I think we came out with really two concrete next steps. One, a research agenda, pulling together what do we know that's already researched, and what are the gaps that need more research. And then what is the strategy for collective action that brings together the diversity, both of those in the room and those who we work with. Because we know the path forward if we don't do anything, but we really do need to be on the path forward when we do the right thing."

*-Maeve McKean (1979–2020), Remarks given at a symposium on "Two Possible Futures: Faith Action to End AIDS," hosted at the Berkley Center on September 5, 2019*

"Faith and HIV in the Next Decade responds to a call from Georgetown colleague Maeve McKean during a September 2019 dialogue—to link continuing, creative research that moves ahead of scientific and social changes to collective action, that truly draws on shared wisdom and energy to bring about change. The vastly diverse religious communities worldwide have vital roles to play during the 2020s, combining care and compassion with a grounded appreciation for lived realities. Mobilization to address HIV has already brought public health and religious communities closer together, recalibrating understandings and moral compasses on both sides. This strategy highlights the path for a continuing journey in the decade ahead."

*-Katherine Marshall*

"We won't end the HIV epidemic by 2030 if we don't address the social issues, and we can't solve the social issues without strong action from religious communities. We already know what to do—we just need to do a lot more of it."

*-David Barstow*

"This process and the document that resulted from it achieved two things quite difficult to do these days: It relied on public health science to inform action in response to this global pandemic, and it allowed for multiple faith perspectives to be heard and respected through a process of deliberation and consensus-building. We now have a map to guide our concerted efforts for the next decade as we work together more effectively toward a world without HIV."

*-John Blevins*

"With more than 80% of the world's population identifying with a faith, and a large percent of health care delivery by faith-based institutions in the world, we cannot end the HIV epidemic without the involvement of faith communities."

*-Ulysses Burley, III*

"Sixteen years ago, I lost a good friend to HIV. Sarah was part of a large Christian organization at which I worked. Sadly, she and her friends conspired to keep her illness secret from the organization for fear of judgement. Stigma—real and assumed—robbed Sarah of vital care she could have received and kept us from walking that journey with her. Poorly equipped faith communities do damage; well-equipped faith communities are powerfully helpful in mitigating the effects of HIV. Global frameworks like this, which are well grounded, serve as guideposts for us to check our progress in assuring that faith communities are well equipped and powerfully helpful. This will help us coalesce our efforts and catalyze a next generation of Christian response."

*-Doug Fountain*

"As a religious leader living with HIV, I witnessed the powerful transformation within religious leaders and communities over the past 30 years from resisters to transformers. We can be witnesses of the end of HIV and AIDS before the end of 2030, but only if religious communities will be essential and meaningful partners with all other role players. This strategy provides the steppingstones to achieve just that."

*-Rev. Christo Greyling*

"In order to end the HIV epidemic, we must address the issues highlighted by the Black Lives Matter movement, including systemic poverty and racism."

*-George Kerr, III*

"The HIV/AIDS pandemic, TB, and COVID-19 have underlined the fact that we live in one world and that our destiny is dependent on how we take care of one another on a global scale. The interdependence and connectedness of all countries in the world, in the North and the South, have been proven by the consequences of climate change and in migration patterns of refugees. It is now highlighted by the fact that diseases know no boundaries, do not differentiate between levels of income or status in society, religious affiliation, or sexual orientation. It is also clear that no sector on its own can solve the problems we are facing—neither governments, nor health agencies, nor business, nor church or faith networks. We have to foster constant dialogue and means of collaborating formally in order to meet the global and local challenges. Faith communities have a holistic interpretation of health and well-being—more than just a medical challenge—and a spiritual ethos to build on the fact that our love and compassion for the well-being and health of everyone is rooted in the fact that God has loved us first, unconditionally. COVID-19 has underlined the fact that knowledge about the diseases facing us, love and care for one another helps us to be proactive, break the stigma associated with such diseases, and take responsibility for one another."

*-Dr. Renier Koegelenberg*

"National governments, multilateral organizations, and non-government partners in the AIDS fight at national and local levels have a great deal to gain from including religious leaders and faith-based organizations in national strategies and HIV and AIDS prevention, treatment, and care programs. They can be key to keeping AIDS on the agenda, providing services, reducing stigma, and bringing community voices to the table. Likewise, religious leaders and organizations need to take AIDS seriously, engage with the entire range of people living with HIV and other partners, and contribute to national and local strategies to end AIDS by 2030."

*-Jimmy Kolker*

"The involvement of religious communities is key to achieving universal health coverage. They are one of the very few organizations closest to the most vulnerable populations in the field. Where there is no hospital, clinic, or dispensary, they are present among the poorest; it is one of their vocations. In addition, these communities often have their own health facilities, their own networks, their own logistics that could be shared to facilitate access to health products for the most vulnerable. There are many local interreligious initiatives that could be better and more widely shared and would feed into many of our reflections at the global level. It is with more than 40 years of experience in the field of health and in contact with the poorest all over the world that I clearly affirm that without a strong involvement of religious communities in major global health approaches, universal coverage will never be achieved."

*-Jean-François de Lavison*

"When religious communities agree on a common cause, they can successfully transcend the confines of their doctrines."

*-Rev. Phumizile Mabizela*

"As we write in the preface, we must take many more helpful actions and many fewer harmful (and I might add hurtful) actions if we are to achieve our global and collective goal to end the epidemic by 2030. Addressing HIV/AIDS is about responding to our shared humanity. It is about sharing grace. To have and to be a person with an active faith is to display a strong belief and trust in God's grace as we understand God. To be a leader is to guide others toward the achievement of shared goals, believing that all things are possible. To be a faith leader, a religious leader, a spiritual leader, and an individual involved in responding to HIV/AIDS is to take God's call to live and lead faithfully in service to our shared humanity."

*-Marsha Martin*

"As fundamental elements of religious institutions, preaching and worship may be what makes a faith community most responsive to address HIV. At the end of the day it is preaching and worship and ordained-lay collaboration that will make the difference. After almost 40 years, those are what people living with and at risk for HIV still seek—faith communities where we are welcomed, supported, and loved."

*-Jesse Milan, Jr.*

"HIV/AIDS is a killer. It affected me so much when it took my elder brother and his dear wife who followed him after ten years. There has been a big change towards eliminating the epidemic. It's possible to end this epidemic if people deal with the social challenges affecting the youths and reach out to the marginalized groups. HIV/AIDS awareness, prevention, and treatment should be taught in institutions of learning, starting as early as the age of 10 years, and in youth groups in religious organizations. The young can bring a tremendous change in eliminating the epidemic. I had been living in pain whenever I remember the last time that I saw my dear late brother. In 2006, I attended a seminar at Kenyatta University, Nairobi, Kenya, about HIV/AIDS awareness and living with those affected by the virus. This changed my attitude towards the fight against the epidemic by encouraging those within my reach to know their HIV status."

*-Fatuma Nelly Muga*

"In 1991, my late husband had just been moved to his new work station as a minister in a rural parish. Although there was no HIV reported yet in that region, the predominant theology was that the infected person was being punished by God for his/her sins, and the church had nothing to do with such a person. Little did my husband know that his first assignment was to deal with the first case of one of his members who suddenly succumbed to AIDS-related complications. On the funeral day, after the casket had arrived at the burial site and mourners already gathered ready for burial, the bishop sent a message to my husband through a senior church leader with a staunch warning not to bury the dead man, "because he died of AIDS, hence should not be buried by the church." Caught between a rock and a hard place, and aware of the consequences of whichever decision he made, he chose to stand with the mourners and bury the man with dignity, and consequently face the wrath of the bishop. Our image as religious leaders has long been tainted as barriers to the elimination of stigma and discrimination around HIV. It is time now that we prove to the world that we are part of the solution, by combating wrong theologies of HIV and promoting a theology of life that respects the dignity and God's image in every human being regardless of their HIV status."

*-Rev. Dr. Lydia Mwaniki*

"The collaboration between faith, faith institutes, and healthcare structures, especially for HIV services, is essential to reach the UNAIDS Fast Track goals. To find a sustainable and successful way forward we need to learn from previous collaborations and initiatives and take success stories to improve HIV services. Faith and faith leaders play a role in health care-seeking behavior regardless. Only if we work together, can we make this an overall positive influence."

*-Martha Ndlovu-Tejema*

"Ending the HIV pandemic requires a multi-pronged response from the faith community and communities at large. Greater collaboration between governments, the private sector, development partners, and communities is vital to sustain the gains made thus far and develop strategies that will turn the tide within the remaining time. Affected communities must be prioritized and meaningfully involved, not just as recipients of services but as key contributors in prevention, treatment, and care, as well as in research. Faith communities can have massive impacts within their communities in ending the pandemic by 2030."

*-Rev. Jane Ng'ang'a*

"We cannot divorce communities from their faith and faith leaders. However, we can influence communities through their faith leaders whom they trust and believe. Communities are as informed as their leaders. It is therefore our responsibility as we seek to end AIDS to seek to influence actions of faith leaders with love and understanding."

*-Nkatha Njeru*

"HIV and AIDS has been a great epidemic challenging the entire world. Initially, Muslim faithful believed that it is a disease of sinners since it is associated with sex. However, as days passed, with clear knowledge on ways of transmission other than sex, the narrative changed. When I attended an HIV and AIDS workshop in 2004 in Nairobi, Kenya, Muslim leaders halted the training when a condom use session was introduced. But, knowing almost 25 members of my congregation who were dying silently for fear of stigma, I took it upon myself to sensitize the sheikhs to remain to the end of the session. Some had already left, but those who remained learned that condom use can be used in halal ways and save lives. Since then, I took it as a calling to counsel, guide, and pray for HIV and AIDS-positive fellow human beings. It became a passion and honor to do so. The journey continues."

*-Dr. Sheikh Hassan Kinyua Omari*

"Faith has played a tremendous role in all pandemics. Many who have lost hope through these crises have found hope in their faith and belief. We wish to acknowledge faith leaders and faith communities for the role that they have played in keeping the light on in times of darkness. 2020 is no different, and our wish is for health, love, and wellness for all."

*-Nuraan Osman*

"To end HIV and AIDS it is critical that we do not condemn religious who have used spiritual healing as a tool against modern medicine, which has resulted in clients terminating their treatments. Rather, we need to understand where they are coming from, extend a hand of love to them through champions from among them, and engage them on an ongoing basis."

*-Dr. Tonny Tumwesigye*

"From the beginning of the HIV pandemic, faith leaders have been involved—sometimes harming and sometimes helping. There is no doubt that we can no longer continue this erratic response. The faith sector can be a huge force for good in ensuring that we end AIDS as a global health threat. It is time that we utilize this force, equipping faith leaders, using the assets of the faith sector, and recording and measuring the impact."

*-Lyn van Rooyen*

"Faith and HIV in the Next Decade demonstrates the growth in our thinking in this field. This is represented most clearly in the call for a focus on the efforts of local and national faith actors (and a move away from a reliance on international actors) and a research agenda that highlights the need for evidence demonstrating effectiveness and impact of faith-based interventions in HIV. These two elements must be responsive to each other—most importantly, the research agenda will be further shaped and contextualized by questions that are relevant to local and national faith actors. This strategy pushes us all to find out what is working and commit to doing that as best we can—these are the steps toward the goal of ensuring that the 2020s are the last decade of the HIV and AIDS epidemic."

*-Olivia Wilkinson, Ph.D.*

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## **ABOUT THE BERKLEY CENTER**

The Berkley Center for Religion, Peace, and World Affairs at Georgetown University seeks a more just and peaceful world by deepening knowledge and solving problems at the intersection of religion and global affairs through research, teaching, and engaging multiple publics.

## **ABOUT THIS EFFORT**

This paper reflects the continuing efforts spurred by the September 5, 2019, event "Two Possible Futures: Faith Action to End AIDS," which was hosted at the Berkley Center and featured many of the contributors to this paper as speakers.

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